Reside _____ Identifie _____ Dat _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Interim Payment Assessment (IPA) 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

1. **Admission** assessment (required by day 14)
2. **Quarterly** review assessment
3. **Annual** assessment
4. **Significant change in status** assessment
5. **Significant correction** to **prior comprehensive** assessment
6. **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**

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

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

A1110. Language

A. What is your preferred language?

Enter Code

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes**
9. **Unable to determine**

A1200. Marital Status

Enter Code

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

☐

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:

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?

No Skip to B0100, Comatose

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 B0700, Makes Self Understood
1. **Yes** → Skip to GG0130, Self-Care

B0700. Makes Self Understood

Enter Code

Ability to express ideas and wants, consider both verbal and non-verbal expression

0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

Section Cognitive

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 ("s*ock, 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. 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 Cognitive

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 D0100, Should Resident Mood Interview be Conducted?
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

Section	Moo

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

Enter Code ☐

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

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the
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 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

Section	Moo

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Section Moo

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
	☐	☐
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

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

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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 - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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**

	5. OBRA/ Interim Performance
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.	

Section GG Functional Abilities and Goals - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)
Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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**

	5. OBRA/ Interim Performance
	Enter Codes in Boxes ↓ →
	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.
	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 Skip to H0100, Appliances
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section H Bladder and Bowel

H0100. Appliances

Check all that apply

- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

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

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

H0500. Bowel Toileting Program

Enter Code ☐

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

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

Section I Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

1. **Stroke**
2. **Non-Traumatic Brain Dysfunction**
3. **Traumatic Brain Dysfunction**
4. **Non-Traumatic Spinal Cord Dysfunction**
5. **Traumatic Spinal Cord Dysfunction**
6. **Progressive Neurological Conditions**
7. **Other Neurological Conditions**
8. **Amputation**
9. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex**

Conditions I0020B. ICD

Code

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

Gastrointestinal

☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Infections

☐ **I1700. Multidrug-Resistant Organism (MDRO)**

☐ **I2000. Pneumonia**

☐ **I2100. Septicemia**

☐ **I2500. Wound Infection** (other than foot)

Metabolic

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

Neurological

☐ **I4300. Aphasia**

☐ **I4400. Cerebral Palsy**

☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke I4900. Hemiplegia or Hemiparesis**

☐ **I5100. Quadriplegia**

☐ **I5200. Multiple Sclerosis**

☐ **(MS) I5300. Parkinson's Disease**

☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

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

Pulmonary

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

☐ **I6300. Respiratory Failure**

None of Above

☐ **I7900. None of the above active diagnoses** within the last 7 days

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

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

Check all that apply

- **C. Shortness of breath** or trouble breathing **when lying flat**
- **Z. None of the above**

J1550. Problem Conditions

Check all that apply

- **A. Fever**
- **B. Vomiting**
- **Z. None of the above**

J2100. Recent Surgery Requiring Active SNF Care

Enter Code

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. **No**
1. **Yes**
8. **Unknown**

Surgical Procedures - Complete only if J2100 = 1

Check all that apply

Major Joint Replacement

J230 Knee Replacement - partial or total
0.

J231 Hip Replacement - partial or total
0.

J232 Ankle Replacement - partial or total
0.

J233 Shoulder Replacement - partial or total
0.

Spinal Surgery

J240 Involving the spinal cord or major spinal nerves
0.

J241 Involving fusion of spinal bones
0.

J242 Involving lamina, discs, or facets
0.

J249 Other major spinal surgery
9.

Other Orthopedic Surgery

J250 Repair fractures of the shoulder (including clavicle and scapula) **or arm** (but not hand)
0.

J251 Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)
0.

J252 Repair but not replace joints
0.

J253 Repair other bones (such as hand, foot, jaw)
0.

J259 Other major orthopedic surgery
9.

Neurological Surgery

J260 Involving the brain, surrounding tissue or blood vessels (excludes skull and skin but includes cranial nerves)
0.

J261 Involving the peripheral or autonomic nervous system - open or percutaneous
0.

J262 Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices

	0.
	J269 **Other major neurological surgery**
	9.
	Cardiopulmonary Surgery
	J270 **Involving the heart or major blood vessels** - open or percutaneous procedures
	0.
☐	**J271** **Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or
☐	**0.** endoscopic
	J279 **Other major cardiopulmonary surgery**
	9.
	Genitourinary Surgery
↓	**J280** **Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**0.**
☐	**J281** **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of
☐	**0.** nephrostomies or urostomies)
☐	**J289** **Other major genitourinary surgery**
	9.

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Section J Health Conditions

Surgical Procedures - Continued

Check all that apply

Other Major Surgery

- ☐ **J2900. Involving tendons, ligaments, or muscles**
- ☐ **J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
- ☐ **J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
- ☐ **J2930. Involving the breast**
- ☐ **J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
- ☐ **J5000. Other major surgery not listed above**

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

Check all that apply

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

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

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

2. While Not a Resident
Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.

3. While a Resident
Performed ***while a resident*** of this facility and within the ***last 7 days***

	2. While Not a Resident	3. While a Resident
	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)		☐
Z. None of the above	☐	☐

Section K Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

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*

	2. While a Resident	3. During Entire 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**	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. **500 cc/day or less** 2. **501 cc/day or more**		

Section M Skin Conditions

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

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this resident have one or more unhealed pressure ulcers/injuries?
0. **No** Skip to M1030, Number of Venous and Arterial Ulcers
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

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 Nu ☐

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

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

Enter Number	eschar **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**

Section M Skin Conditions

M1030. Number of Venous and Arterial Ulcers

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

M1040. Other Ulcers, Wounds and Skin Problems

Check all that apply

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

M1200. Skin and Ulcer/Injury Treatments

Check all that apply

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

Section N Medications

N0350. Insulin

Enter Days	**A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days
Enter Days	**B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner)**

	changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days

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

b. While a Resident Performed ***while a resident*** of this facility and within the ***last 14 days***	**b. While a Resident** **Check all that apply**
Cancer Treatments	
A1. Chemotherapy	☐
B1. Radiation	☐
Respiratory Treatments	
C1. Oxygen therapy	☐
D1. Suctioning	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
Other	
H1. IV Medications	☐
I1. Transfusions	☐
J1. Dialysis	☐
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐
None of the Above	
Z1. None of the above	☐

O0400. Therapies

Enter Number of Days	**D. Respiratory Therapy**
☐	**2. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

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

. .

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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

Section X Correction Request

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
1. **Admission** assessment (required by day 14)
2. **Quarterly** review assessment
3. **Annual** assessment
4. **Significant change in status** assessment
5. **Significant correction** to **prior comprehensive** assessment
6. **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**

X0700. Date on existing record to be modified/inactivated

A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600B = 08

– –
Month Day Year

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

X0800. Correction Number

Enter Number

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

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

Section X Correction Request

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

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code:

B. Version code:

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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