

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Quarterly (NQ) Item Set

Section A	Identification Information
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A0100. Facility Provider Numbers

	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Provider Number:</p>
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A0200. Type of Provider

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>Type of provider</p> <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed
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A0310. Type of Assessment

Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>A. Federal OBRA Reason for Assessment</p> <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. Not OBRA required assessment
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>B. PPS Assessment</p> <p><u>PPS Scheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <p><u>PPS Unscheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <p><u>Not PPS Assessment</u></p> <ol style="list-style-type: none"> 99. Not PPS assessment
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>C. PPS Other Medicare Required Assessment - OMRA</p> <ol style="list-style-type: none"> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input style="width: 20px; height: 20px;" type="text"/>	<p>D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2</p> <ol style="list-style-type: none"> 0. No 1. Yes

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code <input type="checkbox"/>	E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission? 0. No 1. Yes
Enter Code <input type="checkbox"/>	F. Entry/discharge reporting 01. Entry record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility record 99. Not entry/discharge record

A0410. Submission Requirement

Enter Code <input type="checkbox"/>	1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission
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A0500. Legal Name of Resident

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

A0600. Social Security and Medicare Numbers

	A. Social Security Number: _ - _
	B. Medicare number (or comparable railroad insurance number):

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

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A0800. Gender

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

	Month - Day - Year
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A1000. Race/Ethnicity

↓ Check all that apply

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

Section A**Identification Information****A1100. Language**

Enter Code <input type="checkbox"/>	<p>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</p> <p>0. No</p> <p>1. Yes → Specify in A1100B, Preferred language</p> <p>9. Unable to determine</p> <p>B. Preferred language:</p>
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A1200. Marital Status

Enter Code <input type="checkbox"/>	<p>1. Never married</p> <p>2. Married</p> <p>3. Widowed</p> <p>4. Separated</p> <p>5. Divorced</p>
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A1300. Optional Resident Items

	<p>A. Medical record number:</p> <p>B. Room number:</p> <p>C. Name by which resident prefers to be addressed:</p> <p>D. Lifetime occupation(s) - put "/" between two occupations:</p>
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A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code <input type="checkbox"/>	<p>Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?</p> <p>0. No</p> <p>1. Yes</p> <p>9. Not a Medicaid certified unit</p>
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A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓	Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely
	MR/DD With Organic Condition
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to MR/DD
	MR/DD Without Organic Condition
<input type="checkbox"/>	E. MR/DD with no organic condition
	No MR/DD
<input type="checkbox"/>	Z. None of the above

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

Month Day Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

Month Day Year

A2300. Assessment Reference Date**Observation end date:**

Month Day Year

A2400. Medicare Stay

Enter Code

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

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

B. Start date of most recent Medicare stay:

Month Day Year

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

Month Day Year

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code <input style="width: 100%;" type="text"/>	<p>Persistent vegetative state/no discernible consciousness</p> <p>0. No → Continue to B0200, Hearing</p> <p>1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance</p>
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B0200. Hearing

Enter Code <input style="width: 100%;" type="text"/>	<p>Ability to hear (with hearing aid or hearing appliances if normally used)</p> <p>0. Adequate - no difficulty in normal conversation, social interaction, listening to TV</p> <p>1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy)</p> <p>2. Moderate difficulty - speaker has to increase volume and speak distinctly</p> <p>3. Highly impaired - absence of useful hearing</p>
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B0300. Hearing Aid

Enter Code <input style="width: 100%;" type="text"/>	<p>Hearing aid or other hearing appliance used in completing B0200, Hearing</p> <p>0. No</p> <p>1. Yes</p>
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B0600. Speech Clarity

Enter Code <input style="width: 100%;" type="text"/>	<p>Select best description of speech pattern</p> <p>0. Clear speech - distinct intelligible words</p> <p>1. Unclear speech - slurred or mumbled words</p> <p>2. No speech - absence of spoken words</p>
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B0700. Makes Self Understood

Enter Code <input style="width: 100%;" type="text"/>	<p>Ability to express ideas and wants, consider both verbal and non-verbal expression</p> <p>0. Understood</p> <p>1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time</p> <p>2. Sometimes understood - ability is limited to making concrete requests</p> <p>3. Rarely/never understood</p>
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B0800. Ability To Understand Others

Enter Code <input style="width: 100%;" type="text"/>	<p>Understanding verbal content, however able (with hearing aid or device if used)</p> <p>0. Understands - clear comprehension</p> <p>1. Usually understands - misses some part/intent of message but comprehends most conversation</p> <p>2. Sometimes understands - responds adequately to simple, direct communication only</p> <p>3. Rarely/never understands</p>
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B1000. Vision

Enter Code <input style="width: 100%;" type="text"/>	<p>Ability to see in adequate light (with glasses or other visual appliances)</p> <p>0. Adequate - sees fine detail, including regular print in newspapers/books</p> <p>1. Impaired - sees large print, but not regular print in newspapers/books</p> <p>2. Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects</p> <p>3. Highly impaired - object identification in question, but eyes appear to follow objects</p> <p>4. Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects</p>
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B1200. Corrective Lenses

Enter Code <input style="width: 100%;" type="text"/>	<p>Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision</p> <p>0. No</p> <p>1. Yes</p>
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Section C**Cognitive Patterns****C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**

Attempt to conduct interview with all residents

Enter Code

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

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

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed.** Now tell me the three words."*

Number of words repeated after first attempt

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

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

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

Enter Code

Ask resident: *"Please tell me what year it is right now."***A. Able to report correct year**

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

Enter Code

Ask resident: *"What month are we in right now?"***B. Able to report correct month**

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

Enter Code

Ask resident: *"What day of the week is today?"***C. Able to report correct day of the week**

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

C0400. Recall

Enter Code

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

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

Enter Code

B. Able to recall "blue"

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

Enter Code

C. Able to recall "bed"

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

C0500. Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)**Enter 99 if the resident was unable to complete the interview**

Section C**Cognitive Patterns****C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?**

Enter Code

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
 1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code

- Seems or appears to recall after 5 minutes**
 0. **Memory OK**
 1. **Memory problem**

C0800. Long-term Memory OK

Enter Code

- Seems or appears to recall long past**
 0. **Memory OK**
 1. **Memory problem**

C0900. Memory/Recall Ability

↓ Check all that the resident was normally able to recall

A. Current season**B. Location of own room****C. Staff names and faces****D. That he or she is in a nursing home****Z. None of the above** were recalled**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**C1300. Signs and Symptoms of Delirium (from CAM©)**Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

↓ Enter Codes in Boxes	
Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity)	<input type="text"/> A. Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
	<input type="text"/> B. Disorganized thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	<input type="text"/> C. Altered level of consciousness - Did the resident have altered level of consciousness (e.g., vigilant - startled easily to any sound or touch; lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch; stuporous - very difficult to arouse and keep aroused for the interview; comatose - could not be aroused)?
	<input type="text"/> D. Psychomotor retardation - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code

- Is there evidence of an acute change in mental status** from the resident's baseline?
 0. **No**
 1. **Yes**

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

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)**Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"**

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

If yes in column 1, then ask the resident: "About **how often** have you been bothered by this?"

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence

0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency

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

**1.
Symptom
Presence****2.
Symptom
Frequency**

↓ Enter Scores in Boxes ↓

A. Little interest or pleasure in doing things**B. Feeling down, depressed, or hopeless****C. Trouble falling or staying asleep, or sleeping too much****D. Feeling tired or having little energy****E. Poor appetite or overeating****F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down****G. Trouble concentrating on things, such as reading the newspaper or watching television****H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual****I. Thoughts that you would be better off dead, or of hurting yourself in some way****D0300. Total Severity Score**

Enter Score

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

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?

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



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

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

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

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

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

	1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
	0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2)	0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things			<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing down, depressed, or hopeless			<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much			<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy			<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating			<input type="checkbox"/>	<input type="checkbox"/>
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down			<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television			<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual			<input type="checkbox"/>	<input type="checkbox"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self			<input type="checkbox"/>	<input type="checkbox"/>
J. Being short-tempered, easily annoyed			<input type="checkbox"/>	<input type="checkbox"/>

D0600. Total Severity Score

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

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code	Was responsible staff or provider informed that there is a potential for resident self harm?
<input type="text"/>	0. No 1. Yes

Section E**Behavior****E0100. Psychosis**

↓ Check all that apply

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

Behavioral Symptoms**E0200. Behavioral Symptom - Presence & Frequency**

Note presence of symptoms and their frequency

Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	↓ Enter Codes in Boxes	
	<input type="checkbox"/>	A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	<input type="checkbox"/>	B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
	<input type="checkbox"/>	C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Enter Code <input type="checkbox"/>	Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals. 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily
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E0900. Wandering - Presence & Frequency

Enter Code <input type="checkbox"/>	Has the resident wandered? 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily
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Section G**Functional Status****G0110. Activities of Daily Living (ADL) Assistance**

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

Instructions for Rule of 3

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

If none of the above are met, code supervision.

1. ADL Self-Performance

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

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

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

- | | 1.
Self-Performance | 2.
Support |
|---|--------------------------------|--------------------------|
| | ↓ Enter Codes in Boxes ↓ | |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Walk in room - how resident walks between locations in his/her room | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Walk in corridor - how resident walks in corridor on unit | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| 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) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers) | <input type="checkbox"/> | <input type="checkbox"/> |

Section G**Functional Status****G0120. Bathing**

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code <input type="text"/>	A. Self-performance 0. Independent - no help provided 1. Supervision - oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during the entire period
Enter Code <input type="text"/>	B. Support provided (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided , above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding: 0. Steady at all times 1. Not steady, but able to stabilize without human assistance 2. Not steady, only able to stabilize with human assistance 8. Activity did not occur	↓ Enter Codes in Boxes
	<input type="text"/> A. Moving from seated to standing position
	<input type="text"/> B. Walking (with assistive device if used)
	<input type="text"/> C. Turning around and facing the opposite direction while walking
	<input type="text"/> D. Moving on and off toilet
	<input type="text"/> E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides	↓ Enter Codes in Boxes
	<input type="text"/> A. Upper extremity (shoulder, elbow, wrist, hand)
	<input type="text"/> B. Lower extremity (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ Check all that were normally used

<input type="checkbox"/>	A. Cane/crutch
<input type="checkbox"/>	B. Walker
<input type="checkbox"/>	C. Wheelchair (manual or electric)
<input type="checkbox"/>	D. Limb prosthesis
<input type="checkbox"/>	Z. None of the above were used

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

↓ Check all that apply

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

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**

H0300. Urinary Continence

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

H0400. Bowel Continence

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

H0500. Bowel Toileting Program

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

Section I**Active Diagnoses****Active Diagnoses in the last 7 days - Check all that apply**

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Heart/Circulation	
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
Genitourinary	
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
Infections	
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
Musculoskeletal	
<input type="checkbox"/>	I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
<input type="checkbox"/>	I4000. Other Fracture
Neurological	
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	I4800. Dementia (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	I5000. Paraplegia
<input type="checkbox"/>	I5100. Quadriplegia
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)
<input type="checkbox"/>	I5250. Huntington's Disease
<input type="checkbox"/>	I5300. Parkinson's Disease
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)
Nutritional	
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition

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

Psychiatric/Mood Disorder

- I5700. Anxiety Disorder**
- I5800. Depression** (other than bipolar)
- I5900. Manic Depression** (bipolar disease)
- I5950. Psychotic Disorder** (other than schizophrenia)
- I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- I6100. Post Traumatic Stress Disorder (PTSD)**

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**

Other

I8000. Additional active diagnoses

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

- A. _____
- B. _____
- C. _____
- D. _____
- E. _____
- F. _____
- G. _____
- H. _____
- I. _____
- J. _____

Section J**Health Conditions****J0100. Pain Management** - Complete for all residents, regardless of current pain levelAt any time in the last **5** days, has the resident:Enter Code **A. Been on a scheduled pain medication regimen?**

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

Enter Code **B. Received PRN pain medications?**

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

Enter Code **C. Received non-medication intervention for pain?**

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

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code

- 0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
- 1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview**J0300. Pain Presence**Enter Code Ask resident: "**Have you had pain or hurting at any time in the last 5 days?**"

- 0. **No** → Skip to J1100, Shortness of Breath
- 1. **Yes** → Continue to J0400, Pain Frequency
- 9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain FrequencyEnter Code Ask resident: "**How much of the time have you experienced pain or hurting over the last 5 days?**"

- 1. **Almost constantly**
- 2. **Frequently**
- 3. **Occasionally**
- 4. **Rarely**
- 9. **Unable to answer**

J0500. Pain Effect on FunctionEnter Code **A.** Ask resident: "**Over the past 5 days, has pain made it hard for you to sleep at night?**"

- 0. **No**
- 1. **Yes**
- 9. **Unable to answer**

Enter Code **B.** Ask resident: "**Over the past 5 days, have you limited your day-to-day activities because of pain?**"

- 0. **No**
- 1. **Yes**
- 9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)**A. Numeric Rating Scale (00-10)**Enter Rating Ask resident: "**Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.**" (Show resident 00 -10 pain scale)**Enter two-digit response. Enter 99 if unable to answer.****B. Verbal Descriptor Scale**Enter Code Ask resident: "**Please rate the intensity of your worst pain over the last 5 days.**" (Show resident verbal scale)

- 1. **Mild**
- 2. **Moderate**
- 3. **Severe**
- 4. **Very severe, horrible**
- 9. **Unable to answer**



Section J**Health Conditions****J0700. Should the Staff Assessment for Pain be Conducted?**

Enter Code

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
 1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain**J0800. Indicators of Pain or Possible Pain** in the last 5 days

↓ Check all that apply

- A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
 B. Vocal complaints of pain (e.g., that hurts, ouch, stop)
 C. Facial expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
 D. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
 Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code

- Frequency with which resident complains or shows evidence of pain or possible pain
 1. **Indicators of pain** or possible pain observed **1 to 2 days**
 2. **Indicators of pain** or possible pain observed **3 to 4 days**
 3. **Indicators of pain** or possible pain observed **daily**

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

↓ Check all that apply

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

J1400. Prognosis

Enter Code

- Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
 0. **No**
 1. **Yes**

J1550. Problem Conditions

↓ Check all that apply

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

Section J**Health Conditions****J1700. Fall History on Admission**

Complete only if A0310A = 01 or A0310E = 1

Enter Code <input type="checkbox"/>	A. Did the resident have a fall any time in the last month prior to admission? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the last 2-6 months prior to admission? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	C. Did the resident have any fracture related to a fall in the 6 months prior to admission? 0. No 1. Yes 9. Unable to determine

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code <input type="checkbox"/>	Has the resident had any falls since admission or the prior assessment (OBRA, PPS, or Discharge), whichever is more recent? 0. No → Skip to K0100, Swallowing Disorder 1. Yes → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)
--	---

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

↓ Enter Codes in Boxes

Coding: 0. None 1. One 2. Two or more	<input type="checkbox"/>	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/>	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

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**

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

<input type="text"/>	A. Height (in inches). Record most recent height measure since admission
inches	
<input type="text"/>	B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)
pounds	

K0300. Weight Loss

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

K0500. Nutritional Approaches

↓ Check all that apply

- A. Parenteral/IV feeding**
- B. Feeding tube** - nasogastric or abdominal (PEG)
- C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- Z. None of the above**

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

Enter Code	A. Proportion of total calories the resident received through parenteral or tube feeding
<input type="text"/>	1. 25% or less
	2. 26-50%
	3. 51% or more
Enter Code	B. Average fluid intake per day by IV or tube feeding
<input type="text"/>	1. 500 cc/day or less
	2. 501 cc/day or more

Section L**Oral/Dental Status****L0200. Dental**

↓ Check all that apply

- A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- F. Mouth or facial pain, discomfort or difficulty with chewing**

Section M**Skin Conditions****Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage****M0100. Determination of Pressure Ulcer Risk**

↓ Check all that apply

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- C. Clinical assessment**
- Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code **Is this resident at risk of developing pressure ulcers?**
 0. **No**
 1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**
 0. **No** → Skip to M0900, Healed Pressure Ulcers
 1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

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

Enter Number **A. Number of Stage 1 pressure ulcers**
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

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

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

2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

 Month Day Year

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

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

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

Enter Number **D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

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

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

M0300 continued on next page

Section M**Skin Conditions****M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued**

Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar 2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue 2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input type="text"/>	G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar 2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

<input type="text"/> . <input type="text"/> cm	A. Pressure ulcer length: Longest length from head to toe
<input type="text"/> . <input type="text"/> cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> . <input type="text"/> cm	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code <input type="text"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
------------------------------------	---

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0

Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4

Section M**Skin Conditions****M0900. Healed Pressure Ulcers**

Complete only if A0310E = 0

Enter Code <input type="text"/>	A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Enter Number <input type="text"/>	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0
Enter Number <input type="text"/>	B. Stage 2
Enter Number <input type="text"/>	C. Stage 3
Enter Number <input type="text"/>	D. Stage 4

M1030. Number of Venous and Arterial Ulcers

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

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

M1200. Skin and Ulcer Treatments

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

Section N

Medications

N0300. Injections

Enter Days <input type="text"/>	Record the number of days that injections of any type were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received
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N0350. Insulin

Enter Days <input type="text"/>	A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/reentry if less than 7 days
Enter Days <input type="text"/>	B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/reentry if less than 7 days

N0400. Medications Received

↓ Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days	
<input type="checkbox"/>	A. Antipsychotic
<input type="checkbox"/>	B. Antianxiety
<input type="checkbox"/>	C. Antidepressant
<input type="checkbox"/>	D. Hypnotic

Section O**Special Treatments, Procedures, and Programs****O0100. Special Treatments, Procedures, and Programs**Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. While NOT a Resident Performed while NOT a resident of this facility and within the last 14 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. While a Resident Performed while a resident of this facility and within the last 14 days	1. While NOT a Resident	2. While a Resident
↓ Check all that apply ↓		
Cancer Treatments		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Treatments		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
F. Ventilator or respirator	<input type="checkbox"/>	<input type="checkbox"/>
Other		
H. IV medications	<input type="checkbox"/>	<input type="checkbox"/>
I. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
J. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
K. Hospice care		<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		<input type="checkbox"/>

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

Enter Code <input type="checkbox"/>	A. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season? 0. No → Skip to O0250C, If Influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date vaccine received
Enter Code <input type="checkbox"/>	B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? _____ - _____ - _____ Month Day Year
Enter Code <input type="checkbox"/>	C. If Influenza vaccine not received, state reason: 1. Resident not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine due to a declared shortage 9. None of the above

O0300. Pneumococcal Vaccine

Enter Code <input type="checkbox"/>	A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies
Enter Code <input type="checkbox"/>	B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered

Section O**Special Treatments, Procedures, and Programs****O0400. Therapies****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** in the last 7 daysEnter Number of Minutes
[]**2. Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 daysEnter 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** in the last 7 days**If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date**Enter Number of Days
[]**4. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days**5. Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started**6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

- -
 Month Day Year

- -
 Month Day Year

B. Occupational TherapyEnter Number of Minutes
[]**1. Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 daysEnter Number of Minutes
[]**2. Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 daysEnter 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** in the last 7 days**If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date**Enter Number of Days
[]**4. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days**5. Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started**6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

- -
 Month Day Year

- -
 Month Day Year

C. Physical TherapyEnter Number of Minutes
[]**1. Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 daysEnter Number of Minutes
[]**2. Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 daysEnter 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** in the last 7 days**If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date**Enter Number of Days
[]**4. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days**5. Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started**6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

- -
 Month Day Year

- -
 Month Day Year

O0400 continued on next page

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

Enter Number of Days <input type="text"/>	D. Respiratory Therapy
	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Days <input type="text"/>	E. Psychological Therapy (by any licensed mental health professional)
	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

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

Enter Code <input type="text"/>	A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?
	0. No → Skip to O0500, Restorative Nursing Programs 1. Yes
	B. Date on which therapy regimen resumed:
	_____ Month Day Year

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

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

O0600. Physician Examinations

Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?
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O0700. Physician Orders

Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?
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Section P**Restraints****P0100. Physical Restraints**

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

Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	Used in Bed
	<input type="checkbox"/> A. Bed rail
	<input type="checkbox"/> B. Trunk restraint
	<input type="checkbox"/> C. Limb restraint
	<input type="checkbox"/> D. Other
	Used in Chair or Out of Bed
	<input type="checkbox"/> E. Trunk restraint
	<input type="checkbox"/> F. Limb restraint
	<input type="checkbox"/> G. Chair prevents rising
	<input type="checkbox"/> H. Other

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

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

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code <input type="checkbox"/>	A. Resident's overall goal established during assessment process 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. None of the above

Q0400. Discharge Plan

Enter Code <input type="checkbox"/>	A. Is there an active discharge plan in place for the resident to return to the community? 0. No 1. Yes → Skip to Q0600, Referral
Enter Code <input type="checkbox"/>	B. What determination was made by the resident and the care planning team regarding discharge to the community? 0. Determination not made 1. Discharge to community determined to be feasible → Skip to Q0600, Referral 2. Discharge to community determined to be not feasible → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code <input type="checkbox"/>	A. Has the resident been asked about returning to the community? 0. No 1. Yes - previous response was " no " 2. Yes - previous response was " yes " → Skip to Q0600, Referral 3. Yes - previous response was " unknown "
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other if resident is unable to respond): " Do you want to talk to someone about the possibility of returning to the community? " 0. No 1. Yes 9. Unknown or uncertain

Q0600. Referral

Enter Code <input type="checkbox"/>	Has a referral been made to the local contact agency? 0. No - determination has been made by the resident and the care planning team that contact is not required 1. No - referral not made 2. Yes
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Section X**Correction Request****X0100. Type of Record**

Enter Code <input type="text"/>	<ol style="list-style-type: none"> 1. Add new record → Skip to Z0100, Medicare Part A Billing 2. Modify existing record → Continue to X0150, Type of Provider 3. Inactivate existing record → Continue to X0150, Type of Provider
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Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code <input type="text"/>	Type of provider <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed
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X0200. Name of Resident on existing record to be modified/inactivated

	A. First name: C. Last name:
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X0300. Gender on existing record to be modified/inactivated

Enter Code <input type="text"/>	<ol style="list-style-type: none"> 1. Male 2. Female
------------------------------------	--

X0400. Birth Date on existing record to be modified/inactivated

	- - Month Day Year
--	--

X0500. Social Security Number on existing record to be modified/inactivated

	- -
--	--------------------------

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code <input type="text"/>	A. Federal OBRA Reason for Assessment <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. Not OBRA required assessment
Enter Code <input type="text"/>	B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> <ol style="list-style-type: none"> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> <ol style="list-style-type: none"> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> <ol style="list-style-type: none"> 99. Not PPS assessment

X0600 continued on next page

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

Enter Code <input type="checkbox"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="checkbox"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="checkbox"/>	F. Entry/discharge reporting 01. Entry record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility record 99. Not entry/discharge record

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

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

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request**X0800. Correction Number**

Enter Number <input type="checkbox"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
--	--

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

↓ **Check all that apply**

<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	E. End of Therapy - Resumption (EOT-R) date
<input type="checkbox"/>	Z. Other error requiring modification If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

↓ **Check all that apply**

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

Section X

Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month Day Year

Section Z**Assessment Administration****Z0100. Medicare Part A Billing**

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

Z0150. Medicare Part A Non-Therapy Billing

	A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):
	B. RUG version code:

Z0200. State Medicaid Billing (if required by the state)

	A. RUG Case Mix group:
	B. RUG version code:

Z0250. Alternate State Medicaid Billing (if required by the state)

	A. RUG Case Mix group:
	B. RUG version code:

Z0300. Insurance Billing

	A. RUG Case Mix group:
	B. RUG 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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