

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home OMRA-Discharge (NOD) Item Set

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| Section A | Identification Information |
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| A0050. Type of Record | |
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| Enter Code <input style="width: 100%;" type="text"/> | <ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider |
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| A0100. Facility Provider Numbers | |
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| | <p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Provider Number:</p> |
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| A0200. Type of Provider | |
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| Enter Code <input style="width: 100%;" type="text"/> | <p>Type of provider</p> <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed |
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| A0310. Type of Assessment | |
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| Enter Code <input style="width: 100%;" type="text"/> | <p>A. Federal OBRA Reason for Assessment</p> <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. None of the above |
| Enter Code <input style="width: 100%;" type="text"/> | <p>B. PPS Assessment</p> <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. None of the above |
| Enter Code <input style="width: 100%;" type="text"/> | <p>C. PPS Other Medicare Required Assessment - OMRA</p> <ol style="list-style-type: none"> 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 style="width: 100%;" type="text"/> | <p>D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2</p> <ol style="list-style-type: none"> 0. No 1. Yes |

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| A0310 continued on next page |
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| Section A | Identification Information |
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A0310. Type of Assessment - Continued

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| Enter Code <input type="checkbox"/> | E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes |
| Enter Code <input type="checkbox"/> | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above |
| Enter Code <input type="checkbox"/> | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned |

A0410. Submission Requirement

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|--|--|
| Enter Code <input type="checkbox"/> | <ol style="list-style-type: none"> 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

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| | A. First name: | B. Middle initial: |
| | C. Last name: | D. Suffix: |

A0600. Social Security and Medicare Numbers

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| | 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

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| Enter Code <input type="checkbox"/> | <ol style="list-style-type: none"> 1. Male 2. Female |
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A0900. Birth Date

| | |
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| | _____ Month Day Year |
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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 |

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| Section A | Identification Information |
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| A1100. Language |
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| Enter Code <input style="width: 30px; height: 20px;" type="text"/> | <p>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No</p> <p>1. Yes → Specify in A1100B, Preferred language</p> <p>9. Unable to determine</p> <p>B. Preferred language:</p> |
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| A1200. Marital Status |
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| Enter Code <input style="width: 30px; height: 20px;" type="text"/> | <p>1. Never married</p> <p>2. Married</p> <p>3. Widowed</p> <p>4. Separated</p> <p>5. Divorced</p> |
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| A1300. Optional Resident Items |
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| | <p>A. Medical record number:</p> <p>B. Room number:</p> <p>C. Name by which resident prefers to be addressed:</p> <p>D. Lifetime occupation(s) - put "/" between two occupations:</p> |
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| A1500. Preadmission Screening and Resident Review (PASRR) |
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Complete only if A0310A = 01, 03, 04, or 05

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| Enter Code <input style="width: 30px; height: 20px;" type="text"/> | <p>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?</p> <p>0. No → Skip to A1550, Conditions Related to ID/DD Status</p> <p>1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</p> <p>9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status</p> |
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| A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions |
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Complete only if A0310A = 01, 03, 04, or 05

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| ↓ | Check all that apply |
| <input type="checkbox"/> | A. Serious mental illness |
| <input type="checkbox"/> | B. Intellectual Disability ("mental retardation" in federal regulation) |
| <input type="checkbox"/> | C. Other related conditions |

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| Section A | Identification Information |
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A1550. Conditions Related to ID/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 ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

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| | ID/DD With Organic Condition |
| <input type="checkbox"/> | A. Down syndrome |
| <input type="checkbox"/> | B. Autism |
| <input type="checkbox"/> | C. Epilepsy |
| <input type="checkbox"/> | D. Other organic condition related to ID/DD |
| | ID/DD Without Organic Condition |
| <input type="checkbox"/> | E. ID/DD with no organic condition |
| | No ID/DD |
| <input type="checkbox"/> | Z. None of the above |

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

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| | _____ — — Month Day Year |
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A1700. Type of Entry

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| Enter Code | <input type="checkbox"/> 1. Admission <input type="checkbox"/> 2. Reentry |
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A1800. Entered From

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| Enter Code | <input type="checkbox"/> 01. Community (private home/apt., board/care, assisted living, group home) <input type="checkbox"/> 02. Another nursing home or swing bed <input type="checkbox"/> 03. Acute hospital <input type="checkbox"/> 04. Psychiatric hospital <input type="checkbox"/> 05. Inpatient rehabilitation facility <input type="checkbox"/> 06. ID/DD facility <input type="checkbox"/> 07. Hospice <input type="checkbox"/> 09. Long Term Care Hospital (LTCH) <input type="checkbox"/> 99. Other |
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A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

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| | _____ — — Month Day Year |
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A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

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| Enter Code | <input type="checkbox"/> 01. Community (private home/apt., board/care, assisted living, group home) <input type="checkbox"/> 02. Another nursing home or swing bed <input type="checkbox"/> 03. Acute hospital <input type="checkbox"/> 04. Psychiatric hospital <input type="checkbox"/> 05. Inpatient rehabilitation facility <input type="checkbox"/> 06. ID/DD facility <input type="checkbox"/> 07. Hospice <input type="checkbox"/> 08. Deceased <input type="checkbox"/> 09. Long Term Care Hospital (LTCH) <input type="checkbox"/> 99. Other |
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| Section A | Identification Information |
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| A2300. Assessment Reference Date |
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| | Observation end date: <div style="display: flex; justify-content: space-around; width: 80%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 80%;"> Month Day Year </div> |
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| A2400. Medicare Stay |
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| Enter Code <input style="width: 20px; height: 20px;" type="text"/> | 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: <div style="display: flex; justify-content: space-around; width: 80%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 80%;"> Month Day Year </div> C. End date of most recent Medicare stay - Enter dashes if stay is ongoing: <div style="display: flex; justify-content: space-around; width: 80%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 80%;"> Month Day Year </div> |
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Look back period for all items is 7 days unless another time frame is indicated

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| Section B | Hearing, Speech, and Vision |
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| B0100. Comatose |
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| Enter Code <input style="width: 20px; height: 20px;" type="text"/> | Persistent vegetative state/no discernible consciousness 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 |
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| Enter Code <input style="width: 20px; height: 20px;" type="text"/> | 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 |
|---|---|

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?

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| Enter Code <input type="checkbox"/> | 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 |
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Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

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| Enter Code <input type="checkbox"/> | Seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem |
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C1000. Cognitive Skills for Daily Decision Making

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| Enter Code <input type="checkbox"/> | 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 |
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Delirium

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

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

| | | |
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| 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 | |
| | <input type="checkbox"/> | A. Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)? |
| | <input type="checkbox"/> | 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)? |
| | <input type="checkbox"/> | 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)? |
| | <input type="checkbox"/> | 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

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| Enter Code <input type="checkbox"/> | Is there evidence of an acute change in mental status from the resident's baseline? 0. No 1. Yes |
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Section D | **Mood**

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

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| Enter Code | <p>0. No (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)</p> <p>1. Yes → Continue to D0200, Resident Mood Interview (PHQ-9©)</p> |
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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 | 2. Symptom Frequency | | 1. Symptom Presence | 2. Symptom Frequency |
|--|--------------------------|--|--|--------------------------|--------------------------|
| <p>1. Symptom Presence</p> <p>0. No (enter 0 in column 2)</p> <p>1. Yes (enter 0-3 in column 2)</p> <p>9. No response (leave column 2 blank)</p> | | <p>2. Symptom Frequency</p> <p>0. Never or 1 day</p> <p>1. 2-6 days (several days)</p> <p>2. 7-11 days (half or more of the days)</p> <p>3. 12-14 days (nearly every day)</p> | | | |
| ↓ Enter Scores in Boxes ↓ | | | | | |
| A. Little interest or pleasure in doing things | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Feeling down, depressed, or hopeless | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Trouble falling or staying asleep, or sleeping too much | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Feeling tired or having little energy | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Poor appetite or overeating | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down | <input type="checkbox"/> | | | <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"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Thoughts that you would be better off dead, or of hurting yourself in some way | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |

D0300. Total Severity Score

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|-------------|---|
| Enter Score | <p>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).</p> |
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D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

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|------------|---|
| Enter Code | <p>Was responsible staff or provider informed that there is a potential for resident self harm?</p> <p>0. No</p> <p>1. Yes</p> |
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| Section D | Mood |
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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 | 2. Symptom Frequency |
|--|---------------------------|----------------------------|
| 1. Symptom Presence | | |
| 2. Symptom Frequency | | |
| 0. No (enter 0 in column 2) | | |
| 1. Yes (enter 0-3 in column 2) | | |
| 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) | | |
| | ↓ 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

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

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| Section E | Behavior |
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E0100. Potential Indicators of Psychosis

↓ Check all that apply

- | | |
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| <input type="checkbox"/> | A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) |
| <input type="checkbox"/> | B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) |
| <input type="checkbox"/> | Z. None of the above |

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

| | | | | | | | | |
|---|---|--|--------------------------|--|--------------------------|--|--------------------------|---|
| <p>Coding:</p> <ol style="list-style-type: none"> 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 | <p>↓ Enter Codes in Boxes</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; text-align: center;"><input type="checkbox"/></td> <td>A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>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)</td> </tr> </table> | <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) |
| <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

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| <p>Enter Code</p> <input style="width: 30px; height: 20px;" type="text"/> | <p>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 determined to be consistent with resident values, preferences, or goals.</p> <ol style="list-style-type: none"> 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

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| <p>Enter Code</p> <input style="width: 30px; height: 20px;" type="text"/> | <p>Has the resident wandered?</p> <ol style="list-style-type: none"> 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 |
|---|--|

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 did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support ProvidedCode 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** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

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)

| 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"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | |

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 <input type="checkbox"/> | 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 or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period |
|--|---|

Section H**Bladder and Bowel****H0100. Appliances**

↓ Check all that apply

| | |
|--------------------------|--|
| <input type="checkbox"/> | A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) |
| <input type="checkbox"/> | B. External catheter |
| <input type="checkbox"/> | C. Ostomy (including urostomy, ileostomy, and colostomy) |
| <input type="checkbox"/> | D. Intermittent catheterization |
| <input type="checkbox"/> | Z. None of the above |

H0200. Urinary Toileting Program

| | |
|--|--|
| Enter Code <input type="checkbox"/> | A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. No → Skip to H0300, Urinary Continence 1. Yes → Continue to H0200C, Current toileting program or trial 9. Unable to determine → Continue to H0200C, Current toileting program or trial |
| Enter Code <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 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

| | |
|--------------------------|---|
| <input type="checkbox"/> | Heart/Circulation |
| <input type="checkbox"/> | I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) |
| | Genitourinary |
| <input type="checkbox"/> | I1550. Neurogenic Bladder |
| <input type="checkbox"/> | I1650. Obstructive Uropathy |
| | Infections |
| <input type="checkbox"/> | I2000. Pneumonia |
| <input type="checkbox"/> | I2100. Septicemia |
| <input type="checkbox"/> | I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) |
| | 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"/> | I5250. Huntington's Disease |
| <input type="checkbox"/> | I5300. Parkinson's Disease |
| <input type="checkbox"/> | I5350. Tourette's Syndrome |
| | Nutritional |
| <input type="checkbox"/> | I5600. Malnutrition (protein or calorie) or at risk for malnutrition |
| | Psychiatric/Mood Disorder |
| <input type="checkbox"/> | I5700. Anxiety Disorder |
| <input type="checkbox"/> | I5900. Manic Depression (bipolar disease) |
| <input type="checkbox"/> | I5950. Psychotic Disorder (other than schizophrenia) |
| <input type="checkbox"/> | I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders) |
| <input type="checkbox"/> | I6100. Post Traumatic Stress Disorder (PTSD) |
| | 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 I

Active Diagnoses

Active Diagnoses in the last 7 days - Continued

Other

18000. 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. _____

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 <input type="checkbox"/> | A. Received scheduled pain medication regimen? 0. No 1. Yes |
| Enter Code <input type="checkbox"/> | B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes |
| Enter Code <input type="checkbox"/> | 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 <input type="checkbox"/> | 0. No (resident is rarely/never understood) → Skip to J1100, Shortness of Breath 1. Yes → Continue to J0300, Pain Presence |
|--|---|

Pain Assessment Interview

J0300. Pain Presence

| | |
|--|--|
| Enter Code <input type="checkbox"/> | 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 J1100, Shortness of Breath |
|--|--|

J0400. Pain Frequency

| | |
|--|---|
| Enter Code <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 |

| | |
|------------------|--------------------------|
| Section J | Health Conditions |
|------------------|--------------------------|

| |
|--------------------------------|
| Other Health Conditions |
|--------------------------------|

| |
|---|
| J1100. Shortness of Breath (dyspnea) |
|---|

↓ Check all that apply

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring) |
| <input type="checkbox"/> | B. Shortness of breath or trouble breathing when sitting at rest |
| <input type="checkbox"/> | C. Shortness of breath or trouble breathing when lying flat |
| <input type="checkbox"/> | Z. None of the above |

| |
|-------------------------|
| J1400. Prognosis |
|-------------------------|

| | |
|---|--|
| Enter Code <input style="width: 20px; height: 20px;" type="text"/> | 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

- | | |
|--------------------------|-----------------------------|
| <input type="checkbox"/> | A. Fever |
| <input type="checkbox"/> | B. Vomiting |
| <input type="checkbox"/> | C. Dehydrated |
| <input type="checkbox"/> | D. Internal bleeding |
| <input type="checkbox"/> | Z. None of the above |

| |
|--|
| J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent |
|--|

| | |
|---|---|
| Enter Code <input style="width: 20px; height: 20px;" type="text"/> | Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or scheduled PPS), whichever is more recent? 0. No → Skip to K0200, Height and Weight 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) |
|---|---|

| |
|--|
| J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent |
|--|

↓ Enter Codes in Boxes

| | | | | | | | |
|--|---|---|---|---|---|---|---|
| Coding: 0. None 1. One 2. Two or more | <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 2px;">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</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 2px;">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</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 2px;">C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td> </tr> </table> | <input style="width: 20px; height: 20px;" type="text"/> | 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 | <input style="width: 20px; height: 20px;" type="text"/> | 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 | <input style="width: 20px; height: 20px;" type="text"/> | C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma |
| <input style="width: 20px; height: 20px;" type="text"/> | 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 | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | 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 | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma | | | | | | |

Section K**Swallowing/Nutritional Status****K0200. Height and Weight** - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

| | |
|--------------------------------|---|
| <input type="text"/> inches | A. Height (in inches). Record most recent height measure since admission/entry or reentry |
| <input type="text"/> 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 <input type="text"/> | 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 |
|------------------------------------|--|

K0310. Weight Gain

| | |
|------------------------------------|--|
| Enter Code <input type="text"/> | Gain of 5% or more in the last month or gain of 10% or more in last 6 months 0. No or unknown 1. Yes, on physician-prescribed weight-gain regimen 2. Yes, not on physician-prescribed weight-gain regimen |
|------------------------------------|--|

K0510. Nutritional ApproachesCheck all of the following nutritional approaches that were performed during the last **7 days**

| | 1. While NOT a Resident | 2. While a Resident |
|---|----------------------------|--------------------------|
| 1. While NOT a Resident Performed while NOT a resident of this facility and within the last 7 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank | | |
| 2. While a Resident Performed while a resident of this facility and within the last 7 days | | |
| | ↓ Check all that apply ↓ | |
| A. Parenteral/IV feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Feeding tube - nasogastric or abdominal (PEG) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | <input type="checkbox"/> | <input type="checkbox"/> |
| Z. None of the above | <input type="checkbox"/> | <input type="checkbox"/> |

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

| | 1. While NOT a Resident | 2. While a Resident | 3. During Entire 7 Days |
|---|----------------------------|--------------------------|----------------------------|
| 1. While NOT a Resident Performed while NOT a resident of this facility and within the last 7 days . Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank | | | |
| 2. While a Resident Performed while a resident of this facility and within the last 7 days | | | |
| 3. During Entire 7 Days Performed during the entire last 7 days | | | |
| | ↓ Enter Codes ↓ | | |
| A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more | <input type="checkbox"/> | <input type="checkbox"/> | <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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|------------------|------------------------|
| 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

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 Pressure Ulcers at Each Stage |
|------------|--|

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

| | |
|--------------|--|
| Enter Number | 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 1. Number of Stage 2 pressure ulcers |
| 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 |
| 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 |
| Enter Number | E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device |
| Enter Number | F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar |
| Enter Number | G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution 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 2. Number of these unstageable pressure ulcers that were present at time of admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |

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 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:

| | |
|--|---|
| <input style="width: 40px;" type="text"/> . <input style="width: 40px;" type="text"/> cm | A. Pressure ulcer length: Longest length from head to toe |
| <input style="width: 40px;" type="text"/> . <input style="width: 40px;" type="text"/> cm | B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length |
| <input style="width: 40px;" type="text"/> . <input style="width: 40px;" type="text"/> 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) |

| | |
|------------------|------------------------|
| Section M | Skin Conditions |
|------------------|------------------------|

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry
 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 or scheduled PPS) or last admission/entry or reentry. If no current pressure ulcer at a given stage, enter 0

| | |
|---|-------------------|
| Enter Number <input style="width:20px; height:20px;" type="text"/> | A. Stage 2 |
| Enter Number <input style="width:20px; height:20px;" type="text"/> | B. Stage 3 |
| Enter Number <input style="width:20px; height:20px;" type="text"/> | C. Stage 4 |

M0900. Healed Pressure Ulcers
 Complete only if A0310E = 0

| | |
|---|---|
| Enter Code <input style="width:20px; height:20px;" type="text"/> | <p>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</p> <p>0. No → Skip to M1030, Number of Venous and Arterial Ulcers</p> <p>1. Yes → Continue to M0900B, Stage 2</p> |
|---|---|

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

| | |
|---|-------------------|
| Enter Number <input style="width:20px; height:20px;" type="text"/> | B. Stage 2 |
| Enter Number <input style="width:20px; height:20px;" type="text"/> | C. Stage 3 |
| Enter Number <input style="width:20px; height:20px;" type="text"/> | D. Stage 4 |

M1030. Number of Venous and Arterial Ulcers

| | |
|---|---|
| Enter Number <input style="width:20px; height:20px;" type="text"/> | Enter the total number of venous and arterial ulcers present |
|---|---|

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) |
| <input type="checkbox"/> | G. Skin tear(s) |
| <input type="checkbox"/> | H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage) |
| 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

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

| | |
|------------------|--------------------|
| Section N | Medications |
|------------------|--------------------|

N0300. Injections

| | |
|---|---|
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received |
|---|---|

N0350. Insulin

| | |
|---|---|
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | 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/entry or reentry if less than 7 days |

N0410. Medications Received

Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days

| | |
|---|--|
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | A. Antipsychotic |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | B. Antianxiety |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | C. Antidepressant |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | D. Hypnotic |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin) |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | F. Antibiotic |
| Enter Days <input style="width: 30px; height: 20px;" type="text"/> | G. Diuretic |

| 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 | | <input type="checkbox"/> |
| B. Radiation | | <input type="checkbox"/> |
| Respiratory Treatments | | |
| C. Oxygen therapy | | <input type="checkbox"/> |
| E. Tracheostomy care | | <input type="checkbox"/> |
| F. Ventilator or respirator | | <input type="checkbox"/> |
| Other | | |
| H. IV medications | | <input type="checkbox"/> |
| I. Transfusions | | <input type="checkbox"/> |
| J. Dialysis | | <input type="checkbox"/> |
| K. Hospice care | | <input type="checkbox"/> |
| M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | <input type="checkbox"/> |
| O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period | | |
| Enter Code <input type="checkbox"/> | A. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season? 0. No → Continue to O0250C, If Influenza vaccine not received, state reason 1. Yes → Skip to O0300, Pneumococcal Vaccine | |
| Enter Code <input type="checkbox"/> | 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 <input type="checkbox"/> | 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 <input type="checkbox"/> | B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered | |

Section O**Special Treatments, Procedures, and Programs****O0400. Therapies - Continued**

| | |
|---|--|
| | C. Physical Therapy |
| Enter Number of Minutes <input type="text"/> | 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 <input type="text"/> | 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 <input type="text"/> | 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 |
| Enter Number of Minutes <input type="text"/> | If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date |
| Enter Number of Days <input type="text"/> | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days |
| Enter Number of Days <input type="text"/> | 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 |
| | 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 Month Day Year |
| | D. Respiratory Therapy |
| Enter Number of Days <input type="text"/> | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |

O0420. Distinct Calendar Days of Therapy

| | |
|--|--|
| Enter Number of Days <input type="text"/> | Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. |
|--|--|

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

| | |
|------------------------------------|--|
| Enter Code <input type="text"/> | 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? 0. No → Skip to O0500, Restorative Nursing Programs 1. Yes B. Date on which therapy regimen resumed: <div style="text-align: center;"> _____ Month Day Year </div> |
|------------------------------------|--|

| | |
|------------------|---|
| Section O | Special Treatments, Procedures, and Programs |
|------------------|---|

| |
|--|
| 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 |
|---|---------------------------------|
| <input style="width: 20px; height: 20px;" type="text"/> | A. Range of motion (passive) |
| <input style="width: 20px; height: 20px;" type="text"/> | B. Range of motion (active) |
| <input style="width: 20px; height: 20px;" type="text"/> | C. Splint or brace assistance |
| Number of Days | Training and Skill Practice In: |
| <input style="width: 20px; height: 20px;" type="text"/> | D. Bed mobility |
| <input style="width: 20px; height: 20px;" type="text"/> | E. Transfer |
| <input style="width: 20px; height: 20px;" type="text"/> | F. Walking |
| <input style="width: 20px; height: 20px;" type="text"/> | G. Dressing and/or grooming |
| <input style="width: 20px; height: 20px;" type="text"/> | H. Eating and/or swallowing |
| <input style="width: 20px; height: 20px;" type="text"/> | I. Amputation/prostheses care |
| <input style="width: 20px; height: 20px;" type="text"/> | J. Communication |

| | |
|------------------|-------------------|
| 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 | <div style="text-align: center; margin-bottom: 5px;">↓ Enter Codes in Boxes</div> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="padding: 5px;">Used in Bed</th> </tr> </thead> <tbody> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">A. Bed rail</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">B. Trunk restraint</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">C. Limb restraint</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">D. Other</td> </tr> <tr> <th colspan="2" style="padding: 5px;">Used in Chair or Out of Bed</th> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">E. Trunk restraint</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">F. Limb restraint</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">G. Chair prevents rising</td> </tr> <tr> <td style="text-align: center; vertical-align: top;"><input style="width: 20px; height: 20px;" type="text"/></td> <td style="padding: 5px;">H. Other</td> </tr> </tbody> </table> | | Used in Bed | <input style="width: 20px; height: 20px;" type="text"/> | A. Bed rail | <input style="width: 20px; height: 20px;" type="text"/> | B. Trunk restraint | <input style="width: 20px; height: 20px;" type="text"/> | C. Limb restraint | <input style="width: 20px; height: 20px;" type="text"/> | D. Other | Used in Chair or Out of Bed | | <input style="width: 20px; height: 20px;" type="text"/> | E. Trunk restraint | <input style="width: 20px; height: 20px;" type="text"/> | F. Limb restraint | <input style="width: 20px; height: 20px;" type="text"/> | G. Chair prevents rising | <input style="width: 20px; height: 20px;" type="text"/> | H. Other |
|---|--|--|-------------|---|-------------|---|--------------------|---|-------------------|---|----------|-----------------------------|--|---|--------------------|---|-------------------|---|--------------------------|---|----------|
| | Used in Bed | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | A. Bed rail | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | B. Trunk restraint | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | C. Limb restraint | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | D. Other | | | | | | | | | | | | | | | | | | | | |
| Used in Chair or Out of Bed | | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | E. Trunk restraint | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | F. Limb restraint | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | G. Chair prevents rising | | | | | | | | | | | | | | | | | | | | |
| <input style="width: 20px; height: 20px;" type="text"/> | H. Other | | | | | | | | | | | | | | | | | | | | |

Section Q**Participation in Assessment and Goal Setting****Q0100. Participation in Assessment**

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

Q0400. Discharge Plan

| | |
|--|--|
| Enter Code <input type="checkbox"/> | A. Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes |
|--|--|

Q0600. Referral

| | |
|--|---|
| Enter Code <input type="checkbox"/> | Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record) 0. No - referral not needed 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. Yes - referral made |
|--|---|

Section X**Correction Request****Complete Section X only if A0050 = 2 or 3**

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 |
| <input type="text"/> | 1. Nursing home (SNF/NF) |
| | 2. Swing Bed |

X0200. Name of Resident on existing record to be modified/inactivatedA. **First name:**C. **Last name:****X0300. Gender** on existing record to be modified/inactivated

| | |
|----------------------|------------------|
| Enter Code | 1. Male |
| <input type="text"/> | 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 |
| <input type="text"/> | 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. None of the above |

| | |
|----------------------|---|
| Enter Code | B. PPS Assessment |
| <input type="text"/> | 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. None of the above |

| | |
|----------------------|---|
| Enter Code | C. PPS Other Medicare Required Assessment - OMRA |
| <input type="text"/> | 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 |

X0600 continued on next page

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

| | |
|--|---|
| 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 tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above |

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

| | |
|--|---|
| | A. Assessment Reference Date - Complete only if X0600F = 99 <div style="text-align: center;"> - - Month Day Year </div> |
| | B. Discharge Date - Complete only if X0600F = 10, 11, or 12 <div style="text-align: center;"> - - Month Day Year </div> |
| | C. Entry Date - Complete only if X0600F = 01 <div style="text-align: center;"> - - Month Day Year </div> |

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 |
|--|--|

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 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. End of Therapy - Resumption (EOT-R) 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 (A0050 = 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
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:****Z0300. Insurance Billing****A. RUG billing code:****B. RUG billing version:**

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

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