Resident _____ Identifier _____ Date _____

# MINIMUM DATA SET (MDS) - Version 3.0
## RESIDENT ASSESSMENT AND CARE SCREENING
### *Swing Bed Discharge (SD) Item Set*

## Section A Identification Information

### A0050. Type of Record

Enter Code ☐

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

### 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. **None of the above**

Enter Code ☐☐

**B. PPS Assessment**

**PPS Scheduled Assessment for a Medicare Part A Stay**

01. **5-day** scheduled assessment

**PPS Unscheduled Assessment for a Medicare Part A Stay**

08. **IPA** - Interim Payment Assessment

**Not PPS Assessment**

99. **None of the above**

Enter Code ☐

**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 ☐☐

**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 ☐

**G. Type of discharge** - Complete only if A0310F = 10 or 11

1. **Planned**
2. **Unplanned**

Enter Code ☐

**G1. Is this a SNF Part A Interrupted Stay?**

0. **No**
1. **Yes** (Assessment not required at this time)

**A0310 continued on next page**

# Section A Identification Information

## A0310. Type of Assessment - Continued

Enter Code ☐

**H. Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

## A0410. Unit Certification or Licensure Designation

Enter Code ☐

1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

## 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:** ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

## A0800. Gender

Enter Code ☐

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

## A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

## A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

**Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

## Section A Identification Information

**A1010. Race**
What is your race?

**Check all that apply**

- ☐ **A.** White
- ☐ **B.** Black or African American
- ☐ **C.** American Indian or Alaska Native
- ☐ **D.** Asian Indian
- ☐ **E.** Chinese
- ☐ **F.** Filipino
- ☐ **G.** Japanese
- ☐ **H.** Korean
- ☐ **I.** Vietnamese
- ☐ **J.** Other Asian
- ☐ **K.** Native Hawaiian
- ☐ **L.** Guamanian or Chamorro
- ☐ **M.** Samoan
- ☐ **N.** Other Pacific Islander
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond
- ☐ **Z.** None of the above

**A1200. Marital Status**

Enter Code ☐

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

**A1250. Transportation (from NACHC©)**
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310G = 1 and A0310H = 1

**Check all that apply**

- ☐ **A.** Yes, it has kept me from medical appointments or from getting my medications
- ☐ **B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ **C.** No
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

# Section A Identification Information

## 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**:**

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

## Most Recent Admission/Entry or Reentry into this Facility

## A1600. Entry Date

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | – | | | – | | | | |
| Month | | | Day | | | Year | | | |

## A1700. Type of Entry

Enter Code

| |
|---|
| |

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

## A1805. Entered From

Enter Code

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

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

## A1900. Admission Date (Date this episode of care in this facility began)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | – | | | – | | | | |
| Month | | | Day | | | Year | | | |

## A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | – | | | – | | | | |
| Month | | | Day | | | Year | | | |

# Section A Identification Information

**A2105. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

**A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge**

Complete only if A0310H = 1

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date
1. **Yes** - Current reconciled medication list provided to the subsequent provider

**A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider**

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

| Check all that apply ↓ | Route of Transmission |
|---|---|
| ☐ | **A. Electronic Health Record** |
| ☐ | **B. Health Information Exchange** |
| ☐ | **C. Verbal** (e.g., in-person, telephone, video conferencing) |
| ☐ | **D. Paper-based** (e.g., fax, copies, printouts) |
| ☐ | **E. Other methods** (e.g., texting, email, CDs) |

**A2123. Provision of Current Reconciled Medication List to Resident at Discharge**

Complete only if A0310H = 1

Enter Code

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

## Section A Identification Information

**A2124. Route of Current Reconciled Medication List Transmission to Resident**

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

| Check all that apply ↓ | Route of Transmission |
|---|---|
| ☐ | **A. Electronic Health Record** (e.g., electronic access to patient portal) |
| ☐ | **B. Health Information Exchange** |
| ☐ | **C. Verbal** (e.g., in-person, telephone, video conferencing) |
| ☐ | **D. Paper-based** (e.g., fax, copies, printouts) |
| ☐ | **E. Other methods** (e.g., texting, email, CDs) |

**A2300. Assessment Reference Date**

**Observation end date:**

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

**A2400. Medicare Stay**

Enter Code ☐

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

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

**B. Start date of most recent Medicare stay:**

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

## Section B Hearing, Speech, and Vision

### B0100. Comatose

Enter Code ☐

**Persistent vegetative state/no discernible consciousness**

0. **No** → Continue to B1300, Health Literacy
1. **Yes** → Skip to GG0130, Self-Care

### B1300. Health Literacy

Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

# Section C Cognitive Patterns

**C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**
If A0310G = 2 skip to C0700. Otherwise, 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

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.

Enter Code ☐

**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. BIMS 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 Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

## Staff Assessment for Mental Status

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

## C0700. Short-term Memory OK

Enter Code ☐

**Seems or appears to recall after 5 minutes**

0. **Memory OK**
1. **Memory problem**

## C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

**Made decisions regarding tasks of daily life**

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

## Delirium

## C1310. Signs and Symptoms of Delirium (from CAM©)

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

**A. Acute Onset Mental Status Change**

Enter Code ☐

**Is there evidence of an acute change in mental status** from the resident's baseline?

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

**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**

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ **C. 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)?

☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?

- ■ **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

*Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.*

# Section D Mood

**D0100. Should Resident Mood Interview be Conducted?**

If A0310G = 2 skip to D0700. Otherwise, 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 D0150, Resident Mood Interview (PHQ-2 to 9©)

**D0150. Resident Mood Interview (PHQ-2 to 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*** | ☐ | ☐ |
| **If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.** | | |
| **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*** | ☐ | ☐ |

**D0160. Total Severity Score**

Enter Score ☐☐

**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

# Section D Mood

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

Do not conduct if Resident Mood Interview (D0150-D0160) was completed

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

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

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

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

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

## D0600. Total Severity Score

Enter Score ☐☐

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

## D0700. Social Isolation

Enter Code ☐

How often do you feel lonely or isolated from those around you?
0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

# Section E Behavior

## E0100. Potential Indicators of Psychosis

↓ Check all that apply

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

## Behavioral Symptoms

## E0200. Behavioral Symptom - Presence & Frequency

**Note presence of symptoms and their frequency**

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

↓ Enter Codes in Boxes

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

## E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

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

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

## E0900. Wandering - Presence & Frequency

Enter Code ☐

**Has the resident wandered?**

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

## Section GG | Functional Abilities and Goals - Discharge

**GG0130. Self-Care** (Assessment period is the last 3 days of the Stay)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2105 is not = 04.

**Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.**

**Coding:**

**Safety** and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

**If activity was not attempted, code reason:**

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

| 3. Discharge Performance<br>Enter Codes in Boxes ↓ | |
|---|---|
| ☐☐ | **A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| ☐☐ | **B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| ☐☐ | **C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| ☐☐ | **E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| ☐☐ | **F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable. |
| ☐☐ | **G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| ☐☐ | **H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. |

## Section GG | Functional Abilities and Goals - Discharge

**GG0170. Mobility** (Assessment period is the last 3 days of the Stay)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2105 is not = 04.

**Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.**

**Coding:**

**Safety** and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

**If activity was not attempted, code reason:**

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

| 3. Discharge Performance<br>Enter Codes in Boxes ↓ | |
|---|---|
| ☐☐ | **A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| ☐☐ | **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. |
| ☐☐ | **C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support. |
| ☐☐ | **D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| ☐☐ | **E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair). |
| ☐☐ | **F. Toilet transfer:** The ability to get on and off a toilet or commode. |
| ☐☐ | **G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. |
| ☐☐ | **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.<br>If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) |
| ☐☐ | **J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.<br>If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) |
| ☐☐ | **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. |

## Section GG | Functional Abilities and Goals - Discharge

**GG0170. Mobility** (Assessment period is the last 3 days of the Stay)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2105 is not = 04.

**Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.**

**Coding:**

**Safety** and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

*Activities may be completed with or without assistive devices.*

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

**If activity was not attempted, code reason:**

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

| **3. Discharge Performance** Enter Codes in Boxes ↓ | |
|---|---|
| ☐☐ | **L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| ☐☐ | **M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step.<br>If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| ☐☐ | **N. 4 steps:** The ability to go up and down four steps with or without a rail.<br>If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| ☐☐ | **O. 12 steps:** The ability to go up and down 12 steps with or without a rail. |
| ☐☐ | **P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| | ☐ **Q3. Does the resident use a wheelchair and/or scooter?**<br>0. **No** → Skip to H0100, Appliances<br>1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns |
| ☐☐ | **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | ☐ **RR3. Indicate the type of wheelchair or scooter used.**<br>1. **Manual**<br>2. **Motorized** |
| ☐☐ | **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | ☐ **SS3. Indicate the type of wheelchair or scooter used.**<br>1. **Manual**<br>2. **Motorized** |

# Section H Bladder and Bowel

## H0100. Appliances

↓ **Check all that apply**

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

## H0300. Urinary Continence

Enter Code ☐

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

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

## H0400. Bowel Continence

Enter Code ☐

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

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

# Section I Active Diagnoses

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

**Heart/Circulation**

- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

**Genitourinary**

- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

**Infections**

- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**

**Metabolic**

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

**Neurological**

- ☐ **I5250. Huntington's Disease**
- ☐ **I5350. Tourette's Syndrome**

**Nutritional**

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

**Psychiatric/Mood Disorder**

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

**Other**

**I8000. Additional active diagnoses**
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

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

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

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

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

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

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

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

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

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

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

# Section J Health Conditions

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

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

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. **No**
1. **Yes**

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

**J0200. Should Pain Assessment Interview be Conducted?**

If resident is comatose or if A0310G = 2 , skip to J1100, Shortness of Breath (dyspnea). Otherwise, attempt to conduct interview with all residents

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J1100, Shortness of Breath
1. **Yes** → Continue to J0300, Pain Presence

## Pain Assessment Interview

**J0300. Pain Presence**

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0510. Pain Effect on Sleep
9. **Unable to answer** → Skip to J1100, Shortness of Breath (dyspnea)

**J0510. Pain Effect on Sleep**

Enter Code ☐ Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"***
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

**J0520. Pain Interference with Therapy Activities**

Enter Code ☐ Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***
0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

**J0530. Pain Interference with Day-to-Day Activities**

Enter Code ☐ Ask resident: *"Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

# Section J Health Conditions

## Other Health Conditions

### J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

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

### J1400. Prognosis

Enter Code ☐

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

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

### J1550. Problem Conditions

↓ **Check all that apply**

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

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

Enter Code ☐

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

**Coding:**

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

↓ **Enter Codes in Boxes**

- ☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
- ☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
- ☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

# 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

| | |
|---|---|
| ☐☐ inches | **A. Height** (in inches). Record most recent height measure since admission/entry or reentry |
| ☐☐☐ pounds | **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.) |

**K0300. Weight Loss**

Enter Code ☐

**Loss of 5% or more in the last month or loss of 10% or more in last 6 months**
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

**K0310. Weight Gain**

Enter Code ☐

**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

**K0520. Nutritional Approaches**

Check all of the following nutritional approaches that apply

| **4. At Discharge**<br>Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | **4. At Discharge**<br>**Check all that apply** ↓ |
|---|---|
| **A. Parenteral/IV feeding** | ☐ |
| **B. Feeding tube** (e.g., nasogastric or abdominal (PEG)) | ☐ |
| **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | ☐ |
| **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) | ☐ |
| **Z. None of the above** | ☐ |

# Section M Skin Conditions

**Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage**

## M0100. Determination of Pressure Ulcer/Injury Risk

↓ **Check all that apply**

☐ **A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**

## M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

**Does this resident have one or more unhealed pressure ulcers/injuries?**

0. **No** → Skip to N0415, High-Risk Drug Classes: Use and Indication
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

## M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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

Enter Number ☐

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

Enter Number ☐

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

**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

Enter Number ☐

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

Enter Number ☐

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

**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

Enter Number ☐

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

Enter Number ☐

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

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

Enter Number ☐

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

Enter Number ☐

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

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

Enter Number ☐

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

Enter Number ☐

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

**M0300 continued on next page**

## Section M Skin Conditions

### M0300 - Continued

**G. Unstageable - Deep tissue injury:**

Enter Number ☐

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to N0410, Medications Received

Enter Number ☐

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

## Section N Medications

### N0415. High-Risk Drug Classes: Use and Indication

**1. Is taking**
Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days

**2. Indication noted**
If Column 1 is checked, check if there is an indication noted for all medications in the drug class

| | 1. Is taking | 2. Indication noted |
|---|---|---|
| | ↓ Check all that apply ↓ | |
| **A. Antipsychotic** | ☐ | ☐ |
| **B. Antianxiety** | ☐ | ☐ |
| **C. Antidepressant** | ☐ | ☐ |
| **D. Hypnotic** | ☐ | ☐ |
| **E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin) | ☐ | ☐ |
| **F. Antibiotic** | ☐ | ☐ |
| **G. Diuretic** | ☐ | ☐ |
| **H. Opioid** | ☐ | ☐ |
| **I. Antiplatelet** | ☐ | ☐ |
| **J. Hypoglycemic** (including insulin) | ☐ | ☐ |
| **Z. None of the above** | ☐ | |

### N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code ☐

**Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?**

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

# Section O Special Treatments, Procedures, and Programs

**O0110. Special Treatments, Procedures, and Programs**
Check all of the following treatments, procedures, and programs that were performed

| **c. At Discharge**<br>Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | **c. At Discharge**<br>**Check all that apply** ↓ |
|---|---|
| **Cancer Treatments** | |
| **A1. Chemotherapy** | ☐ |
| **A2. IV** | ☐ |
| **A3. Oral** | ☐ |
| **A10. Other** | ☐ |
| **B1. Radiation** | ☐ |
| **Respiratory Treatments** | |
| **C1. Oxygen therapy** | ☐ |
| **C2. Continuous** | ☐ |
| **C3. Intermittent** | ☐ |
| **C4. High-concentration** | ☐ |
| **D1. Suctioning** | ☐ |
| **D2. Scheduled** | ☐ |
| **D3. As needed** | ☐ |
| **E1. Tracheostomy care** | ☐ |
| **F1. Invasive Mechanical Ventilator** (ventilator or respirator) | ☐ |
| **G1. Non-invasive Mechanical Ventilator** | ☐ |
| **G2. BiPAP** | ☐ |
| **G3. CPAP** | ☐ |
| **Other** | |
| **H1. IV Medications** | ☐ |
| **H2. Vasoactive medications** | ☐ |
| **H3. Antibiotics** | ☐ |
| **H4. Anticoagulant** | ☐ |
| **H10. Other** | ☐ |
| **I1. Transfusions** | ☐ |

**O0110 continued on next page**

# Section O Special Treatments, Procedures, and Programs

**O0110. Special Treatments, Procedures, and Programs**
Check all of the following treatments, procedures, and programs that were performed

| **c. At Discharge**<br>Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | **c. At Discharge**<br>**Check all that apply** ↓ |
|---|---|
| **J1. Dialysis** | ☐ |
| **J2. Hemodialysis** | ☐ |
| **J3. Peritoneal dialysis** | ☐ |
| **K1. Hospice care** | |
| **M1. Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions) | |
| **O1. IV Access** | ☐ |
| **O2. Peripheral** | ☐ |
| **O3. Midline** | ☐ |
| **O4. Central** (e.g., PICC, tunneled, port) | ☐ |
| **None of the Above** | |
| **Z1. None of the above** | ☐ |

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

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

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

**O0300. Pneumococcal Vaccine**

Enter Code ☐

**A. Is the resident's Pneumococcal vaccination up to date**?
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0425, Part A Therapies

Enter Code ☐

**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

## O0425. Part A Therapies

Complete only if A0310H = 1

### A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

**If the sum of individual, concurrent, and group minutes is zero,** → skip to O0425B, Occupational Therapy

Enter Number of Minutes ☐☐☐☐

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days ☐☐☐

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

### B. Occupational Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

**If the sum of individual, concurrent, and group minutes is zero,** → skip to O0425C, Physical Therapy

Enter Number of Minutes ☐☐☐☐

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days ☐☐☐

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

### C. Physical Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

**If the sum of individual, concurrent, and group minutes is zero,** → skip to O0430, Distinct Calendar Days of Part A Therapy

Enter Number of Minutes ☐☐☐☐

4. **Co-treatment minutes -** record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days ☐☐☐

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

## O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days ☐☐☐

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 since the start date of the resident's most recent Medicare Part A stay (A2400B)

# Section P Restraints and Alarms

## P0100. Physical Restraints

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

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

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

## Section Q Participation in Assessment and Goal Setting

### Q0400. Discharge Plan

Enter Code ☐

**C. Is active discharge planning already occurring for the resident to return to the community?**
0. **No**
1. **Yes**

### Q0610. Referral

Enter Code ☐

**A. Has a referral been made to the Local Contact Agency (LCA)?**
0. **No**
1. **Yes**

### Q0620. Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0

Enter Code ☐

**Indicate reason why referral to LCA was not made**
1. **LCA unknown**
2. **Referral previously made**
3. **Referral not wanted**
4. **Discharge date 3 or fewer months away**
5. **Discharge date more than 3 months away**

## 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 (A0200 on existing record to be modified/inactivated)

Enter Code ☐

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

### X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

**A. First name:**

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

**C. Last name:**

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

## Section X Correction Request

**X0300. Gender** (A0800 on existing record to be modified/inactivated)

Enter Code

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

**X0400. Birth Date** (A0900 on existing record to be modified/inactivated)

Month – Day – Year

**X0500. Social Security Number** (A0600A on existing record to be modified/inactivated)

**X0600. Type of Assessment** (A0310 on existing record to be modified/inactivated)

Enter Code

**A. Federal OBRA Reason for Assessment**

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

**B. PPS Assessment**

**PPS Scheduled Assessment for a Medicare Part A Stay**

01. **5-day** scheduled assessment

**PPS Unscheduled Assessment for a Medicare Part A Stay**

08. **IPA** - Interim Payment Assessment

**Not PPS Assessment**

99. **None of the above**

Enter Code

**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

**H. Is this a SNF Part A PPS Discharge Assessment?**

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

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

**A. Assessment Reference Date** (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99

Month – Day – Year

**B. Discharge Date** (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12

Month – Day – Year

**C. Entry Date** (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01

Month – Day – Year

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

**X0800. Correction Number**

Enter Number

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

## Section X Correction Request

**X0900. Reasons for Modification -** Complete only if Type of Record is to modify a record in error (A0050 = 2)

**Check all that apply**

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

**X1050. Reasons for Inactivation -** Complete only if Type of Record is to inactivate a record in error (A0050 = 3)

**Check all that apply**

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

**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

**Z0300. Insurance Billing**

**A. Billing code:**

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

**B. 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 | | | |