

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

<b>Section A</b>		<b>Identification Information</b>
<b>A0050. Type of Record</b>		
Enter Code <input type="checkbox"/>	1. <b>Add new record</b> → Continue to A0100, Facility Provider Numbers 2. <b>Modify existing record</b> → Continue to A0100, Facility Provider Numbers 3. <b>Inactivate existing record</b> Skip to X0150, Type of Provider	
<b>A0100. Facility Provider Numbers</b>		
<b>A. National Provider Identifier (NPI):</b> <input style="width: 100%; height: 20px;" type="text"/>		
<b>B. CMS Certification Number (CCN):</b> <input style="width: 100%; height: 20px;" type="text"/>		
<b>C. State Provider Number:</b> <input style="width: 100%; height: 20px;" type="text"/>		
<b>A0200. Type of Provider</b>		
Enter Code <input type="checkbox"/>	<b>Type of provider</b> 1. <b>Nursing home (SNF/NF)</b> 2. <b>Swing Bed</b>	
<b>A0310. Type of Assessment</b>		
Enter Code <input type="checkbox"/>	<b>A. Federal OBRA Reason for Assessment</b> 1. <b>Admission</b> assessment (required by day 14) 2. <b>Quarterly</b> review assessment 3. <b>Annual</b> assessment 4. <b>Significant change in status</b> assessment 5. <b>Significant correction to prior comprehensive</b> assessment 6. <b>Significant correction to prior quarterly</b> assessment 99. <b>None of the above</b>	
Enter Code <input type="checkbox"/>	<b>B. PPS Assessment</b> <b>PPS Scheduled Assessment for a Medicare Part A Stay</b> 01. <b>5-day</b> scheduled assessment <b>PPS Unscheduled Assessment for a Medicare Part A Stay</b> 08. <b>IPA</b> - Interim Payment Assessment <b>Not PPS Assessment</b> 99. <b>None of the above</b>	
Enter Code <input type="checkbox"/>	<b>E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</b> 0. <b>No</b> 1. <b>Yes</b>	
Enter Code <input type="checkbox"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>	
Enter Code <input type="checkbox"/>	<b>G. Type of discharge</b> - Complete only if A0310F = 10 or 11 1. <b>Planned</b> 2. <b>Unplanned</b>	
Enter Code <input type="checkbox"/>	<b>G1. Is this a SNF Part A Interrupted Stay?</b> 0. <b>No</b> 1. <b>Yes</b> (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

### A1000. Race/Ethnicity replaced by A1005 Ethnicity and A1010 Race

Check all that apply:

- A. American Indian or Alaska Native
- B. Asian
- C. Black or African American
- D. Hispanic or Latino
- E. Native Hawaiian or Other Pacific Islander
- F. White
-



**Section A Identification Information**

**A2000. Discharge Date**

Complete only if A0310F = 10, 11, or 12

Month		Day		Year					

**A2100. Discharge Status Replaced with A2105 Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code	<ol style="list-style-type: none"> <li>1. <del>Community</del> (private home/apt., board/care, assisted living, group home)</li> <li>2. <del>Another nursing home or swing bed</del></li> <li>3. <del>Acute hospital</del></li> <li>4. <del>Psychiatric hospital</del></li> <li>5. <del>Inpatient rehabilitation facility</del></li> <li>6. <del>ID/DD facility.</del></li> <li>7. <del>Hospice</del></li> <li>8. <del>Deceased</del></li> <li>9. <del>Long Term Care Hospital (LTCH)</del></li> <li>99. <del>Other</del></li> </ol>
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**A2300. Assessment Reference Date**

Observation end date:

Month		Day		Year					

**A2400. Medicare Stay**

Enter Code	<p><b>A. Has the resident had a Medicare-covered stay since the most recent entry?</b></p> <p>0. <del>No</del> → Skip to B0100, Comatose</p> <p>1. <b>Yes</b> → Continue to A2400B, Start date of most recent Medicare stay</p> <p><b>B. Start date of most recent Medicare stay:</b></p> <table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> <p><b>C. End date of most recent Medicare stay</b> - Enter dashes if stay is ongoing:</p> <table border="1"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td colspan="2" style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month		Day		Year												Month		Day		Year			
Month		Day		Year																													
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	<p><b>Persistent vegetative state/no discernible consciousness</b></p> <p>0. <del>No</del> → Continue to C0100, Should Brief Interview for Mental Status (C0200-C0500) be Conducted?</p> <p>1. <b>Yes</b> → Skip to G0110, Activities of Daily Living (ADL) Assistance</p>
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**Section****Cognitive****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

0. **No** (resident is rarely/never understood) Skip to and complete C0700-C1000, Staff Assessment for Mental Status  
 1. **Yes** → Continue to C0200, Repetition of Three Words

**Brief Interview for Mental Status (BIMS)****C0200. Repetition of Three Words**Enter  
Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three.*

*The words are: **sock, blue, and bed.** Now tell me the three words."*

**Number of words repeated after first attempt**

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

**C0300. Temporal Orientation** (orientation to year, month, and day)Enter  
Code

Ask resident: *"Please tell me what year it is right now."*

**A. Able to report correct year**

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter  
Code

Ask resident: *"What month are we in right now?"*

**B. Able to report correct month**

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter  
Code

Ask resident: *"What day of the week is today?"*

**C. Able to report correct day of the week**

0. **Incorrect** or no answer
1. **Correct**

**C0400. Recall**Enter  
Code

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

**A. Able to recall "sock"**

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter  
Code**B. Able to recall "blue"**

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter  
Code**C. Able to recall "bed"**

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

**C0500. 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 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**

**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

**Coding:**

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

*Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.*

<b>Section</b>	<b>Moo</b>
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**D0100. Should Resident Mood Interview be Conducted?** - If A0310G = 2 skip to E0100. 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 D0200, Resident Mood Interview (PHQ-9©)

**~~D0200. Resident Mood Interview (PHQ-9©) Replaced by D0150~~**

**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.

- |                                              |                                                |
|----------------------------------------------|------------------------------------------------|
| <b>1. Symptom Presence</b>                   | <b>2. Symptom Frequency</b>                    |
| 0. <b>No</b> (enter 0 in column 2)           | 0. <b>Never or 1 day</b>                       |
| 1. <b>Yes</b> (enter 0-3 in column 2)        | 1. <b>2-6 days</b> (several days)              |
| 9. <b>No response</b> (leave column 2 blank) | 2. <b>7-11 days</b> (half or more of the days) |
|                                              | 3. <b>12-14 days</b> (nearly every day)        |

	<b>1- Sympto m Presen ce</b>	<b>2 - Sympto m Frequen cy</b>
	<b>Enter Scores in Boxes</b>	
<b>A. Little interest or pleasure in doing things</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Feeling down, depressed, or hopeless</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Trouble falling or staying asleep, or sleeping too much</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Feeling tired or having little energy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Poor appetite or overeating</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Trouble concentrating on things, such as reading the newspaper or watching television</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>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</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Thoughts that you would be better off dead, or of hurting yourself in some way</b>	<input type="checkbox"/>	<input type="checkbox"/>

**~~D030 Total Severity Score Replaced by D0160~~**

**0.** Enter Score

**Add scores for all frequency responses in Column 2, Symptom Frequency.** Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

**Section**

**Moo**

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**Section****Moo****D0500. Staff Assessment of Resident Mood (PHQ-9-OV\*)**

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

Then move to column 2, Symptom Frequency, and indicate symptom frequency.

**1. Symptom Presence**0. **No** (enter 0 in column 2)1. **Yes** (enter 0-3 in column 2)**2. Symptom Frequency**0. **Never or 1 day**1. **2-6 days** (several days)2. **7-11 days** (half or more of the days)3. **12-14 days** (nearly every day)

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

**D0600. Total Severity Score**

Enter \_\_\_\_\_

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

<b>Section E</b>	<b>Behavior</b>										
<b>E0100. Potential Indicators of Psychosis</b>											
Check all that apply											
<input type="checkbox"/>	<b>A. Hallucinations</b> (perceptual experiences in the absence of real external sensory stimuli)										
<input type="checkbox"/>	<b>B. Delusions</b> (misconceptions or beliefs that are firmly held, contrary to reality)										
<input type="checkbox"/>	<b>Z. None of the above</b>										
<b>Behavioral Symptoms</b>											
<b>E0200. Behavioral Symptom - Presence &amp; Frequency</b>											
Note presence of symptoms and their frequency											
<b>Coding:</b> 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	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center;">Enter Codes in Boxes</th> </tr> <tr> <td style="width:10%; text-align: center;">↓</td> <td style="width:90%;"><b>A. Physical behavioral symptoms directed toward others</b> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>B. Verbal behavioral symptoms directed toward others</b> (e.g., threatening others, screaming at others, cursing at others)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td><b>C. Other behavioral symptoms not directed toward others</b> (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> </tr> </table>	Enter Codes in Boxes		↓	<b>A. Physical behavioral symptoms directed toward others</b> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)	<input type="checkbox"/>	<b>B. Verbal behavioral symptoms directed toward others</b> (e.g., threatening others, screaming at others, cursing at others)	<input type="checkbox"/>	<b>C. Other behavioral symptoms not directed toward others</b> (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)	<input type="checkbox"/>	
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<input type="checkbox"/>											
<b>E0800. Rejection of Care - Presence &amp; Frequency</b>											
Enter Code <input type="checkbox"/>	<b>Did the resident reject evaluation or care</b> (e.g., bloodwork, taking medications, ADL assistance) <b>that is necessary to achieve the resident's goals for health and well-being?</b> 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										
<b>E0900. Wandering - Presence &amp; Frequency</b>											
Enter Code <input type="checkbox"/>	<b>Has the resident wandered?</b> 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily										

**Section G****Functional Status****G0110. Activities of Daily Living (ADL) Assistance**

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

**Instructions for Rule of 3**

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

**If none of the above are met, code supervision.**

**1. ADL Self-Performance****2. ADL Support Provided**

Code for **resident's performance** over all shifts—not including setup. If the ADL activity **provided** over all occurred 3 or more times at various levels of assistance, code the most dependent—except for shifts; code regardless of resident's self total dependence, which requires full staff performance every time. performance classification

**Coding:****Coding:****Activity Occurred 3 or More Times**

0. **No** setup or physical help from staff.

0. **Independent**—no help or staff oversight at any time

1. **Setup** help only.

1. **Supervision**—oversight, encouragement or cueing

2. **One** person physical assist

2. **Limited assistance**—resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance family

3. **Two+** persons physical

3. **Extensive assistance**—resident involved in activity, staff provide weight-bearing support

8. ADL activity itself **did not occur** or

4. **Total dependence**—full staff performance every time during entire 7-day period over the

and/or non-facility staff provided care

100% of the time for that activity—

**Activity Occurred 2 or Fewer Times**

entire 7-day period

7. **Activity occurred only once or twice**—activity did occur but only once or twice

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

1. Self- Performance	2. Suppo rt
----------------------------	-------------------

**Enter Codes in Boxes**

**A. Bed mobility**—how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

**B. Transfer**—how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)

**C. Walk in room**—how resident walks between locations in his/her room

**D. Walk in corridor**—how resident walks in corridor on unit.

**E. Locomotion on unit**—how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair

**F. Locomotion off unit**—how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor,** how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair

**G. Dressing**—how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses

**H. Eating**—how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)

**I. Toilet use**—how resident uses the toilet room, commode, bedpan, or urinal; transfers

<p><del>on/off</del>  <del>toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag</del></p>		
<p><del>J. <b>Personal hygiene</b> -- how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (<b>excludes</b> baths and showers)</del></p>		

↓

<input type="checkbox"/>
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<b>Section G</b>	<b>Functional Status</b>
<b>G0120. Bathing</b>	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower ( <b>excludes</b> washing of back and hair). Code for <b>most dependent</b> in self-performance and support.	
Enter Code <input type="checkbox"/>	<p><b>A. Self-performance</b></p> <p>0. <b>Independent</b>—no help provided</p> <p>1. <b>Supervision</b>—oversight help only.</p> <p>2. <b>Physical help limited to transfer only</b></p> <p>3. <b>Physical help in part of bathing activity</b></p> <p>4. <b>Total dependence</b></p> <p>8. <b>Activity itself did not occur</b> or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period</p>

<b>Section GG</b>	<b>Functional Abilities and Goals - Discharge (End of SNF PPS Stay)</b>
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**GG0130. Self-Care** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)  
 Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS 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 him/herself 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



- |  |                                                                                                                                                                                                                                      |
|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <b>A. Eating:</b> 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>B. Oral hygiene:</b> 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. |
|  | <b>C. Toileting hygiene:</b> 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.             |
|  | <b>E. Shower/bathe self:</b> 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.                                         |
|  | <b>F. Upper body dressing:</b> The ability to dress and undress above the waist; including fasteners, if applicable.                                                                                                                 |
|  | <b>G. Lower body dressing:</b> 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 (End of SNF PPS Stay)**

**GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)

Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS 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 him/herself 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**

<b>3</b> <b>Discharge</b> <b>Performance</b>	
Enter Codes in Boxes	
<input type="text"/> <input type="text"/>	<b>A. Roll left and right:</b> The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
<input type="text"/> <input type="text"/>	<b>B. Sit to lying:</b> The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/> <input type="text"/>	<b>C. Lying to sitting on side of bed:</b> The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
<input type="text"/> <input type="text"/>	<b>D. Sit to stand:</b> The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
<input type="text"/> <input type="text"/>	<b>E. Chair/bed-to-chair transfer:</b> The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/> <input type="text"/>	<b>F. Toilet transfer:</b> The ability to get on and off a toilet or commode.
<input type="text"/> <input type="text"/>	<b>G. Car transfer:</b> 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.
	<b>I. Walk 10 feet:</b> Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 Skip to GG0170M, 1 step (curb)
	<b>J. Walk 50 feet with two turns:</b> Once standing, the ability to walk at least 50 feet and make two turns.
	<b>K. Walk 150 feet:</b> Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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





**Section GG**      **Functional Abilities and Goals - Discharge (End of SNF PPS Stay)**

**GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - Continued Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS 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 him/herself with no assistance from a helper.
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**If activity was not attempted, code reason:**

- 07. **Resident refused**
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- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

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

<b>Section H</b>	<b>Bladder and Bowel</b>
------------------	--------------------------

**H0100. Appliances**

↓ Check all that apply

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

**H0300. Urinary Continence**

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

- |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <b>0. Always continent</b><br><b>1. Occasionally incontinent</b> (less than 7 episodes of incontinence)<br><b>2. Frequently incontinent</b> (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)<br><b>3. Always incontinent</b> (no episodes of continent voiding)<br><b>9. Not rated</b> , 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

- |                          |                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <b>0. Always continent</b><br><b>1. Occasionally incontinent</b> (one episode of bowel incontinence)<br><b>2. Frequently incontinent</b> (2 or more episodes of bowel incontinence, but at least one continent bowel movement)<br><b>3. Always incontinent</b> (no episodes of continent bowel movements)<br><b>9. Not rated</b> , resident had an ostomy or did not have a bowel movement for the entire 7 days |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

<b>Section I</b>	<b>Active Diagnoses</b>
------------------	-------------------------

**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.

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C.		<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>										
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<b>Section J</b>	<b>Health Conditions</b>
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**J0100. Pain Management** - Complete for all residents, regardless of current pain level

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

Enter Code <input type="checkbox"/>	<b>A. Received scheduled pain medication regimen?</b> 0. No 1. Yes
Enter Code <input type="checkbox"/>	<b>B. Received PRN pain medications OR was offered and declined?</b> 0. No 1. Yes
Enter Code <input type="checkbox"/>	<b>C. Received non-medication intervention for pain?</b> 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 <input type="checkbox"/>	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 <input type="checkbox"/>	Ask resident: " <b>Have you had pain or hurting at any time in the last 5 days?</b> " 0. No → Skip to J1100, Shortness of Breath 1. Yes → Continue to J0400, Pain Frequency 9. Unable to answer Skip to J1100, Shortness of Breath (dyspnea)
----------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

~~**J0400. Pain Frequency**~~

Enter Code <input type="checkbox"/>	Ask resident: " <del><b>How much of the time have you experienced pain or hurting over the last 5 days?</b></del> " 1. <del><b>Almost constantly</b></del> 2. <del><b>Frequently</b></del> 3. <del><b>Occasionally</b></del> 4. <del><b>Rarely</b></del> 9. <del><b>Unable to answer</b></del>
----------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

~~**J0500. Pain Effect on Function**~~

Enter Code <input type="checkbox"/>	<del><b>A. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"</b></del> 0. <del><b>No</b></del> 1. <del><b>Yes</b></del> 9. <del><b>Unable to answer</b></del>
Enter Code <input type="checkbox"/>	<del><b>B. Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"</b></del> 0. <del><b>No</b></del> 1. <del><b>Yes</b></del> 9. <del><b>Unable to answer</b></del>

~~**J0600. Pain Intensity**~~ -- Administer ~~**ONLY ONE**~~ of the following pain intensity questions (A or B)

Enter Rating <input type="text"/>	<del><b>A. Numeric Rating Scale (00-10)</b></del> Ask resident: " <del><b>Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.</b></del> " (Show resident 00-10 pain scale) <del><b>Enter two-digit response. Enter 99 if unable to answer.</b></del>
Enter Code <input type="text"/>	<del><b>B. Verbal Descriptor Scale</b></del> Ask resident: " <del><b>Please rate the intensity of your worst pain over the last 5 days.</b></del> " (Show resident verbal scale) 1. <del><b>Mild</b></del> 2. <del><b>Moderate</b></del> 3. <del><b>Severe</b></del>

~~4. Very severe, horrible~~  
~~9. 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**

#### J1950. 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

Enter Codes in Boxes

#### Coding:

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

**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

<b>Section K</b>	<b>Swallowing/Nutritional Status</b>
------------------	--------------------------------------

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

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> inches	<b>A. Height</b> (in inches). Record most recent height measure since admission/entry or reentry
<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> pounds	<b>B. Weight</b> (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	<b>Loss of 5% or more in the last month or loss of 10% or more in last 6 months</b> 0. <b>No</b> or unknown 1. <b>Yes, on</b> physician-prescribed weight-loss regimen 2. <b>Yes, not on</b> physician-prescribed weight-loss regimen
<input style="width: 20px; height: 20px;" type="text"/>	

**K0310. Weight Gain**

Enter Code	<b>Gain of 5% or more in the last month or gain of 10% or more in last 6 months</b> 0. <b>No</b> or unknown 1. <b>Yes, on</b> physician-prescribed weight-gain regimen 2. <b>Yes, not on</b> physician-prescribed weight-gain regimen
<input style="width: 20px; height: 20px;" type="text"/>	

**K0510. Nutritional Approaches Replaced by K0520 Nutritional Approaches**

Check all of the following nutritional approaches that were performed during the last 7 days

	1. While NOT a Resident	2 While a Resident
<b>1. While NOT a Resident</b> Performed <del>while NOT a resident</del> of this facility and within the <del>last 7 days</del> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank <b>2. While a Resident:</b> Performed <del>while a resident</del> of this facility and within the <del>last 7 days</del>		
<b>Check all that apply</b>		
<del>A. Parenteral/IV feeding</del>		
<del>B. Feeding tube</del> -- nasogastric or abdominal (PEG)		
For the following items, if A0310G = 2, skip to M0100, Determination of Pressure Ulcer/Injury Risk		
<del>C. Mechanically altered diet</del> -- require change in texture of food or liquids (e.g., pureed food, thickened liquids)		<input type="checkbox"/>
<del>D. Therapeutic diet</del> (e.g., low salt, diabetic, low cholesterol)		<input type="checkbox"/>
<del>Z. None of the above</del>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Section M</b>	<b>Skin Conditions</b>
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**Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage**

<b>M0100. Determination of Pressure Ulcer/Injury Risk</b>	
Check all that apply	
<input type="checkbox"/>	<b>A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device</b>
<b>M0210. Unhealed Pressure Ulcers/Injuries</b>	
Enter Code	<b>Does this resident have one or more unhealed pressure ulcers/injuries?</b>
<input type="checkbox"/>	0. <b>No</b> Skip to N0410, Medications Received
<input type="checkbox"/>	1. <b>Yes</b> → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
<b>M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</b>	
<input type="checkbox"/>	<b>B. Stage 2:</b> 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	<b>1. Number of Stage 2 pressure ulcers</b> - If 0 Skip to M0300C, Stage 3
<input type="checkbox"/>	→
Enter Number	<b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<input type="checkbox"/>	<b>C. Stage 3:</b> 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	<b>1. Number of Stage 3 pressure ulcers</b> → If 0 Skip to M0300D, Stage 4
<input type="checkbox"/>	<b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number	<b>D. Stage 4:</b> 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	<b>1. Number of Stage 4 pressure ulcers</b> → If 0 Skip to M0300E, Unstageable - Non-removable dressing/device
<input type="checkbox"/>	<b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number	<b>E. Unstageable - Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device
Enter Number	<b>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</b> - If 0 Skip to M0300F, Unstageable - Slough and/or eschar
<input type="checkbox"/>	<b>2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number	<b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> - If 0 Skip to M0300G, Unstageable - Deep tissue injury
<input type="checkbox"/>	→
Enter Number	<b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<b>M0300 continued on next page</b>	

Section M	Skin Conditions
<b>M0300 - Continued</b>	
Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<b>G. Unstageable - Deep tissue injury:</b>
Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<b>1. Number of unstageable pressure injuries presenting as deep tissue injury</b> - If 0 Skip to N0410, Medications Received
	<b>2. Number of <u>these</u> unstageable pressure injuries that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry

Section N	Medications
<b><del>N0410. Medications Received Replaced by N0415 High-Risk Drug Classes: Use and Indication</del></b>	
<b><del>Indicate the number of DAYS the resident received the following 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. Enter "0" if medication was not received by the resident during the last 7 days</del></b>	
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Antipsychotic.</b>
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>B. Antianxiety</b>
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>C. Antidepressant.</b>
<input style="width: 30px; height: 20px;" type="text"/>	<b>D. Hypnotic.</b>
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>E. Anticoagulant</b> (e.g., warfarin, heparin, or low-molecular-weight heparin)
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>F. Antibiotic</b>
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>G. Diuretic.</b>
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	<b>H. Opioid</b>
<b>N <input style="width: 30px; height: 20px;" type="text"/> 05. Medication Intervention</b> - Complete only if A0310H = 1	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>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?</b>
	0. <b>No</b> 1. <b>Yes</b> 9. <b>NA</b> - 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****~~00100. Special Treatments, Procedures, and Programs Replaced by O)110 Special Treatments, Procedures, and Programs~~**Check all of the following treatments, procedures, and programs that were performed during the last **14 days****1. While NOT a Resident**Performed **while NOT a resident** of this facility and within the **last 14 days**. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank**2. While a Resident:**Performed **while a resident** of this facility and within the **last 14 days****1.  
While  
NOT a  
Resident****2  
.  
While  
a  
Reside  
nt**

Check all that apply

**~~K. Hospice care.~~****00250. 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 00250C, If influenza vaccine not received, state reason  
 1. **Yes** Continue to 00250B, Date influenza vaccine received

**B. Date influenza vaccine received** Complete date and skip to 00300A, 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**

**00300. Pneumococcal Vaccine**

Enter Code

**A. Is the resident's Pneumococcal vaccination up to date?**

0. **No** Continue to 00300B, If Pneumococcal vaccine not received, state reason  
 1. **Yes** Skip to 00425, 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

### 00425. 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 Minutes   
**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 Days   
**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)

**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 Days   
**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)

**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)

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

### 00430. 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)

Input boxes for number of days

Input boxes for number of days

Input boxes for number of days

Input boxes for number of days





Section	Correction
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<b>X0300. Gender</b> (A0800 on existing record to be modified/inactivated)
----------------------------------------------------------------------------

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	1. <b>Male</b> 2. <b>Female</b>
--------------------------------------------------------------------	------------------------------------

<b>X0400. Birth Date</b> (A0900 on existing record to be modified/inactivated)
--------------------------------------------------------------------------------

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Month		Day		Year

<b>X0500. Social Security Number</b> (A0600A on existing record to be modified/inactivated)
---------------------------------------------------------------------------------------------

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
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<b>X0600. Type of Assessment</b> (A0310 on existing record to be modified/inactivated)
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Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 1. <b>Admission</b> assessment (required by day 14) 2. <b>Quarterly</b> review assessment 3. <b>Annual</b> assessment 4. <b>Significant change in status</b> assessment 5. <b>Significant correction to prior comprehensive</b> assessment 6. <b>Significant correction to prior quarterly</b> assessment 99. <b>None of the above</b>
--------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<b>B. PPS Assessment</b> <b>PPS Scheduled Assessment for a Medicare Part A Stay</b> 1. <b>5-day</b> scheduled assessment <b>PPS Unscheduled Assessment for a Medicare Part A Stay</b> 08. <b>IPA</b> - Interim Payment Assessment <b>Not PPS Assessment</b> 99. <b>None of the above</b>
--------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment-return not anticipated 11. <b>Discharge</b> assessment-return anticipated 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>
--------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<input style="width: 20px; height: 20px;" type="text"/>	<b>H. Is this a SNF Part A PPS Discharge Assessment?</b> 0. <b>No</b> 1. <b>Yes</b>
---------------------------------------------------------	-------------------------------------------------------------------------------------------

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

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

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

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Month		Day		Year

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

<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Month		Day		Year

<b>C. Entry Date</b> (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01
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<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	-	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
Month		Day		Year

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

<b>X0800. Correction Number</b>
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Enter Number <input style="width: 20px; height: 20px;" type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
----------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------

**Section****Correction**

**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**

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- Day

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Year

Month

**Section Z****Assessment Administration**

**Z0300. Insurance Billing**

**A. Billing code:**

**B. Billing version:**

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**Section Z Assessment Administration**

**Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting**

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

**Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**

**A. Signature:** \_\_\_\_\_

**B. Date RN Assessment Coordinator signed assessment as complete:**

-   -      
 Month Day Year

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