Appendix H: MDS 3.0 Forms

APPENDIX H MDS 3.0 FORMS

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October 2023 Appendix H-1

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Legend: X = item set is affected

na = not applicable; changed item does not affect this item set

Version 1.18.11 Changes

Section A Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|---|----|----|----|-------|-----|----|-----|----|----|
| Footer | Version incremented to 1.18.11 with an effective date 10/01/2023 | Х | Х | Х | Х | Х | Х | Х | Х | Х |
| A0300A | Item and responses retired | X | Х | Х | Х | Х | Х | Х | na | na |
| A1000 | Item and responses retired | Х | Х | Х | Х | Х | Х | Х | Х | Х |
| A1005 | New item and responses added: A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin? Check all that apply A. No, not of Hispanic, Latino/a, or Spanish origin B. Yes, Mexican, Mexican American, Chicano/a C. Yes, Puerto Rican D. Yes, Cuban E. Yes, another Hispanic, Latino/a, or Spanish origin X. Resident unable to respond Y. Resident declines to respond | X | Х | х | х | X | x | х | х | х |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| A1010 | New item and responses added: A1010. Race What is your race? Check all that apply A. White B. Black or African American C. American Indian or Alaska Native D. Asian Indian E. Chinese F. Filipino G. Japanese H. Korean I. Vietnamese J. Other Asian K. Native Hawaiian L. Guamanian or Chamorro M. Samoan N. Other Pacific Islander X. Resident unable to respond Y. Resident declines to respond Z. None of the above | X | X | X | X | X | X | X | X | X |
| A1100 | Items and responses retired | Х | Х | Х | na | Х | Х | Х | Х | Х |
| A1110 | New items and responses added: A1110. Language A. What is your preferred language? B. Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine | х | x | х | na | na | X | х | х | na |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|---|----|----|----|-------|-----|----|-----|----|----|
| A1250 | New item and responses added: A1250. Transportation (from NACHC©) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply A. Yes, it has kept me from medical appointments or from getting my medications B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need C. No X. Resident unable to respond Y. Resident declines to respond © 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC. | na | na | na | na | X | X | na | X | na |
| A1250 | New item and responses added: A1250. Transportation (from NACHC©) Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1 Check all that apply A. Yes, it has kept me from medical appointments or from getting my medications B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need C. No X. Resident unable to respond Y. Resident declines to respond © 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without written consent from NACHC. | X | x | x | na | na | na | na | na | na |

| • | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|---|--|--|--|--|--|--|--|---|--|
| ew item and responses added: I250. Transportation (from NACHC©) as lack of transportation kept you from medical appointments, meetings, work, or om getting things needed for daily living? complete only if A0310G = 1 and A0310H = 1 neck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond 2019. National Association of Community Health Centers, Inc., Association of sian Pacific Community Health Organizations, Oregon Primary Care Association. RAPARE and its resources are proprietary information of NACHC and its partners, tended for use by NACHC, its partners, and authorized recipients. Do not publish, they, or distribute this information in part or whole without written consent from ACHC. | na | na | na | na | na | na | na | na | X |
| em retired | Х | Х | Х | Х | Х | Х | na | Х | Х |
| ew item and responses added: 1805. Entered From 1. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 2. Nursing Home (long-term care facility) 3. Skilled Nursing Facility (SNF, swing beds) 4. Short-Term General Hospital (acute hospital, IPPS) 5. Long-Term Care Hospital (LTCH) 6. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 7. Inpatient Psychiatric Facility (psychiatric hospital or unit) 8. Intermediate Care Facility (ID/DD facility) 9. Hospice (home/non-institutional) 9. Hospice (institutional facility) 1. Critical Access Hospital (CAH) | X | X | X | X | X | X | na | X | Х |
| 2. Home under care of organized home health service organization 3. Not listed | | | | | | | | | |
| asia con | s lack of transportation kept you from medical appointments, meetings, work, or meeting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident declines to respond Resident declines to respond Resident declines to respond One Pacific Community Health Organizations, Oregon Primary Care Association. APARE and its resources are proprietary information of NACHC and its partners, and ed for use by NACHC, its partners, and authorized recipients. Do not publish, by, or distribute this information in part or whole without written consent from CHC. In retired we item and responses added: One Temporal Momery (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IPF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) | s lack of transportation kept you from medical appointments, meetings, work, or m getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident declines to respond Resident desident desident of Community Health Centers, Inc., Association of an Pacific Community Health Organizations, Oregon Primary Care Association. APARE and its resources are proprietary information of NACHC and its partners, and ed for use by NACHC, its partners, and authorized recipients. Do not publish, by, or distribute this information in part or whole without written consent from CHC. In retired W item and responses added: 305. Entered From Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (institutional facility) | s lack of transportation kept you from medical appointments, meetings, work, or m getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident declines to respond Resident declines to respond Resident declines to respond of Community Health Centers, Inc., Association of an Pacific Community Health Organizations, Oregon Primary Care Association. APARE and its resources are proprietary information of NACHC and its partners, and authorized recipients. Do not publish, by, or distribute this information in part or whole without written consent from CHC. In retired X X Witem and responses added: 305. Entered From Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IPKF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (institutional facility) | s lack of transportation kept you from medical appointments, meetings, work, or m getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident unable to respond Resident declines to respond Resident declines to respond Resident unable to respond respondent systems, or from Resident unable to respond Resident unable to respond respondent systems, or from Resident unable to respond Resident unabl | s lack of transportation kept you from medical appointments, meetings, work, or m getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No na | s lack of transportation kept you from medical appointments, meetings, work, or m getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident unable to respond Resident declines to respond With the time of time of the time of the time of tim | s lack of transportation kept you from medical appointments, meetings, work, or no getting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident declines to respond Resident declines to respond Resident declines to respond In a na | s lack of transportation kept you from medical appointments, meetings, work, or meeting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident declines to respond Resident unable | s lack of transportation kept you from medical appointments, meetings, work, or meeting things needed for daily living? mplete only if A0310G = 1 and A0310H = 1 eck all that apply Yes, it has kept me from medical appointments or from getting my medications Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need No Resident unable to respond Resident unable to respond Resident declines to respond Resident unable to respo |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| A2105 | New item and responses added: A2105. Discharge Status Complete only if A0310F = 10, 11, or 12 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 13. Deceased 99. Not listed → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge | X | X | x | na | na | X | na | X | X |
| A2105 | New item and responses added: A2105. Discharge Status Complete only if A0310F = 10, 11, or 12 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 13. Deceased 99. Not listed | na | na | na | X | na | na | na | na | na |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|---|----|----|----|-------|-----|----|-----|----|----|
| A2121 | New item and responses added: A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge Complete only if A0310H = 1 and A2105 = 02-12 At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? 0. No - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. Yes - Current reconciled medication list provided to the subsequent provider | Х | х | na | na | na | na | na | na | na |
| A2121 | New item and responses added: A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge Complete only if A0310H = 1 and A2105 = 02-12 At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? 0. No - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the subsequent provider | na | na | х | na | na | х | na | х | х |
| A2121 | New item and responses added: A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge Complete only if A0310H = 1 At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? 0. No - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the subsequent provider | na | na | na | na | Х | na | na | na | na |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| A2122 | New item and responses added: A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider. Complete only if A2121 = 1 Route of Transmission Check all that apply A. Electronic Health Record B. Health Information Exchange C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other methods (e.g., texting, email, CDs) | X | X | X | na | X | X | na | X | X |
| A2123 | New item and responses added: A2123. Provision of Current Reconciled Medication List to Resident at Discharge Complete only if A0310H = 1 and A2105 = 01, 99 At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 0. No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver | х | X | na | na | na | na | na | na | na |
| A2123 | New item and responses added: A2123. Provision of Current Reconciled Medication List to Resident at Discharge Complete only if A0310H = 1 and A2105 = 01, 99 At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 0. No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver | na | na | Х | na | na | x | na | х | х |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| A2124 | New item and responses added: A2124. Route of Current Reconciled Medication List Transmission to Resident Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver. Complete only if A2123 = 1 Route of Transmission Check all that apply A. Electronic Health Record (e.g., electronic access to patient portal) B. Health Information Exchange C. Verbal (e.g., in-person, telephone, video conferencing) D. Paper-based (e.g., fax, copies, printouts) E. Other methods (e.g., texting, email, CDs) | x | X | X | na | na | X | na | X | Х |
| A2200 | Item and response removed | na | na | na | na | na | Х | na | na | na |
| A2400 | Item revised: Skip pattern for option 0 modified to: 0. No → Skip to B1300, Health Literacy | na | na | na | na | Х | na | na | na | na |

Section B Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| B0100 | Item revised: Skip pattern for option 1 modified to: 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities | Х | Х | na | na | na | х | na | х | na |
| B0100 | Item revised: Skip pattern for option 0 modified to: 0. No → Continue to B1300, Health Literacy | na | na | Х | na | na | na | na | na | Х |
| B0100 | Item revised: Skip pattern for option 1 modified to: 1. Yes → Skip to GG0130, Self-Care | na | na | X | na | na | na | Х | na | х |
| B1300 | New item and responses added: B1300. Health Literacy Complete only if A0310B = 01 or A0310G = 1 and A0310H = 1 How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License. | X | X | X | na | na | X | na | X | × |
| B1300 | New item and responses added: B1300. Health Literacy How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License. | na | na | na | na | X | na | na | na | na |

Section C Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| C0100 | New items and responses added: C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all residents No (resident is rarely/never understood) → Skip to and complete C1310. Signs and Symptoms of Delirium (from CAM©) Yes → Continue to C0200, Repetition of Three Words | na | na | na | na | Х | na | na | na | na |
| C0200 | New items and responses added: Brief Interview for Mental Status (BIMS) C0200. Repetition of Three Words 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. | na | na | na | na | Х | na | na | na | na |
| C0300 | New items and responses added: C0300. Temporal Orientation (orientation to year, month, and day) 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 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 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 | na | na | na | na | X | na | na | na | na |
| C0400 | Correct New items and responses added: | na | na | na | na | Х | na | na | na | |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|---|----|----|----|-------|-----|----|-----|----|-----|
| | C0400. Recall | | | | | | | | | |
| | Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" | | | | | | | | | |
| | If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. | | | | | | | | | |
| | A. Able to recall "sock" | | | | | | | | | |
| | 0. No - could not recall | | | | | | | | | |
| | 1. Yes, after cueing ("something to wear") | | | | | | | | | |
| | 2. Yes, no cue required | | | | | | | | | |
| | B. Able to recall "blue" | | | | | | | | | |
| | 0. No - could not recall | | | | | | | | | |
| | 1. Yes, after cueing ("a color") | | | | | | | | | |
| | 2. Yes, no cue required | | | | | | | | | |
| | C. Able to recall "bed" | | | | | | | | | |
| | 0. No - could not recall | | | | | | | | | |
| | 1. Yes, after cueing ("a piece of furniture") | | | | | | | | | |
| | 2. Yes, no cue required | | | | | | | | | |
| | New items and responses added: | | | | | | | | | |
| C0500 | C0500. BIMS Summary Score | no | no | no | no | × | no | no | no | na |
| C0300 | Add scores for questions C0200-C0400 and fill in total score (00-15) | na | na | na | na | ^ | na | na | na | IIa |
| | Enter 99 if the resident was unable to complete the interview | | | | | | | | | |
| C0900D | Item revised: Option D modified to: | | | | | | | | | |
| C0900D | D. That they are in a nursing home/hospital swing bed | X | Х | na | na | na | Х | na | X | na |
| | Item revised: Copyright language modified to: | | | | | | | | | |
| C1310 | Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion | Х | Х | X | na | na | X | na | X | X |
| 0.0.0 | Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be | | | | ii.a | 110 | | 110 | | |
| | reproduced without permission. | | | | | | | | | |
| | New items and responses added: | | | | | | | | | |
| | Delirium | | | | | | | | | |
| | C1310. Signs and Symptoms of Delirium (from CAM©) | | | | | | | | | |
| | A. Acute Onset Mental Status Change | | | | | | | | | |
| | Is there evidence of an acute change in mental status from the resident's baseline? 0. No | | | | | | | | | |
| C1310 | 1. Yes | na | na | na | na | X | na | na | na | na |
| | Coding: | | | | | | | | | |
| | O. Behavior not present | | | | | | | | | |
| | Behavior continuously present, does not fluctuate | | | | | | 1 | 1 | | |
| | Behavior present, fluctuates (comes and goes, changes in severity) | | | | | | 1 | 1 | | |
| | | | | | | | | | | |
| | Enter Codes in Boxes | | | | | | 1 | 1 | | |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|------|--|----|----|----|-------|-----|----|-----|----|----|
| | B. Inattention - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? | | | | | | | | | |
| | C. Disorganized Thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? | | | | | | | | | |
| | D. Altered Level of Consciousness - Did the resident have altered level of consciousness, as indicated by any of the following criteria? | | | | | | | | | |
| | ■ vigilant - startled easily to any sound or touch | | | | | | | | | |
| | lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch | | | | | | | | | |
| | ■ stuporous - very difficult to arouse and keep aroused for the interview | | | | | | | | | |
| | ■ comatose - could not be aroused | | | | | | | | | |
| | Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission. | | | | | | | | | |

Section D Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| D0100 | New items and responses added: D0100. Should Resident Mood Interview be Conducted? Attempt to conduct interview with all residents 0. No (resident is rarely/never understood) → Skip to D0700, Social Isolation 1. Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©) | na | na | na | na | х | na | na | na | na |
| D0100 | Item revised: Skip pattern for option 1 modified to: D0100. Should Resident Mood Interview be Conducted? 1. Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©). | Х | Х | na | na | na | Х | Х | Х | na |
| D0100 | Item revised: Instructional language and skip pattern modified for option 1 to: D0100. Should Resident Mood Interview be Conducted? If A0310G = 2 skip to D0700. Otherwise, attempt to conduct interview with all residents 1. Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©). | na | na | х | na | na | na | na | na | х |
| D0150 | New items and responses added: D0150. Resident Mood Interview (PHQ-2 to 9©) Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?" If symptom is present, enter 1 (yes) in column 1, Symptom Presence. | х | Х | х | na | х | х | х | х | х |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|---|----|----|----|-------|-----|----|-----|----|----|
| | 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) | | | | | | | | | |
| | Enter Scores in Boxes | | | | | | | | | |
| | A. Little interest or pleasure in doing things | | | | | | | | | |
| | B. Feeling down, depressed, or hopeless | | | | | | | | | |
| | If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue | | | | | | | | | |
| | C. Trouble falling or staying asleep, or sleeping too much | | | | | | | | | |
| | D. Feeling tired or having little energy | | | | | | | | | |
| | E. Poor appetite or overeating | | | | | | | | | |
| | F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down | | | | | | | | | |
| | G. Trouble concentrating on things, such as reading the newspaper or watching television | | | | | | | | | |
| | H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual | | | | | | | | | |
| | I. Thoughts that you would be better off dead, or of hurting yourself in some way | | | | | | | | | |
| D0160 | New item and responses added: | | | | | | | | | |
| | D0160. Total Severity Score | | | | | | | | | |
| | Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 02 and 27. | X | Х | Х | na | X | Х | Х | х | Х |
| | Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items). | | | | | | | | | |
| D0200 | Item retired | Х | Х | Х | na | na | Х | Х | Х | Х |
| D0300 | Item retired | Х | Х | Х | na | na | Х | Х | Х | Х |
| D0500 | Item revised: Instructional language modified to: Do not conduct if Resident Mood Interview (D0150-D0160) was completed | Х | Х | х | na | na | х | х | х | Х |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|--|----|----|----|-------|-----|----|-----|----|----|
| D0500F | Item revised: Option F modified to: F. Indicating that they feel bad about self, are a failure, or have let self or family down | х | х | х | na | na | х | х | Х | х |
| D0500H | Item revised: Option H modified to: H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual | х | х | х | na | na | х | х | х | х |
| D0700 | New item and responses added: D0700. Social Isolation How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | Х | X | na | na | х | х | na | х | na |
| D0700 | New item and responses added: D0700. Social Isolation Complete only if A0310G = 1 How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | na | na | х | na | na | na | na | na | х |

Section F Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| F0700 | Item revised: Instructional language for option 0 modified to: 0. No (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete GG0100, Prior Functioning: Everyday Activities | Х | na | na | na | na | na | na | na | na |

Section G Items

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--------------------|----|----|----|-------|-----|----|-----|----|----|
| G0110 | Item retired | Х | Х | Х | na | na | Х | na | Х | Х |
| G0120 | Item retired | Х | Х | Х | na | na | Х | na | Х | Х |
| G0300 | Item retired | Х | Х | na | na | na | Х | na | Х | na |
| G0400 | Item retired | Х | Х | na | na | na | Х | na | Х | na |
| G0600 | Item retired | Х | Х | na | na | na | Х | na | Х | na |
| G0900 | Item retired | Х | na | na | na | na | na | na | na | na |

Section GG Items

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|------------------------------|--|----|----|----|-------|-----|----|-----|----|----|
| GG | Heading revised: Section heading modified to: Functional Abilities and Goals | Х | х | × | na | na | х | na | Х | na |
| GG0100 | Item revised: Coding instructions modified to: Coding: Independent - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper. Needed Some Help - Resident needed partial assistance from another person to complete any activities. Dependent - A helper completed all the activities for the resident. Unknown. Not Applicable. | Х | Х | na | na | na | Х | na | Х | na |
| GG0115A and GG0115B | New items and responses added: GG0115. Functional Limitation in Range of Motion Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides Enter Codes in Boxes A. Upper extremity (shoulder, elbow, wrist, hand) B. Lower extremity (hip, knee, ankle, foot) | Х | Х | na | na | na | Х | na | Х | na |
| GG0120A- D and GG0120Z | New items and responses added: GG0120. Mobility Devices Check all that were normally used in the last 7 days A. Cane/crutch B. Walker C. Wheelchair (manual or electric) D. Limb prosthesis Z. None of the above were used | х | Х | na | na | na | na | na | na | na |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|---------------------------------|---|----|----|----|-------|-----|----|-----|----|----|
| GG0130 Column 1, Column 2 | Heading revised: Section heading, item heading, instructional language (Admission) changed to: Functional Abilities and Goals – Admission GG0130. Self-Care (Assessment period is the first 3 days of the stay) Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01. When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600. Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s). | Х | x | na | na | na | X | na | Х | na |
| GG0130 | Item revised: Coding instruction language for option 06 modified to: 06. Independent - Resident completes the activity by themself with no assistance from a helper. | Х | х | Х | na | Х | Х | Х | Х | х |
| GG0130 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0130. Self-Care (Assessment period is the last 3 days of the stay) Complete column 3 when A0310F = 10 or 11 or when A0310H = 1. When A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000. Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason. | Х | х | х | na | na | Х | na | Х | na |
| GG0130 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0130. Self-Care (Assessment period is the last 3 days of the stay) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04. Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason. | na | na | na | na | na | na | na | na | Х |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--|--|----|----|----|-------|-----|----|-----|----|----|
| GG0130 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0130. Self-Care (Assessment period is the last 3 days of the stay) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2. Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason. | na | na | na | na | х | na | na | na | na |
| GG0130 Column 1 (black-out in Column 2) | New item added: I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). | X | Х | na | na | na | na | na | na | na |
| GG0130 Column 3 | New item added: I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). | x | х | х | na | na | na | na | na | na |
| GG0130 Column 5 | New item and response added: Section GG. Functional Abilities and Goals - OBRA/Interim GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days) Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason. Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices. 06. Independent - Resident completes the activity by themself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the | X | X | na | na | na | na | na | na | na |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------|---|----|----|-----|-------|---------|----|-----|----|------------|
| | resident to complete the activity. | | | | | | | | | |
| | If activity was not attempted, code reason: | | | | | | | | | |
| | 07. Resident refused | | | | | | | | | |
| | 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury | | | | | | | | | |
| | 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) | | | | | | | | | |
| | 88. Not attempted due to medical condition or safety concerns | | | | | | | | | |
| | 5. OBRA/Interim Performance | | | | | | | | | |
| | Enter Codes in Boxes | | | | | | | | | |
| | A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. | | | | | | | | | |
| | B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. | | | | | | | | | |
| | C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. | | | | | | | | | |
| | E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. | | | | | | | | | |
| | F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. | | | | | | | | | |
| | G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. | | | | | | | | | |
| | H. Putting on/taking off footwear: The ability to put on and take off socks and shoes | | | | | | | | | |
| | or other footwear that is appropriate for safe mobility; including fasteners, if applicable. | | | | | | | | | |
| | I. Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). | | | | | | | | | |
| GG0130 | Heading revised: Section heading and instructional language modified to: | | | | | | | | | |
| Column 5 | Functional Abilities and Goals - OBRA/Interim | | | | | | | | | |
| | GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days) | nc | nc | m = | n- | | | v | nc | n - |
| | Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. | na | na | na | na | na | na | Х | na | na |
| | Column numbering changed to: | | | 1 | | | | | | |
| | 5. OBRA/Interim Performance | | | | | | | | | |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|---------------------------------|---|----|----|----|-------|-----|----|-----|----|----|
| GG0170 Column 1, Column 2 | Heading revised: Section heading, item heading, instructional language (Admission) changed to: Functional Abilities and Goals – Admission GG0170. Mobility (Assessment period is the first 3 days of the stay) Complete column 1 when A0310A = 01. Complete Column 1 and 2 when A0310B = 01. When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600. Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s). | Х | х | na | na | na | Х | na | х | na |
| GG0170 | Item revised: Coding instruction language for option 06 modified to: 06. Independent - Resident completes the activity by themself with no assistance from a helper. | Х | Х | Х | na | Х | Х | Х | Х | х |
| GG0170 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0170. Mobility (Assessment period is the last 3 days of the stay) Complete column 3 when A0310F = 10 or 11 or when A0310H = 1. When A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000. Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason. | Х | Х | х | na | na | Х | na | Х | na |
| GG0170 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0170. Mobility (Assessment period is the last 3 days of the Stay) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04. | na | na | na | na | na | na | na | na | X |
| GG0170 Column 3 | Heading revised: Section heading, item heading, instructional language (Discharge) changed to: Functional Abilities and Goals – Discharge GG0170. Mobility (Assessment period is the last 3 days of the Stay) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2. | na | na | na | na | Х | na | na | na | na |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--|--|----|----|----|-------|-----|----|-----|----|----|
| GG0170 Column 1 (black-out in Column 2) | New item added: FF. Tub/shower transfer: The ability to get in and out of a tub/shower. | Х | х | na | na | na | na | na | na | na |
| GG0170 Column 3 | New item added: FF. Tub/shower transfer: The ability to get in and out of a tub/shower. | Х | Х | х | na | na | na | na | na | na |
| GG0170C | Item revised: Option C language revised to: C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. | Х | х | х | na | Х | х | х | х | х |
| GG0170 Column 5 | New item and response added: Functional Abilities and Goals - OBRA/Interim GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days) Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason. Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices. 06. Independent - Resident completes the activity by themself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. 17. Resident refused 18. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 18. Not attempted due to medical condition or safety concerns | X | X | na | na | na | na | na | na | na |

| Items | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------|--|----|----|----|-------|-----|----|-----|----|----|
| | 5. OBRA/Interim Performance | | | | | | | | | |
| | Enter Codes in Boxes | | | | | | | | | |
| | A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. | | | | | | | | | |
| | B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. | | | | | | | | | |
| | C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. | | | | | | | | | |
| | D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. | | | | | | | | | |
| | E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). | | | | | | | | | |
| | F. Toilet transfer: The ability to get on and off a toilet or commode. | | | | | | | | | |
| | FF. Tub/shower transfer: The ability to get in and out of a tub/shower. | | | | | | | | | |
| | I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. | | | | | | | | | |
| | If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or | | | | | | | | | |
| | scooter? | | | | | | | | | |
| | J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. | | | | | | | | | |
| | K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. | | | | | | | | | |
| | Q5. Does the resident use a wheelchair and/or scooter? | | | | | | | | | |
| | 0. No → Skip to H0100, Appliances | | | | | | | | | |
| | 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns | | | | | | | | | |
| | R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. | | | | | | | | | |
| | RR5. Indicate the type of wheelchair or scooter used. | | | | | | | | | |
| | 1. Manual. | | | | | | | | | |
| | 2. Motorized. | | | | | | | | | |
| | S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. | | | | | | | | | |
| | SS5. Indicate the type of wheelchair or scooter used. | | | | | | | | | |
| | 1. Manual. | | | | | | | | | |
| | 2. Motorized. | | | | | | | | | |
| GG0170 | Heading revised: Section heading, instructional language modified to: | | | | | | | | | |
| Column 5 | Functional Abilities and Goals - OBRA/Interim | 1 | | | | | | | | |
| | GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days) | 1 | | | | | | | | |
| | Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. | na | na | na | na | na | na | X | na | na |
| | Column numbering changed to: | | | | | | | | | |
| | 5. OBRA/Interim Performance | 1 | 1 | | | | | | | 1 |

Section J Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------------------|--|----|----|----|-------|-----|----|-----|----|----|
| J0200 | New item and response added: J0200. Should Pain Assessment Interview be Conducted? Attempt to conduct interview with all residents. If resident is comatose or if A0310G = 2, skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS). Otherwise, attempt to conduct interview with all residents. 0. No (resident is rarely/never understood) → Skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent 1. Yes → Continue to J0300, Pain Presence | na | na | na | na | х | na | na | na | na |
| J0300 | Item revised: Instructional language added: Pain Assessment Interview Complete only if A0310G = 1 | na | na | х | na | na | na | na | na | na |
| J0300 | Item revised: Skip pattern for option 1 modified to: 1. Yes → Continue to J0410, Pain Frequency | Х | Х | Х | na | na | Х | na | Х | na |
| J0300 | Item revised: Skip pattern for option 1 modified to: 1. Yes → Continue to J0510. Pain Effect on Sleep | na | na | na | na | na | na | na | na | Х |
| J0300 | New item and response added: Pain Assessment Interview J0300. Pain Presence. Ask resident: "Have you had pain or hurting at any time in the last 5 days?" 0. No → Skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent 1. Yes → Continue to J0510. Pain Effect on Sleep 9. Unable to answer → Skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent | na | na | na | na | x | na | na | na | na |
| J0400 | Item retired | Х | Х | Х | na | na | Х | na | Х | Х |
| J0410 | New item and responses added: J0410. Pain Frequency Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 9. Unable to answer | х | х | х | na | na | x | na | × | na |
| J0500A and J0500B | Items retired | х | Х | Х | na | na | Х | na | Х | Х |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|--|----|----|----|-------|-----|----|-----|----|----|
| J0510 | New item and responses added: J0510. Pain Effect on Sleep Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | х | х | х | na | х | х | na | х | х |
| J0520 | New item and responses added: J0520. Pain Interference with Therapy Activities Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" 0. Does not apply - I have not received rehabilitation therapy in the past 5 days 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | х | х | х | na | х | х | na | х | х |
| J0530 | New item and responses added: J0530. Pain Interference with Day-to-Day Activities Ask resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | х | х | х | na | х | х | na | х | х |
| J0600 | Item removed | na | na | na | na | na | na | na | na | Х |
| J0700 | Item revised: Item number in the parenthetical instruction modified to: 0. No (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) 1. Yes (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain | Х | х | na | na | na | х | na | х | na |
| J1800 | Item revised: Skip pattern for option 0 modified to: 0. No → Skip to K0520, Nutritional Approaches | na | na | na | na | Х | na | na | na | na |
| J2800 | Item revised: Language modified to: J2800. Involving genital systems (such as prostate, testes, ovaries, uterus, vagina, external genitalia) | х | х | na | na | na | Х | Х | х | na |

Section K Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-----------------------|--|----|----|----|-------|-----|----|-----|----|----|
| K0510 | Item retired | Х | Х | Х | na | na | Х | Х | Х | Х |
| K0520 Column 1 - 4 | New item and responses added: K0520. Nutritional Approaches Check all of the following nutritional approaches that apply 1. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B 2. While Not a Resident Performed while NOT a resident of this facility and within the last 7 days. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank. 3. While a Resident Performed while a resident of this facility and within the last 7 days 4. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C A. Parenteral/IV feeding B. Feeding tube (e.g., nasogastric or abdominal (PEG)) C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Z. None of the above | X | X | na | na | na | X | na | X | na |
| K0520 Column 2, 3 | New item and responses added: K0520. Nutritional Approaches Check all of the following nutritional approaches that apply 2. While Not a Resident Performed while NOT a resident of this facility and within the last 7 days. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank. 3. While a Resident Performed while a resident of this facility and within the last 7 days A. Parenteral/IV feeding B. Feeding tube (e.g., nasogastric or abdominal (PEG)) C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) Z. None of the above | na | na | na | na | na | na | X | na | na |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------------------|---|----|----|----|-------|-----|----|-----|----|----|
| K0520 Column 3, 4 | New item and responses added: K0520. Nutritional Approaches Check all of the following nutritional approaches that apply 3. While a Resident Performed while a resident of this facility and within the last 7 days 4. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C A. Parenteral/IV feeding B. Feeding tube (e.g., nasogastric or abdominal (PEG)) C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Z. None of the above | na | na | х | na | na | na | na | na | na |
| K0520 Column 4 | New item and responses added: K0520. Nutritional Approaches Check all of the following nutritional approaches that apply 4. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C A. Parenteral/IV feeding B. Feeding tube (e.g., nasogastric or abdominal (PEG)) C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids) D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) Z. None of the above | na | na | na | na | х | na | na | na | X |
| K0710 | Item revised: Coding instruction language modified to: Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B. | х | Х | na | na | na | х | Х | Х | na |

Section M Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|---|----|----|----|-------|-----|----|-----|----|----|
| M0210 | Item revised: Skip pattern for option 0 modified to: 0. No → Skip to N0415, High-Risk Drug Classes: Use and Indication | na | na | Х | na | Х | na | na | na | х |
| M0300G | Item revised: Skip pattern for option 1 modified to: 1. Number of unstageable pressure injuries presenting as deep tissue injury: If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication | na | na | X | na | na | na | na | na | х |

Section N Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|---|----|----|----|-------|-----|----|-----|----|----|
| N0300 | Item revised: Skip pattern changed to: Skip to N0415, High-Risk Drug Classes: Use and Indication | Х | Х | na | na | na | х | na | Х | na |
| N0410 | Item and responses retired | Х | Х | Х | na | na | Х | na | Х | Х |
| N0415 | New items and responses added: N0415: High-Risk Drug Classes: Use and Indication 1. Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days 2. Indication noted If Column 1 is checked, check if there is an indication noted for all medications in the drug class Check all that apply A. Antipsychotic B. Antianxiety C. Antidepressant D. Hypnotic E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) F. Antibiotic G. Diuretic H. Opioid I. Antiplatelet J. Hypoglycemic (including insulin) Z. None of the above | X | x | x | na | X | X | na | X | X |

Section O Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------------|--|----|----|----|-------|-----|----|-----|----|----|
| O0100 | Items and responses retired | Х | Х | Х | na | na | Х | Х | Х | Х |
| O0110 | New items and responses added: | | | | | | | | | |
| Column a - c | O0110. Special Treatments, Procedures, and Programs | | | | | | | | | |
| | Check all of the following treatments, procedures, and programs that were performed | | | | | | | | | |
| | a. On Admission | | | | | | | | | |
| | Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B b. While a Resident | | | | | | | | | |
| | Performed while a resident of this facility and within the last 14 days | | | | | | | | | |
| | c. At Discharge | | | | | | | | | |
| | Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | | | | | | | | | |
| | Check all that apply | | | | | | | | | |
| | Cancer Treatments | | | | | | | | | |
| | A1. Chemotherapy | | | | | | | | | |
| | A2. IV | | | | | | | | | |
| | A3. Oral | | | | | | | | | |
| | A10. Other | | | | | | | | | |
| | B1. Radiation | | | | | | | | | |
| | Respiratory Treatments | V | V | | | | V | | V | |
| | C1. Oxygen therapy | X | X | na | na | na | X | na | X | na |
| | C2. Continuous | | | | | | | | | |
| | C3. Intermittent | | | | | | | | | |
| | C4. High-concentration | | | | | | | | | |
| | D1. Suctioning | | | | | | | | | |
| | D2. Scheduled | | | | | | | | | |
| | D3. As needed | | | | | | | | | |
| | E1. Tracheostomy care | | | | | | | | | |
| | F1. Invasive Mechanical Ventilator (ventilator or respirator) | | | | | | | | | |
| | G1. Non-invasive Mechanical Ventilator | | | | | | | | | |
| | G2. BiPAP | | | | | | | | | |
| | G3. CPAP | | | | | | | | | |
| | Other | | | | | | | | | |
| | H1. IV Medications | | | 1 | | | 1 | | | |
| | H2. Vasoactive medications | | | | | | | | | |
| | H3. Antibiotics | | | | | | | | | |
| | H4. Anticoagulant | | | | | | | | | |
| | H10. Other | | | | | | | | | |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------------|--|----|----|-----|-------|-----|----|-----|----|----|
| | I1. Transfusions J1. Dialysis | | | | | | | | | |
| | J2. Hemodialysis | | | | | | | | | |
| | J3. Peritoneal dialysis | | | | | | | | | |
| | K1. Hospice care | | | | | | | | | |
| | M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | | | | | | | | |
| | O1. IV Access | | | | | | | | | |
| | O2. Peripheral | | | | | | | | | |
| | O3. Midline | | | | | | | | | |
| | O4. Central (e.g., PICC, tunneled, port) | | | | | | | | | |
| | None of the Above | | | | | | | | | |
| | Z1. None of the above | | | | | | | | | |
| O0110 | New items and responses added: | | | | | | | | | |
| Column b, c | O0110. Special Treatments, Procedures, and Programs | | | | | | | | | |
| | Check all of the following treatments, procedures, and programs that were performed | | | | | | | | | |
| | b. While a Resident | | | | | | | | | |
| | Performed while a resident of this facility and within the last 14 days | | | | | | | | | |
| | c. At Discharge | | | | | | | | | |
| | Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | | | | | | | | | |
| | Check all that apply | | | | | | | | | |
| | Cancer Treatments | | | | | | | | | |
| | A1. Chemotherapy | | | | | | | | | |
| | A2. IV | | | | | | | | | |
| | A3. Oral | no | no | × | no | no | no | no | no | no |
| | A10. Other | na | na | _ ^ | na | na | na | na | na | na |
| | B1. Radiation | | | | | | | | | |
| | Respiratory Treatments | | | | | | | | | |
| | C1. Oxygen therapy | | | | | | | | | |
| | C2. Continuous | | | | | | | | | |
| | C3. Intermittent | | | | | | | | | |
| | C4. High-concentration | | | | | | | | | |
| | D1. Suctioning | | | | | | | | | |
| | D2. Scheduled | | | | | | | | | |
| | D3. As needed | | | | | | | | | |
| | E1. Tracheostomy care | | | | | | | | | |
| | F1. Invasive Mechanical Ventilator (ventilator or respirator) | | | | | | | | | |
| | G1. Non-invasive Mechanical Ventilator | | | | | | | | | |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------|--|----|----|----|-------|-----|----|-----|----|----|
| | G2. BiPAP | | | | | | | | | |
| | G3. CPAP | | | | | | | | | |
| | Other | | | | | | | | | |
| | H1. IV Medications | | | | | | | | | |
| | H2. Vasoactive medications | | | | | | | | | |
| | H3. Antibiotics | | | | | | | | | |
| | H4. Anticoagulant | | | | | | | | | |
| | H10. Other | | | | | | | | | |
| | I1. Transfusions | | | | | | | | | |
| | J1. Dialysis | | | | | | | | | |
| | J2. Hemodialysis | | | | | | | | | |
| | J3. Peritoneal dialysis | | | | | | | | | |
| | K1. Hospice care | | | | | | | | | |
| | M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | | | | | | | | |
| | O1. IV Access | | | | | | | | | |
| | O2. Peripheral | | | | | | | | | |
| | O3. Midline | | | | | | | | | |
| | O4. Central (e.g., PICC, tunneled, port) | | | | | | | | | |
| | None of the Above | | | | | | | | | |
| | Z1. None of the above | | | | | | | | | |
| O0110 | New items and responses added: | | | | | | | | | |
| Column c | O0110. Special Treatments, Procedures, and Programs | | | | | | | | | |
| | Check all of the following treatments, procedures, and programs that were | | | | | | | | | |
| | performed | | | | | | | | | |
| | c. At Discharge | | | | | | | | | |
| | Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | | | | | | | | | |
| | Check all that apply | | | | | | | | | |
| | Cancer Treatments | | | | | | | | | |
| | A1. Chemotherapy | | | | | X | | | | X |
| | A2. IV | na | na | na | na | ^ | na | na | na | ^ |
| | A3. Oral | | | | | | | | | |
| | A10. Other | | | | | | | | | |
| | B1. Radiation | | | | | | | | | |
| | Respiratory Treatments | | | | | | | | | |
| | C1. Oxygen therapy | | | | | | | | | |
| | C2. Continuous | | 1 | | | | | 1 | | |
| | C3. Intermittent | | 1 | | | | | 1 | | |
| | C4. High-concentration | | 1 | | | | | 1 | | |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------|--|----|----|----|-------|-----|----|-----|----|----|
| | D1. Suctioning | | | | | | | | | |
| | D2. Scheduled | | | | | | | | | |
| | D3. As needed | | | | | | | | | |
| | E1. Tracheostomy care | | | | | | | | | |
| | F1. Invasive Mechanical Ventilator (ventilator or respirator) | | | | | | | | | |
| | G1. Non-invasive Mechanical Ventilator | | | | | | | | | |
| | G2. BiPAP | | | | | | | | | |
| | G3. CPAP | | | | | | | | | |
| | Other | | | | | | | | | |
| | H1. IV Medications | | | | | | | | | |
| | H2. Vasoactive medications | | | | | | | | | |
| | H3. Antibiotics | | | | | | | | | |
| | H4. Anticoagulant | | | | | | | | | |
| | H10. Other | | | | | | | | | |
| | I1. Transfusions | | | | | | | | | |
| | J1. Dialysis | | | | | | | | | |
| | J2. Hemodialysis | | | | | | | | | |
| | J3. Peritoneal dialysis | | | | | | | | | |
| | K1. Hospice care | | | | | | | | | |
| | M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | | | | | | | | |
| | O1. IV Access | | | | | | | | | |
| | O2. Peripheral | | | | | | | | | |
| | O3. Midline | | | | | | | | | |
| | O4. Central (e.g., PICC, tunneled, port) | | | | | | | | | |
| | None of the Above | | | | | | | | | |
| | Z1. None of the above | | | | | | | | | |
| O0110 | New items and responses added: | | | | | | | | | |
| Column b | O0110. Special Treatments, Procedures, and Programs | | | | | | | | | |
| | Check all of the following treatments, procedures, and programs that were performed | | | | | | | | | |
| | b. While a Resident | | | | | | | | | |
| | Performed while a resident of this facility and within the last 14 days | | | | | | | | | |
| | Check all that apply | na | na | na | na | na | na | X | na | na |
| | Cancer Treatments | | 1 | | | | | 1 | | 1 |
| | A1. Chemotherapy | | | | | | | | | 1 |
| | B1. Radiation | | | | | | | | | 1 |
| | Respiratory Treatments | | | | | | | | | 1 |
| | C1. Oxygen therapy | | 1 | | | | | 1 | | 1 |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|--|----|----|----|-------|-----|----|-----|----|----|
| | D1. Suctioning | | | | | | | | | |
| | E1. Tracheostomy care | | | | | | | | | |
| | F1. Invasive Mechanical Ventilator (ventilator or respirator) | | | | | | | | | |
| | Other | | | | | | | | | |
| | H1. IV Medications | | | | | | | | | |
| | I1. Transfusions | | | | | | | | | |
| | J1. Dialysis | | | | | | | | | |
| | M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | | | | | | | | |
| | None of the Above | | | | | | | | | |
| | Z1. None of the above | | | | | | | | | |
| O0300A | Item revised: Skip pattern for response 1 changed to: | na | na | Х | na | na | na | na | na | na |
| | 1. Yes → Skip to O0425, Part A Therapies | | | | | | | | | |
| O0400 | Completion language added: | Х | Х | na | na | na | na | na | na | na |
| | Complete only when A0310B = 01 (complete O0400D2 when required by state) | | | | | | | | | |
| O0400 | Completion language added: | na | na | na | na | na | Х | na | Х | na |
| | Complete only when A0310B = 01. | | | | | | | | | |
| O0400 | Item removed | na | na | Х | na | na | na | na | na | na |
| O0420 | Completion language added: | Х | Х | na | na | na | Х | na | na | na |
| | Complete only when A0310B = 01. | | | | | | | | | |
| O0600 | Item retired | Х | Х | na | na | na | Х | na | Х | na |
| O0700 | Item retired | Х | Х | na | na | na | Х | na | Х | na |

Section Q Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|----------------------------------|-----------------------------|----|----|----|-------|-----|----|-----|----|----|
| Q0100A, Q0100B, and Q0100C | Items and responses retired | х | X | na | na | na | Х | na | Х | na |

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------------------|---|----|----|----|-------|-----|----|-----|----|----|
| Q0110 | New item and responses added: Q0110. Participation in Assessment and Goal Setting Identify all active participants in the assessment process Check all that apply A. Resident B. Family C. Significant other D. Legal guardian E. Other legally authorized representative Z. None of the above | x | х | na | na | na | х | na | х | na |
| Q0300A and Q0300B | Items and responses retired | х | Х | na | na | na | х | na | Х | na |
| Q0310A and Q0310B | New items and responses added: Q0310. Resident's Overall Goal Complete only if A0310E = 1 A. Resident's overall goal for discharge established during the assessment process 1. Discharge to the community 2. Remain in this facility 3. Discharge to another facility/institution 9. Unknown or uncertain B. Indicate information source for Q0310A 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | X | X | na | na | na | X | na | X | na |
| Q0400 | Item revised: Item option modified to: A. Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes → Skip to Q0610, Referral | Х | Х | na | na | na | Х | na | Х | na |
| Q0400 | Item revised: Item option modified to: A. Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes | na | na | Х | na | na | na | na | na | Х |

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| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|--|----|----|----|-------|-----|----|-----|----|----|
| Q0490 | Item revised: Language and skip pattern modified to: Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B Complete only if A0310A = 02, 06, or 99 Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment? 0. No. 1. Yes → Skip to Q0610, Referral | х | х | na | na | na | Х | na | х | na |
| Q0500B | Item revised: Option B language modified to: B. Ask the resident (or family or significant other or guardian or legally authorized representative only if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" | X | X | na | na | na | Х | na | Х | na |
| Q0500C | New items and responses added: Q0500C. Indicate information source for Q0500B 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | Х | х | na | na | na | Х | na | х | na |
| Q0550A | Item revised: Modified language and option to: Q0550. Resident's Preference to Avoid Being Asked Question Q0500B A. Does resident (or family or significant other or guardian or legally authorized representative only if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than on comprehensive assessments alone) 0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. Yes 8. Information not available | × | х | na | na | na | X | na | x | na |
| Q0550B | Items and responses retired | Х | Х | na | na | na | Х | na | Х | na |
| Q0550C | New item and responses added: C. Indicate information source for Q0550A 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | х | х | na | na | na | х | na | х | na |
| Q0600 | Item and responses retired | Х | Х | Х | na | na | Х | na | Х | Х |

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| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|-------|---|----|----|----|-------|-----|----|-----|----|----|
| Q0610 | New item and responses added: Q0610. Referral A. Has a referral been made to the Local Contact Agency (LCA)? 0. No 1. Yes | х | x | х | na | na | х | na | х | х |
| Q0620 | New item and responses added: Q0620. Reason Referral to Local Contact Agency (LCA) Not Made Complete only if Q0610 = 0 Indicate reason why referral to LCA was not made | | | | | | | | | |
| | LCA unknown Referral previously made Referral not wanted Discharge date 3 or fewer months away Discharge date more than 3 months away | X | X | X | na | na | X | na | X | X |

Section V Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|---|----|----|----|-------|-----|----|-----|----|----|
| V0100E | Item revised: Item number in parenthetical instruction revised to: E. Prior Assessment Resident Mood Interview (PH-Q2 to 9©) Total Severity Score (D0160 value from prior assessment) | Х | na | na | na | na | na | na | na | na |

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Section X Items

| Item | Change Description | NC | NQ | ND | NT/ST | NPE | NP | IPA | SP | SD |
|--------|-----------------------------|----|----|----|-------|-----|----|-----|----|----|
| X0570A | Items and responses retired | Х | Х | Х | Х | Χ | Χ | Х | na | na |

| Resident | 1.1 | D-1- |
|----------|------------|------|
| Resident | Identitier | Date |
| | | |

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

| Castian | Λ | . Identification | Information |
|---------|----|------------------|-------------|
| Section | Δ. | . INPHILICATION | Intormation |

| Secul | on A - Identification information |
|------------|---|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): |
| | |
| | B. CMS Certification Number (CCN): |
| | |
| | C. State Provider Number: |
| | |
| A0200. | Type of Provider |
| Enter Code | Type of provider |
| | 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

A0310 continued on next page

| Resident | | Identifier | Date |
|------------|--|---|--------------------|
| Section | on A - Identification Information | | |
| A0310. | Type of Assessment - Continued | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |
| A0410. | Unit Certification or Licensure Designation | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and Unit is neither Medicare nor Medicaid certified but Medicare and/or Medicaid certified | MDS data is not required by the State MDS data is required by the State | |
| A0500. | Legal Name of Resident | | |
| | A. First name: | | B. Middle initial: |
| | | | П |
| | 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 Medicai | d recipient | |
| | | \Box | |
| A0800. | Gender | | |
| Enter Code | 1. Male 2. Female | | |
| A0900. | Birth Date | | |
| | Month Day Year | | |

| Resident | | Identifier Date |
|------------|--------|--|
| Section | on. | A - Identification Information |
| A1005. | Eth | nnicity |
| Are you o | f Hisp | panic, Latino/a, or Spanish origin? |
| <u></u> | Che | eck all that apply |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin |
| | В. | Yes, Mexican, Mexican American, Chicano/a |
| | C. | Yes, Puerto Rican |
| | D. | Yes, Cuban |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin |
| | Χ. | Resident unable to respond |
| | Y. | Resident declines to respond |
| A1010. | Ra | ce |
| What is yo | our ra | ace? |
| <u></u> | Che | eck all that apply |
| | A. | White |
| | В. | Black or African American |
| | C. | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | Н. | Korean |
| | I. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1110. | Laı | nguage |
| | A. | What is your preferred language? |
| | | |
| Enter Code | B. | Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine |



| Resident | | | | | | | | | _ lo | dentifier | | | | | | D | ate | | | |
|----------------|---------|---|----------------------------|---------------------|----------------------------|--------------------|------------|---------------|--------------|-----------|----------|----------|---------|---------|----------|---------|---------|-----------|-----------|------|
| Section | n. | A - Ider | ntific | atio | n Inf | orm | atio | n | | | | | | | | | | | | |
| A1200. | Ма | rital Status | ; | | | | | | | | | | | | | | | | | |
| Enter Code | | Never r Married Widowe Separa Divorce | d ed ted | | | | | | | | | | | | | | | | | |
| Has lack of | of trar | insportation has portation ke if A0310B = 0 | pt you f | from med | dical appo | | | tings, | wor | k, or fro | om gett | ing thi | ngs nee | eded fo | or daily | living? | | | | |
| ↓ | Che | eck all that ap | ply | | | | | | | | | | | | | | | | | |
| | A. | Yes, it has ke | ept me | from me | edical appo | ointmen | nts or fro | m ge | tting | my me | edicatio | ns | | | | | | | | |
| | B. | Yes, it has ke | ept me | from nor | n-medical | meeting | gs, app | ointm | ents | , work, | or from | n gettin | g thing | s that | l need | | | | | |
| | C. | No | | | | | | | | | | | | | | | | | | |
| | X. | Resident una | able to ı | respond | | | | | | | | | | | | | | | | |
| | Y. | Resident ded | clines to | respon | ıd | | | | | | | | | | | | | | | |
| and its resour | ces a | ssociation of Co re proprietary in part or whole wit | nformatic | on of NAC | CHC and its | s partner | | | | | | | | | | | | | | |
| A1300. | Op | tional Resi | dent l | tems | | | | | | | | | | | | | | | | |
| | A. | Medical rec | ord nu | mber: | | П | | | | | | | | | | | | | | |
| | В. | Room numb | oer: | | i i | | _ | | | | | | | | | | | | | |
| | | Щ | ᆜ | <u></u> | <u> </u> | ! | | | | | | | | | | | | | | |
| | C. | Name by wh | nich res | sident p | orefers to | be add | dressed | i: | - | | 1 | | | | | 1 | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| | D. | Lifetime occ | cupatio | n(s) - pu | ut "/" betw | een two | occup | ations | S: | | | | | | | | | | | |
| | | | | | | Ш | ļ | | | | | | | | | | | | | |
| | | eadmission if A0310A = 0 | | _ | | sident | t Revi | ew (| PAS | SRR) | | | | | | | | | | |
| Enter Code | | the resident content condition $0. No \rightarrow Sk$ 1. Yes $\rightarrow C$ 9. Not a Me | n? tip to A1 ontinue | 1550, Co to A151 | onditions F 10, Level I | Related I Pread | to ID/D | D Sta Scre | itus enin | ig and f | Reside | nt Revi | ew (PA | | | | or inte | ellectual | disabilit | y or |
| | | vel II Pread if A0310A = 0 | | | _ | and F | Reside | nt F | Revi | ew (P | ASRF | R) Co | nditio | ns | | | | | | |
| Ţ | Che | eck all that ap | ply | | | | | | | | | | | | | | | | | |
| | A. | Serious mei | ntal illn | ess | | | | | | | | | | | | | | | | |
| | В. | Intellectual | Disabil | ity | | | | | | | | | | | | | | | | |
| | C | Other relate | d cond | litione | | | | | | | | | | | | | | | | |



| Resident | | Identifier Date Date |
|---------------|--|--|
| Section | n | A - Identification Information |
| If the resid | lent i | inditions Related to ID/DD Status is 22 years of age or older, complete only if A0310A = 01 is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05 |
| 11 (110 10310 | | |
| \downarrow | | eck all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely D/DD With Organic Condition |
| | A. | Down syndrome |
| | B. | Autism |
| | C. | Epilepsy |
| | D. | Other organic condition related to ID/DD |
| _ | II | D/DD Without Organic Condition |
| | E. | ID/DD with no organic condition |
| | N | lo ID/DD |
| | Z. | None of the above |
| Most Re | cer | nt Admission/Entry or Reentry into this Facility |
| A1600. | En | try Date |
| | | Month Day Year |
| A1700. | Тур | pe of Entry |
| Enter Code | 1. 2. | Admission Reentry |
| A1805. | En | tered From |
| Enter Code | 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. 99. | Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health service organization Not listed |
| A1900. | Ad | mission Date (Date this episode of care in this facility began) |
| | | Month Day Year |
| | | scharge Date if A0310F = 10, 11, or 12 |
| | | Month Day Year |

| esident | | Identifier | | Date |
|--------------------|--|---|----------------------------------|----------------------------------|
| Section | on A | A - Identification Information | | |
| | | charge Status FA0310F = 10, 11, or 12 | | |
| Enter Code | ar 02. Ni 03. Si 04. Si 05. Lc 06. In 07. In 08. In 09. Hi 11. Ci 12. Hi 13. Di | Home/Community (e.g., private home/apt., board/care, assisted living, gro arrangements) → Skip to A2123, Provision of Current Reconciled Medication Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health service organization Deceased Not listed → Skip to A2123, Provision of Current Reconciled Medication Li | on List to Resident at Discharge | er residential care |
| | | vision of Current Reconciled Medication List to Subseque A0310H = 1 and A2105 = 02-12 | nt Provider at Discharge | |
| Enter Code | At the t | e time of discharge to another provider, did your facility provide the resident | s current reconciled medication | list to the subsequent provider? |
| | | No - Current reconciled medication list not provided to the subsequent Date for Significant Correction Yes - Current reconciled medication list provided to the subsequent pro | | vious Assessment Reference |
| Indicate th | ne route(| te of Current Reconciled Medication List Transmission to e(s) of transmission of the current reconciled medication list to the subsequence A2121 = 1 | • | |
| \downarrow | Check | k all that apply | | |
| | R | Route of Transmission | | |
| | A. El | Electronic Health Record | | |
| | B. H | Health Information Exchange | | |
| | C. Ve | Verbal (e.g., in-person, telephone, video conferencing) | | |
| | D. Pa | Paper-based (e.g., fax, copies, printouts) | | |
| | E. 0 | Other methods (e.g., texting, email, CDs) | | |
| A2123. Complete | | vision of Current Reconciled Medication List to Resident a A0310H = 1 and A2105 = 01, 99 | nt Discharge | |
| Enter Code | At the t | e time of discharge, did your facility provide the resident's current reconciled | medication list to the resident, | family and/or caregiver? |
| | | No - Current reconciled medication list not provided to the resident, far Reference Date for Significant Correction Yes - Current reconciled medication list provided to the resident, family | | A2200, Previous Assessment |
| | | | | |

| Resident | | Identifier | Date |
|--------------|--|------------------|------|
| Sectio | on A - Identification Information | | |
| Indicate the | Route of Current Reconciled Medication List Transe route(s) of transmission of the current reconciled medication list only if A2123 = 1 | | |
| ↓ Che | eck all that apply | | |
| | Route of Transmission | | |
| | A. Electronic Health Record (e.g., electronic access to patien | t portal) | |
| | B. Health Information Exchange | | |
| | C. Verbal (e.g., in-person, telephone, video conferencing) | | |
| | D. Paper-based (e.g., fax, copies, printouts) | | |
| | E. Other methods (e.g., texting, email, CDs) | | |
| | Previous Assessment Reference Date for Significationly if A0310A = 05 or 06 | ant Correction | |
| | Month Day Year | | |
| A2300. | Assessment Reference Date | | |
| | Observation end date: Month Day Year | | |
| | Medicare Stay only if A0310G1 = 0 | | |
| Enter Code | A. Has the resident had a Medicare-covered stay since the 0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent | - | |
| | B. Start date of most recent Medicare stay: Month Day Year | | |
| | C. End date of most recent Medicare stay - Enter dashes if s Month Day Year | stay is ongoing: | |

| Resident | Identifier | Date |
|----------|------------|------|

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

| Section | on B - Hearing, Speech, and Vision |
|------------|---|
| B0100. | Comatose |
| Enter Code | Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities |
| B0200. | Hearing |
| Enter Code | Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly Highly impaired - absence of useful hearing |
| B0300. | Hearing Aid |
| Enter Code | Hearing aid or other hearing appliance used in completing B0200, Hearing 0. No 1. Yes |
| B0600. | Speech Clarity |
| Enter Code | Select best description of speech pattern 0. Clear speech - distinct intelligible words 1. Unclear speech - slurred or mumbled words 2. No speech - absence of spoken words |
| B0700. | Makes Self Understood |
| Enter Code | Ability to express ideas and wants, consider both verbal and non-verbal expression 0. Understood 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/never understood |
| B0800. | Ability To Understand Others |
| Enter Code | Understanding verbal content, however able (with hearing aid or device if used) 0. Understands - clear comprehension 1. Usually understands - misses some part/intent of message but comprehends most conversation 2. Sometimes understands - responds adequately to simple, direct communication only Rarely/never understands |
| B1000. | Vision |
| Enter Code | Ability to see in adequate light (with glasses or other visual appliances) O. Adequate - sees fine detail, such as regular print in newspapers/books Impaired - sees large print, but not regular print in newspapers/books Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects Highly impaired - object identification in question, but eyes appear to follow objects Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects |
| B1200. | Corrective Lenses |
| Enter Code | Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision 0. No 1. Yes |

| Resident | | | ldentifier | Date |
|------------|---|--|--|---|
| Section | on B | Hearing, Speech, an | nd Vision | |
| | | Literacy 310B = 01 or A0310G = 1 and A0310H = | :1 | |
| Enter Code | How ofte pharmac 0. 1. 2. 3. 4. 7. 8. | | u when you read instructions, pamphlets, | or other written material from your doctor or |

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| Resident | | Identifier | Date |
|-------------|--|-----------------------|--|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C02 conduct interview with all residents | 00-C0500) be Conducte | d? |
| Enter Code | No (resident is rarely/never understood) → Skip Yes → Continue to C0200, Repetition of Three \(\) | • | J, Staff Assessment for Mental Status |
| Brief I | Interview for Mental Status (BII | VIS) | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to rem The words are: sock, blue, and bed. Now tell me the the Number of words repeated after first attempt 0. None 1. One 2. Two | • | Is after I have said all three. |
| | Three After the resident's first attempt, repeat the words using cuthe words up to two more times. | • | blue, a color; bed, a piece of furniture"). You may repeat |
| C0300. | Temporal Orientation (orientation to year, month, and | d 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. | | | |
| Enter Code | Ask resident: "Let's go back to an earlier question. What well funable to remember a word, give cue (something to wear 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 scorenter 99 if the resident was unable to complete the interest of the complete the comp | , | |



| Resident | | | dentifier | Date |
|---------------------|-----------------------|--|---|------|
| Section | on C | - Cognitive Patterns | | |
| C0600. | Should | d the Staff Assessment for Mental Status (C0 | 700 - C1000) be Conducted? | |
| Enter Code | 0. 1. | No (resident was able to complete Brief Interview for Me Yes (resident was unable to complete Brief Interview for | | |
| Staff As | sessm | ent for Mental Status | | |
| Do not co | nduct if B | Brief Interview for Mental Status (C0200-C0500) was compl | eted | |
| C0700. | Short- | term Memory OK | | |
| Enter Code | | or appears to recall after 5 minutes Memory OK Memory problem | | |
| C0800. | Long- | term Memory OK | | |
| Enter Code | | or appears to recall long past Memory OK Memory problem | | |
| C0900. | Memor | ry/Recall Ability | | |
| \downarrow | Check a | all that the resident was normally able to recall | | |
| | A. Cu | irrent season | | |
| | B. Lo | cation of own room | | |
| | C. Sta | aff names and faces | | |
| | D. Th | at they are in a nursing home/hospital swing bed | | |
| | Z. No | one of the above were recalled | | |
| C1000. | Cognit | tive Skills for Daily Decision Making | | |
| Enter Code | | lecisions regarding tasks of daily life Independent - decisions consistent/reasonable Modified independence - some difficulty in new situatic Moderately impaired - decisions poor; cues/supervisior Severely impaired - never/rarely made decisions | ons only n required | |
| Deliriun C1310. | | and Symptoms of Delirium (from CAM©) | | |
| | _ | eting Brief Interview for Mental Status or Staff Assessment | , and reviewing medical record | |
| | - | t Mental Status Change | | |
| Enter Code | ls there 0. No 1. Yes | e evidence of an acute change in mental status from the o s | resident's baseline? | |
| 1. Be | havior c | not present continuously present, does not fluctuate present, fluctuates (comes and goes, changes in severity) | | |
| Enter Code in Boxes | s | | | |
| | wh | attention - Did the resident have difficulty focusing attention at was being said? sorganized Thinking - Was the resident's thinking disorga | nized or incoherent (rambling or irrelevant con- | |
| | flov | w of ideas, or unpredictable switching from subject to subject tered Level of Consciousness - Did the resident have alto vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being asked questions, stuporous - very difficult to arouse and keep aroused for the incomatose - could not be aroused | ect)? ered level of consciousness, as indicated by an but responded to voice or touch | • |

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

| eside | nt | Ider | itifier | Date | |
|-----------------------|--|--|-------------------------------------|--------------------------|-------------|
| Se | ctio | on D - Mood | | | |
| D0′ | 100. | Should Resident Mood Interview be Conducted? - Atte | mpt to conduct interview with all r | residents | |
| Enter | Code | No (resident is rarely/never understood) → Skip to and complete Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to | | nt of Resident Mood (P | HQ-9-OV) |
| D0′ | 150. | Resident Mood Interview (PHQ-2 to 9©) | | | |
| If sy If ye Rea | mptores in conduction depth de | resident: "Over the last 2 weeks, have you been bother in is present, enter 1 (yes) in column 1, Symptom Presence. column 1, then ask the resident: "About how often have you been both is show the resident a card with the symptom frequency choices. Indicate inptom Presence No (enter 0 in column 2) Yes (enter 0-3 in column 2) No response (leave column 2 blank) | thered by this?" | | |
| 2. | Syn | nptom Frequency | | 1. | 2. |
| | | Never or 1 day 2-6 days (several days) | | Symptom | Symptom |
| | 2. | 7-11 days (half or more of the days) | | Presence | Frequency |
| | 3. | 12-14 days (nearly every day) | | ↓ Enter Scores in Boxes↓ | |
| A. | Litt | le interest or pleasure in doing things | | | |
| В. | Fee | ling down, depressed, or hopeless | | | |
| If bo | oth D(| 0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 | are coded 0 or 1, END the PHQ | interview; otherwise | , continue. |
| C. | Tro | uble falling or staying asleep, or sleeping too much | | | |
| D. | Fee | ling tired or having little energy | | | |
| E. | Pod | r appetite or overeating | | | |
| F. | | ling bad about yourself - or that you are a failure or ha ily down | ve let yourself or your | | |
| G. | | uble concentrating on things, such as reading the new vision | spaper or watching | | |
| Н. | opp | ring or speaking so slowly that other people could have osite - being so fidgety or restless that you have been re than usual | | | |
| l. | Tho | ughts that you would be better off dead, or of hurting | yourself in some way | | |
| | | Total Severity Score | | | |
| Enter | Score | Add scores for all frequency responses in Column 2, Symptom Fr Enter 99 if unable to complete interview (i.e., Symptom Frequency is | | | |



| Resident | | Identifier | Date | |
|--|--|--------------------------------------|------------------|-----------|
| Sectio | n D - Mood | | | |
| | Staff Assessment of Resident Mood (PHQ-9-OV*) duct if Resident Mood Interview (D0150-D0160) was completed | | | |
| If symptom Then move 1. Sym l 0. | last 2 weeks, did the resident have any of the foll is present, enter 1 (yes) in column 1, Symptom Presence. to column 2, Symptom Frequency, and indicate symptom frequentom Presence No (enter 0 in column 2) Yes (enter 0-3 in column 2) | | s? | |
| | otom Frequency | | 1. | 2. |
| | Never or 1 day | | Symptom | Symptom |
| | 2-6 days (several days) | | Presence | Frequency |
| | 7-11 days (half or more of the days) 12-14 days (nearly every day) | | ↓ Enter Scores i | |
| | nterest or pleasure in doing things | | Line ocores ii | T Boxes↓ |
| B. Feelin | g or appearing down, depressed, or hopeless | | | |
| C. Troub | e falling or staying asleep, or sleeping too much | | | |
| D. Feelin | g tired or having little energy | | | |
| E. Poor a | ppetite or overeating | | | |
| F. Indica | ting that they feel bad about self, are a failure, or have let se | lf or family down | | |
| G. Troub | e concentrating on things, such as reading the newspaper of | or watching television | | |
| | g or speaking so slowly that other people have noticed. Or t so fidgety or restless that they have been moving around a | | | |
| I. States | that life isn't worth living, wishes for death, or attempts to h | narm self | | |
| J. Being | short-tempered, easily annoyed | | | |
| D0600. | Total Severity Score | | | |
| Enter Score | Add scores for all frequency responses in Column 2, Sympto | m Frequency. Total score must be bei | tween 00 and 30. | |
| D0700. | Social Isolation | | | |
| Enter Code | How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | | | |
| | | | | |



| Resident | | Identifier [| Date |
|--------------|----------------------------|--|--|
| Secti | on | n E - Behavior | |
| E0100. | Pot | otential Indicators of Psychosis | |
| ↓ C | heck | ck all that apply | |
| | A. | A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) | |
| | В. | B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) | |
| | Z. | Z. None of the above | |
| Behav | ioral | al Symptoms | |
| E0200. | Be | Behavioral Symptom - Presence & Frequency | |
| Note pre | esence | nce of symptoms and their frequency | |
| 1. E 2. E | Behavi Behavi Behavi | avior not exhibited avior of this type occurred 1 to 3 days avior of this type occurred 4 to 6 days, but less than daily avior of this type occurred daily | |
| Enter Code | A. | A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing | g, abusing others sexually) |
| Enter Code | В. | 3. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursin | g at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratce rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/voca disruptive sounds) | ching self, pacing, al symptoms like screaming, |
| E0300. | Ov | Overall Presence of Behavioral Symptoms | |
| Enter Code | We | Vere any behavioral symptoms in questions E0200 coded 1, 2, or 3? 0. No → Skip to E0800, Rejection of Care 1. Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below | |
| E0500. | lm | mpact on Resident | |
| | | id any of the identified symptom(s): | |
| Enter Code | A. | A. Put the resident at significant risk for physical illness or injury?0. No1. Yes | |
| Enter Code | B. | 3. Significantly interfere with the resident's care? 0. No 1. Yes | |
| Enter Code | C. | Significantly interfere with the resident's participation in activities or social interactions? No Yes | |
| E0600. | lm | mpact on Others | |
| | | olid any of the identified symptom(s): | |
| Enter Code | A. | A. Put others at significant risk for physical injury?0. No1. Yes | |
| Enter Code | В. | Significantly intrude on the privacy or activity of others?NoYes | |
| Enter Code | C. | | |

| Resident | | Identifier | Date |
|------------|--|---|--|
| Section | on E - Behavior | | |
| E0800. | Rejection of Care - Presence & Frequency | | |
| Enter Code | Did the resident reject evaluation or care (e.g., bloody goals for health and well-being? Do not include behave resident or family), and determined to be consistent with 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 a series of the stype occurred 4 to 6 days, but a series of this type occurred daily | iors that have already been addre resident values, preferences, or o | essed (e.g., by discussion or care planning with the |
| E0900. | Wandering - Presence & Frequency | | |
| Enter Code | Has the resident wandered? 0. Behavior not exhibited → Skip to E1100, Ch. 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, b. 3. Behavior of this type occurred daily | | oms |
| E1000. | Wandering - Impact | | |
| Enter Code | A. Does the wandering place the resident at signific facility)? 0. No 1. Yes | cant risk of getting to a potenti | ally dangerous place (e.g., stairs, outside of the |
| Enter Code | B. Does the wandering significantly intrude on the 0. No 1. Yes | privacy or activities of others? | |
| | Change in Behavior or Other Symptoms all of the symptoms assessed in items E0100 through E10 | 00 | |
| Enter Code | How does resident's current behavior status, care rejection 0. Same 1. Improved 2. Worse 3. N/A because no prior MDS assessment | on, or wandering compare to pri | or assessment (OBRA or Scheduled PPS)? |

| Resident | | lden | tifier _ | Date | |
|----------------------|---------------------------|---|----------------|--|-------------------------|
| Secti | on | - Preferences for Customary Ro | utiı | ne and Activities | |
| F0300. If resider | Sho nt is un | build Interview for Daily and Activity Preferences beable to complete, attempt to complete interview with family memb | er or s | enducted? - Attempt to interview all resident significant other | ts able to communicate. |
| Enter Code | | No (resident is rarely/never understood <u>and</u> family/significar Daily and Activity Preferences Yes → Continue to F0400, Interview for Daily Preferences | t othe | er not available) $ ightarrow$ Skip to and complete F08 | 00, Staff Assessment of |
| F0400. | Inte | rview for Daily Preferences | | | |
| Show res | sident | he response options and say: "While you are in this facility | ." | | |
| 2. S | ery im Somew ot ver | portant hat important y important Boxes | 4. 5. 9. | Important, but can't do or no choice | |
| | Α. | how important is it to you to choose what clothes to wear? | | | |
| | В. | how important is it to you to take care of your personal belo | ngin | ngs or things? | |
| | C. | how important is it to you to choose between a tub bath, sh | ower, | r, bed bath, or sponge bath? | |
| | D. | how important is it to you to have snacks available between | mea | als? | |
| | E. | how important is it to you to choose your own bedtime? | | | |
| | F. | how important is it to you to have your family or a close frie | nd in | nvolved in discussions about your care | ? |
| | G. | how important is it to you to be able to use the phone in pri | /ate? | ? | |
| | Н. | how important is it to you to have a place to lock your thing | s to k | keep them safe? | |
| F0500. | | rview for Activity Preferences | | | |
| | | he response options and say: "While you are in this facility | ty' | ,, | |
| 2. S | ery im | portant hat important y important | 4. 5. 9. | | |
| Enter Cod | les in l | Boxes | | | |
| | Α. | how important is it to you to have books, newspapers, and i | naga | azines to read? | |
| | B. | how important is it to you to listen to music you like? | | | |
| | C. | how important is it to you to be around animals such as pet | s? | | |
| | D. | how important is it to you to keep up with the news? | | | |
| | E. | how important is it to you to do things with groups of peopl | e? | | |
| | F. | how important is it to you to do your favorite activities? | | | |
| | G. | how important is it to you to go outside to get fresh air when | n the | e weather is good? | |
| F0600. | | how important is it to you to participate in religious services y and Activity Preferences Primary Respondent | or p | practices? | |
| . 00001 | | cate primary respondent for Daily and Activity Preferences (F04 | 00 and | nd F0500) | |
| Enter Code | ···· | 1. Resident | | , | |
| | | Family or significant other (close friend or other represented). Interview could not be completed by resident or family/significant other represented. | nifica | ant other ("No response" to 3 or more items) | ·11) @ |
| MDS 3.0 N | Nursin | Home Comprehensive (NC) Version 1.18.11 Effective 10/0 | 1/202 | 023 | Page 16 of 58 |

| Sect | ion | F - Preferences for Customary Routine and Activities |
|------------|----------|---|
| F0700 | . Sho | ould the Staff Assessment of Daily and Activity Preferences be Conducted? |
| Enter Code | | 0. No (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → |
| Ш | | Skip to and complete GG0100, Prior Functioning: Everyday Activities Yes (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences |
| F0800 | . Sta | ff Assessment of Daily and Activity Preferences |
| o not cor | nduct if | Interview for Daily and Activity Preferences (F0400-F0500) was completed |
| Reside | nt Prefe | ers: |
| ↓ (| Check | all that apply |
| | A. | Choosing clothes to wear |
| | В. | Caring for personal belongings |
| | C. | Receiving tub bath |
| | D. | Receiving shower |
| | E. | Receiving bed bath |
| | F. | Receiving sponge bath |
| | G. | Snacks between meals |
| | H. | Staying up past 8:00 p.m. |
| | l. | Family or significant other involvement in care discussions |
| | J. | Use of phone in private |
| | K. | Place to lock personal belongings |
| | L. | Reading books, newspapers, or magazines |
| | М. | Listening to music |
| | N. | Being around animals such as pets |
| | 0. | Keeping up with the news |
| | P. | Doing things with groups of people |
| | Q. | Participating in favorite activities |
| | R. | Spending time away from the nursing home |
| | S. | Spending time outdoors |
| | T. | Participating in religious activities or practices |
| | Z. | None of the above |
| | | |
| | | |

Resident

| Section | on | GG - Functional Abilities and Goals |
|---------------------|-----------------------------------|--|
| GG0100 exacerbat |). Pi | rior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, |
| Coding: | • | |
| 2. Need | ut an a ed Sc n to c | nt - Resident completed all the activities by themself, with or assistive device, with no assistance from a helper. 9. Not Applicable. Not Applicable. 1 - A helper completed all the activities for the resident. |
| nter Code | | · · |
| ↓ | | Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation or injury. |
| | В. | Indoor Mobility (Ambulation): Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. |
| | C. | Stairs: Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. |
| | D. | Functional Cognition: Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury. |
| | | rior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury if A0310B = 01 |
| check all t | hat a | pply |
| Ů | A. | Manual wheelchair |
| | В. | Motorized wheelchair and/or scooter |
| | C. | Mechanical lift |
| | D. | Walker |
| | E. | Orthotics/Prosthetics |
| | Z. | None of the above |
| | | unctional Limitation in Range of Motion |
| | limita | ation that interfered with daily functions or placed resident at risk of injury in the last 7 days |
| | irmen | nent t on one side t on both sides |
| inter Code | es in l | Boxes |
| | A. | Upper extremity (shoulder, elbow, wrist, hand) |
| | B. | Lower extremity (hip, knee, ankle, foot) |
| | | obility Devices |
| heck all t | hat w | ere normally used in the last 7 days |
| Ò | A. | Cane/crutch |
| | В. | Walker |
| | C. | Wheelchair (manual or electric) |
| | D. | Limb prosthesis |
| | Z. | None of the above were used |

| esident | | | Identifier Date |
|--|--|--|---|
| Sectio | n GG | - Fı | unctional Abilities and Goals - Admission |
| Complete | column 1 w | /hen / | seessment period is the first 3 days of the stay) A0310A = 01. Complete columns 1 and 2 when A0310B = 01. begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| at the star | t of the stay | / (adr | performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted nission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of ermissible to code end of SNF PPS stay (discharge) goal(s). |
| amount of Activities n 06. Ind 05. Set 04. Sup con 03. Par the 02. Sul effc 01. Dep req If activity v 07. Res 09. Not 10. Not | assistance properties assistance properties assistance properties activities assistance and pervision or a strain and properties assistantial assistance and properties assistance and properties assistance assi | rovide leted Reside I-up a r touc rity. As te as elper reside empte ed - Not due f | rmance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to ed. with or without assistive devices. ent completes the activity by themself with no assistance from a helper. ssistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. hing assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident issistance may be provided throughout the activity or intermittently. sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half I assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is ent to complete the activity. add, code reason: attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. to environmental limitations (e.g., lack of equipment, weather constraints) or medical condition or safety concerns |
| 1. dmission erformance | 2. Discharge Goal | | |
| Enter Codes | in Boxes | | |
| | | A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| | | В. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| | | C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| | | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| | | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| | | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| | | Н. | 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. |
| | | I. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |

| Resident | Identifier | Date | | | |
|--|---|--|--|--|--|
| Section GG - Functional Abilities and G | oals - Admission | | | | |
| GG0170. Mobility (Assessment period is the first 3 days of the stay) Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01. When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600. | | | | | |
| Code the resident's usual performance at the start of the stay (admissi at the start of the stay (admission), code the reason. Code the resident codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (dis | 's end of SNF PPS stay (discharge) goal(s) u | If activity was not attempted sing the 6-point scale. Use of | | | |
| Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices. 06. Independent - Resident completes the activity by themself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. | | | | | |
| 09. Not applicable - Not attempted and the resident did not perform this 10. Not attempted due to environmental limitations (e.g., lack of equilibrium) 88. Not attempted due to medical condition or safety concerns 1. 2. | | , or injury. | | | |
| Admission Discharge Performance Goal Enter Codes in Boxes | | | | | |
| <u> </u> | g on back to left and right side, and return to lyir | ig on back on the bed. | | | |
| B. Sit to lying: The ability to move from sitting or | n side of bed to lying flat on the bed. | | | | |
| C. Lying to sitting on side of bed: The ability to support. | move from lying on the back to sitting on the si | de of the bed and with no back | | | |
| D. Sit to stand: The ability to come to a standing | position from sitting in a chair, wheelchair, or o | n the side of the bed. | | | |
| E. Chair/bed-to-chair transfer: The ability to tra | nsfer to and from a bed to a chair (or wheelchai | r). | | | |
| F. Toilet transfer: The ability to get on and off a | toilet or commode. | | | | |
| FF. Tub/shower transfer: The ability to get in and | out of a tub/shower. | | | | |
| G. Car transfer: The ability to transfer in and out door or fasten seat belt. | of a car or van on the passenger side. Does no | t include the ability to open/close | | | |
| I. Walk 10 feet: Once standing, the ability to wa is coded 07, 09, 10, or 88 → Skip to GG0170 | lk at least 10 feet in a room, corridor, or similar s M, 1 step (curb) | space. If admission performance | | | |
| J. Walk 50 feet with two turns: Once standing, | the ability to walk at least 50 feet and make two | turns. | | | |
| K. Walk 150 feet: Once standing, the ability to w | alk at least 150 feet in a corridor or similar spac | ə. | | | |

| Resident | Identifier Date |
|---|--|
| Section GG - F | unctional Abilities and Goals - Admission |
| Complete column 1 when | sessment period is the first 3 days of the stay) A0310A = 01. Complete columns 1 and 2 when A0310B = 01. y begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| at the start of the stay (ad | performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted mission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of permissible to code end of SNF PPS stay (discharge) goal(s). |
| amount of assistance provid Activities may be completed 06. Independent - Resi 05. Setup or clean-up a 04. Supervision or tou completes activity. A 03. Partial/moderate as the effort. 02. Substantial/maxim effort. 01. Dependent - Helper required for the resid 16. Resident refused 09. Not applicable - Not 10. Not attempted due | with or without assistive devices. dent completes the activity by themself with no assistance from a helper. dent completes the activity by themself with no assistance from a helper. desistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. Ching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident assistance may be provided throughout the activity or intermittently. Sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is lent to complete the activity. |
| 1. 2. Admission Discharge Performance Goal Enter Codes in Boxes L. | Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| M. | 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| N. | 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or $88 \rightarrow \text{Skip}$ to GG0170P, Picking up object |
| O. | 12 steps: The ability to go up and down 12 steps with or without a rail. |
| P. | Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| | Q1. Does the resident use a wheelchair and/or scooter? |
| | No → Skip to GG0130, Self Care (Discharge) Yes → Continue to GG0170R, Wheel 50 feet with two turns |
| R. | Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized |
| s. | Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | SS1. Indicate the type of wheelchair or scooter used. |
| | 1. Manual 2. Motorized |

| Resident . | | Identifier Date |
|---|---|--|
| Sect | tion | GG - Functional Abilities and Goals - Discharge |
| Compl When A For all | l ete col u A0310G other Di | elf-Care (Assessment period is the last 3 days of the stay) umn 3 when A0310F = 10 or 11 or when A0310H = 1. is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. ischarge assessments, the stay ends on A2000. |
| | | dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end ode the reason. |
| amoun Activitie 06. 05. 04. 03. 02. 01. If activ 07. 09. 10. | and Quit of assi es may Indepe Setup of Superv comple Partial/ the effor Substa effort. Depender required rity was Reside Not app Not att | rality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to stance provided. be completed with or without assistive devices. ndent - Resident completes the activity by themself with no assistance from a helper. or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. rision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident tes activity. Assistance may be provided throughout the activity or intermittently. Impoderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half wit. Intrial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the dent - 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 d for the resident to complete the activity. not attempted, code reason: Int refused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. empted due to environmental limitations (e.g., lack of equipment, weather constraints) empted due to medical condition or safety concerns |
| Discha Perform | ance | res |
| | A . | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| |] B. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| |] C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| |] E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| |] F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| |] H. | Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. |
| |] I. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |
| | | |

| esident | | | ldentifier | Date | |
|--|--|--|--|--|----|
| Sec | tion | n GG - Functional Abilities | and Goals - Discharg | је | |
| Comp When | lete co A03100 | Mobility (Assessment period is the last 3 days o olumn 3 when A0310F = 10 or 11 or when A0310 G is not = 2 and A0310H = 1 and A2400C minus A Discharge assessments, the stay ends on A2000. | H = 1. | ot = 04, the stay ends on A2400C. | |
| | | sident's usual performance at the end of the sta code the reason. | ay for each activity using the 6-point | scale. If an activity was not attempted at the en | ıd |
| amour Activities 06. 05. 04. 03. 02. 01. If activity 07. 09. 10. | y and Q at of assies may Indep Setup Super compl Partia the eff Subst effort. Deper require vity wa Resid Not a Not at the set of th | stantial/maximal assistance - Helper does MORE | self with no assistance from a helper. In sup; resident completes activity. Helper Is verbal cues and/or touching/steadying out the activity or intermittently. In HALF the effort. Helper lifts, holds, or THAN HALF the effort. Helper lifts or he It es none of the effort to complete the activity prior to the current It perform this activity prior to the current It lack of equipment, weather constraints | er assists only prior to or following the activity. and/or contact guard assistance as resident supports trunk or limbs, but provides less than half trunk or limbs and provides more than half the tivity. Or, the assistance of 2 or more helpers is illness, exacerbation, or injury. | |
| 3. Discha Perform Enter Cod | arge ance des in Bo | Boxes A. Roll left and right: The ability to roll from lying | on back to left and right side, and retur | n to lying on back on the bed. | |
| | _] В. | 3. Sit to lying: The ability to move from sitting on | side of bed to lying flat on the bed. | | |
| | c. | C. Lying to sitting on side of bed: The ability to support. | move from lying on the back to sitting o | n the side of the bed and with no back | |
| | D. | D. Sit to stand: The ability to come to a standing | position from sitting in a chair, wheelcha | ir, or on the side of the bed. | |
| |] E. | E. Chair/bed-to-chair transfer: The ability to tran | sfer to and from a bed to a chair (or wh | eelchair). | |
| |] F. | Toilet transfer: The ability to get on and off a to | oilet or commode. | | |
| | FF | F. Tub/shower transfer: The ability to get in and | out of a tub/shower. | | |
| | G. | G. Car transfer: The ability to transfer in and out of door or fasten seat belt. | of a car or van on the passenger side. C | oes not include the ability to open/close | |
| |] 1. | . Walk 10 feet: Once standing, the ability to walk is coded 07, 09, 10, or 88 → Skip to GG0170N | c at least 10 feet in a room, corridor, or s 1, 1 step (curb) | imilar space. If discharge performance | |
| | J. | J. Walk 50 feet with two turns: Once standing, to | he ability to walk at least 50 feet and ma | ike two turns. | |
| |] K. | K. Walk 150 feet: Once standing, the ability to wa | lk at least 150 feet in a corridor or simila | ır space. | |

| esident | | | | Identifier | Date |
|---|--|---|--|--|--|
| Sect | tio | n (| GG - Functional Abilities and G | Goals - Discha | rge |
| Comp When | lete d A031 | olu 0G i | obility (Assessment period is the last 3 days of the stay) umn 3 when A0310F = 10 or 11 or when A0310H = 1. is not = 2 and A0310H = 1 and A2400C minus A2400B is gracharge assessments, the stay ends on A2000. | reater than 2 and A2105 is | s not = 04, the stay ends on A2400C. |
| | | | dent's usual performance at the end of the stay for each de the reason. | activity using the 6-poir | nt scale. If an activity was not attempted at the end |
| amoun Activiti 06. 05. 04. 03. 02. 01. If activ 07. 09. 10. | r and to fa a des mades mades mades mades mades Setu Supposer the Subposer Deprequentity was Not Not | ssis ay b per per po pervi plete ial/r effor star t. end ired ider app atte | pality of Performance - If helper assistance is required becaustance provided. be completed with or without assistive devices. Indent - Resident completes the activity by themself with no or clean-up assistance - Helper sets up or cleans up; residing rision or touching assistance - Helper provides verbal cue tes activity. Assistance may be provided throughout the activity activity. Assistance - Helper does LESS THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN HALF the ort. Intial/maximal assistance - Helper does MORE THAN | assistance from a helper. ent completes activity. He s and/or touching/steadyir vity or intermittently. effort. Helper lifts, holds, .F the effort. Helper lifts or the effort to complete the a | Iper assists only prior to or following the activity. Iper and/or contact guard assistance as resident or supports trunk or limbs, but provides less than half holds trunk or limbs and provides more than half the activity. Or, the assistance of 2 or more helpers is ent illness, exacerbation, or injury. |
| 3. Discha Performa Enter Coo | ance les in | | wes Walking 10 feet on uneven surfaces: The ability to walk | 10 feet on uneven or slopi | ing surfaces (indoor or outdoor), such as turf or gravel. |
| |] ' | VI. | 1 step (curb): The ability to go up and down a curb and/or If discharge performance is coded 07, 09, 10, or 88 → Ski | | object |
| |] ' | ٧. | 4 steps: The ability to go up and down four steps with or w If discharge performance is coded 07, 09, 10, or $88 \rightarrow 8ki$ | vithout a rail. p to GG0170P, Picking up | object |
| |] ' | Э. | 12 steps: The ability to go up and down 12 steps with or w | rithout a rail. | |
| |] ' | Ρ. | Picking up object: The ability to bend/stoop from a standi | ng position to pick up a sr | nall object, such as a spoon, from the floor. |
| | | | Q3. Does the resident use a wheelchair and/or scool 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet | | |
| |] | ₹. | Wheel 50 feet with two turns: Once seated in wheelchair | /scooter, the ability to whe | eel at least 50 feet and make two turns. |
| | | | RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized | | |
| |] [| S. | Wheel 150 feet: Once seated in wheelchair/scooter, the al | bility to wheel at least 150 | feet in a corridor or similar space. |
| | | | SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized | | |
| | | | | | |

| A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is place before the resident. B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into a from the mouth, and manage denture soaking and rinsing with use of equipment. C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobil including fasteners, if applicable. | esident | | Identifier Date |
|--|---|--|--|
| Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason. Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices. 105. Independent - Resident completes the activity by themself with no assistance from a helper. 106. Setup or clean-up assistance - Helper sets up or cleans up, resident completes activity. Helper assists only prior to or following the activity. 107. Supervision or touching assistance - Helper govided houghout the activity or intermittently. 108. Partialmoderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than the effort. 109. Substantialmaximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half effort. 101. 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. 118. Activity was not attempted, code reason: 119. Resident refused 110. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 120. Rot applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 120. Rot applicable - Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 121. A Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is plan before the resident. 121. C Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equ | Secti | on | GG - Functional Abilities and Goals - OBRA/Interim |
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| nter Codes in Boxes A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is place before the resident. B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into a from the mouth, and manage denture soaking and rinsing with use of equipment. C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does no include transferring in/out of tub/shower. F. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable. G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobil including fasteners, if applicable. | amount of Activities 06. In 05. S 04. S 05. P 1t 02. S 1t 07. R 09. N 10. N | of assisted and the complete c | stance provided. See completed with or without assistive devices. Indent - Resident completes the activity by themself with no assistance from a helper. For clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. Isision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident es activity. Assistance may be provided throughout the activity or intermittently. For clean-up assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the set assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the set activity. 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 a for the resident to complete the activity. For the resident to complete the activity. For the resident does and the resident did not perform this activity prior to the current illness, exacerbation, or injury. For the resident to environmental limitations (e.g., lack of equipment, weather constraints) |
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| G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobil including fasteners, if applicable. | | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| 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 mobil including fasteners, if applicable. | | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| including fasteners, if applicable. | | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| Perconal hygiona: The ability to maintain personal hygional including combine bein cheving combine makeum weeking/draing feed | | Н. | 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. |
| hands (excludes baths, showers, and oral hygiene). | | l. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |

| esident | | | Identifier | Date |
|---|---|---|--|--|
| Sect | tion | GG - Functional Abilities | s and Goals - OBRA/Int | terim |
| | | obility (Assessment period is the ARD plus 2 | • • | |
| • | | mn 5 when A0310A = 02 - 06 and A0310B = lent's usual performance for each activity u | | not attempted, code the reason. |
| Coding Safety amoun Activiti 06. 05. 04. 03. 02. 01. If activ 07. 09. 10. | g: and Quit of assises may be Independent Setup of Superv complete Partial/ the effort. Dependent Dependent Partial/ be Substate | ality of Performance - If helper assistance is restance provided. be completed with or without assistive devices. ndent - Resident completes the activity by there or clean-up assistance - Helper sets up or cle ision or touching assistance - Helper provides activity. Assistance may be provided throug moderate assistance - Helper does LESS TH t. | required because resident's performance is mself with no assistance from a helper, ans up; resident completes activity. Helper as verbal cues and/or touching/steadying ar hout the activity or intermittently. AN HALF the effort. Helper lifts, holds, or so that the terminal transfer is the complete the activity of perform this activity prior to the current ill g., lack of equipment, weather constraints) | assists only prior to or following the activity. nd/or contact guard assistance as resident upports trunk or limbs, but provides less than half ds trunk or limbs and provides more than half the rity. Or, the assistance of 2 or more helpers is |
| OBRA/ Perfor | | es Roll left and right: The ability to roll from lyin | ng on back to left and right side, and return t | to lying on back on the bed. |
| | _] В. | Sit to lying: The ability to move from sitting of | n side of bed to lying flat on the bed. | |
| |] c. | Lying to sitting on side of bed: The ability to | o move from lying on the back to sitting on t | the side of the bed and with no back support. |
| | D. | Sit to stand: The ability to come to a standing | g position from sitting in a chair, wheelchair, | , or on the side of the bed. |
| |] E. | Chair/bed-to-chair transfer: The ability to tra | ansfer to and from a bed to a chair (or whee | elchair). |
| |] F. | Toilet transfer: The ability to get on and off a | toilet or commode. | |
| | FF. | Tub/shower transfer: The ability to get in an | d out of a tub/shower. | |
| |] I. | Walk 10 feet: Once standing, the ability to wa coded 07, 09, 10, or 88 → Skip to GG0170Q | alk at least 10 feet in a room, corridor, or sin 5, Does the resident use a wheelchair and/o | nilar space. If performance in the last 7 days is or scooter? |
| |] J. | Walk 50 feet with two turns: Once standing, | the ability to walk at least 50 feet and make | e two turns. |
| |] K. | Walk 150 feet: Once standing, the ability to w | alk at least 150 feet in a corridor or similar | space. |
| | | | | |

| esident | Identifier | Date |
|---|--|---|
| Section GG - Functional Ab | ilities and Goals - OBRA/Int | terim |
| GG0170. Mobility (Assessment period is the Al | RD plus 2 previous calendar days) | |
| Complete column 5 when A0310A = 02 - 06 and A | | |
| Code the resident's usual performance for each a | activity using the 6-point scale. If an activity was | not attempted, code the reason. |
| 04. Supervision or touching assistance - Help completes activity. Assistance may be provided. 03. Partial/moderate assistance - Helper does the effort. 02. Substantial/maximal assistance - Helper does effort. 01. Dependent - Helper does ALL of the effort. Required for the resident to complete the activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident. | ty by themself with no assistance from a helper. up or cleans up; resident completes activity. Helper a er provides verbal cues and/or touching/steadying an ed throughout the activity or intermittently. LESS THAN HALF the effort. Helper lifts, holds, or su oes MORE THAN HALF the effort. Helper lifts or hold desident does none of the effort to complete the activity. Ident did not perform this activity prior to the current illustrions (e.g., lack of equipment, weather constraints) | assists only prior to or following the activity. nd/or contact guard assistance as resident upports trunk or limbs, but provides less than half ds trunk or limbs and provides more than half the ity. Or, the assistance of 2 or more helpers is |
| 5. OBRA/Interim Performance | | |
| Enter Codes in Boxes | | |
| Q5. Does the resident use a wh | eelchair and/or scooter? | |
| 0. No \rightarrow Skip to H0100, A 1. Yes \rightarrow Continue to GG | ppliances 0170R, Wheel 50 feet with two turns | |
| R. Wheel 50 feet with two turns: O | nce seated in wheelchair/scooter, the ability to wheel | at least 50 feet and make two turns. |
| RR5. Indicate the type of wheeld | hair or scooter used. | |
| 1. Manual 2. Motorized | | |
| S. Wheel 150 feet: Once seated in v | wheelchair/scooter, the ability to wheel at least 150 fe | et in a corridor or similar space. |
| SS5. Indicate the type of wheelc | hair or scooter used. | |
| 1. Manual 2. Motorized | | |
| | | |

| Resident | | ldentifier | Date |
|--------------|------|--|--------------------------------|
| Section | n | H - Bladder and Bowel | |
| H0100. | Ар | pliances | |
| \downarrow | Che | eck 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. | Uri | inary Toileting Program | |
| Enter Code | Α. | Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) bee or reentry or since urinary incontinence was noted in this facility? No → Skip to H0300, Urinary Continence Yes → Continue to H0200B, Response Unable to determine → Skip to H0200C, Current toileting program or trial | n attempted on admission/entry |
| Enter Code | B. | Response - What was the resident's response to the trial program? 0. No improvement 1. Decreased wetness 2. Completely dry (continent) 9. Unable to determine or trial in progress | |
| Enter Code | C. | Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bla used to manage the resident's urinary continence? 0. No 1. Yes | dder training) currently being |
| H0300. | | inary Continence | |
| Enter Code | Urii | nary continence - Select the one category that best describes the resident Always continent Occasionally incontinent (less than 7 episodes of incontinence) Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of contines Always incontinent (no episodes of continent voiding) Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire | C, |
| H0400. | | wel Continence | |
| Enter Code | Bov | wel continence - Select the one category that best describes the resident Always continent Occasionally incontinent (one episode of bowel incontinence) Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movements) Always incontinent (no episodes of continent bowel movements) Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days | ovement) |
| H0500. | | wel Toileting Program | |
| Enter Code | ls a | a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes | |
| H0600. | Во | wel Patterns | |
| Enter Code | Cor | nstipation present? 0. No 1. Yes | |

| esident | | Identifier | Date |
|--------------------|---|--|---------|
| Section | on I - Active Diagnoses | | |
| I0020. Complete | Indicate the resident's primary medical condition only if A0310B = 01 or if state requires completion with an OBRA | | |
| Enter Code | Indicate the resident's primary medical condition category to 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions 10020B. ICD Code | hat best describes the primary reason for ad | nission |
| | | | |

| Resident | | Identifier | Date | |
|---------------------------|---|--|--|--|
| Section | on I - Active Diagnose | es | | |
| | Diagnoses in the last 7 days - C s listed in parentheses are provided as e. | heck all that apply kamples and should not be considered as all-inclusive lists | S | |
| Cancer | | | | |
| | 10100. Cancer (with or without metasta | isis) | | |
| Heart/Circ | culation | | | |
| | 10400. Coronary Artery Disease (CAI 10500. Deep Venous Thrombosis (DN 10600. Heart Failure (e.g., congestive 10700. Hypertension 10800. Orthostatic Hypotension | ciency, pernicious, and sickle cell) crhythmias (e.g., bradycardias and tachycardias) O) (e.g., angina, myocardial infarction, and atherosclerotic (T), Pulmonary Embolus (PE), or Pulmonary Thrombo- heart failure (CHF) and pulmonary edema) PVD) or Peripheral Arterial Disease (PAD) | * ** | |
| Gastrointe | estinal | | | |
| | | ease (GERD) or Ulcer (e.g., esophageal, gastric, and pep ease, or Inflammatory Bowel Disease | tic ulcers) | |
| Genitouri | nary | | | |
| | I1550. Neurogenic Bladder I1650. Obstructive Uropathy | (BPH) ure, or End-Stage Renal Disease (ESRD) | | |
| Infections | | | | |
| | 11700. Multidrug-Resistant Organism 12000. Pneumonia 12100. Septicemia 12200. Tuberculosis 12300. Urinary Tract Infection (UTI) (L 12400. Viral Hepatitis (e.g., Hepatitis A 12500. Wound Infection (other than foo | AST 30 DAYS) , B, C, D, and E) | | |
| Metabolic | · · · · · · · · · · · · · · · · · · · | | | |
| | I3100. Hyponatremia I3200. Hyperkalemia I3300. Hyperlipidemia (e.g., hyperchol | abetic retinopathy, nephropathy, and neuropathy) esterolemia) roidism, hyperthyroidism, and Hashimoto's thyroiditis) | | |
| Musculos | keletal | | | |
| | I3800. Osteoporosis | t disease (DJD), osteoarthritis, and rheumatoid arthritis (R | , | |
| Neurological Neurological | | | | |
| | I4200. Alzheimer's Disease I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebrovascular Accident (CV | A), Transient Ischemic Attack (TIA), or Stroke g. Lewy body dementia, vascular or multi-infarct dementia d to stroke, Parkinson's or Creutzfeldt-Jakob diseases) | ; mixed dementia; frontotemporal dementia such | |
| Neur | as Pick's disease; and dementia related ological Diagnoses continued | | | |
| | | | | |

| Resident | Ide | entifier | | Date | | |
|----------|---|----------------------------------|--|-----------|----------|--|
| Section | Section I - Active Diagnoses | | | | | |
| | Diagnoses in the last 7 days - Check all that apply s listed in parentheses are provided as examples and should not be co | onsidered as all-inclusive lists | | | | |
| Neurolog | jical - Continued | | | | | |
| | I4900. Hemiplegia or Hemiparesis I5000. Paraplegia I5100. Quadriplegia I5200. Multiple Sclerosis (MS) I5250. Huntington's Disease I5300. Parkinson's Disease I5350. Tourette's Syndrome I5400. Seizure Disorder or Epilepsy I5500. Traumatic Brain Injury (TBI) | | | | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | | | | |
| Psychiat | ric/Mood Disorder | | | | | |
| | I5700. Anxiety Disorder I5800. Depression (other than bipolar) I5900. Bipolar Disorder I5950. Psychotic Disorder (other than schizophrenia) I6000. Schizophrenia (e.g., schizoaffective and schizophreniform di I6100. Post Traumatic Stress Disorder (PTSD) | sorders) | | | | |
| Pulmona | ry | | | | | |
| | 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 | | | | | |
| Vision | | | | | | |
| | I6500. Cataracts, Glaucoma, or Macular Degeneration | | | | | |
| None of | | | | | | |
| Other | 17900. None of the above active diagnoses within the last 7 days | | | | | |
| Other | Other 18000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box. | | | | | |
| A | | | | | Щ | |
| В | | | | | | |
| C | | | | | Щ | |
| D | | | | +++ | <u> </u> | |
| E | | <u>L</u> | | +++ | Щ | |
| F | | L | | <u> </u> | | |
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| Resident | | | ldentifier | Date | | |
|-------------|---------------------------|---|--|------------------------|--|--|
| Section | n J - | - Health Conditions | | | | |
| J0100. | Pain M | lanagement - Complete for all residents, regardless of | current pain level | | | |
| At any time | e in the la | ast 5 days, has the resident: | | | | |
| Enter Code | A. Re 0. 1. | ceived scheduled pain medication regimen? No Yes | | | | |
| Enter Code | B. Re 0. 1. | ceived PRN pain medications OR was offered and dec No Yes | lined? | | | |
| Enter Code | C. Re 0. 1. | ceived non-medication intervention for pain? No Yes | | | | |
| J0200. | Should | d 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. 1. | No (resident is rarely/never understood) \rightarrow Skip to and Yes \rightarrow Continue to J0300, Pain Presence | complete J0800, Indicators of Pain or Possible | Pain | | |
| Pain A | Pain Assessment Interview | | | | | |
| J0300. | Pain P | resence | | | | |
| Enter Code | 0. | dent: "Have you had pain or hurting at any time in the No → Skip to J1100, Shortness of Breath Yes → Continue to J0410, Pain Frequency Unable to answer → Skip to J0800, Indicators of Pain | | | | |
| J0410. | Pain F | requency | | | | |
| Enter Code | | dent: "How much of the time have you experienced pa Rarely or not at all Occasionally Frequently Almost constantly Unable to answer | in or hurting over the last 5 days?" | | | |
| J0510. | Pain E | ffect on Sleep | | | | |
| Enter Code | 1. 2. 3. | dent: "Over the past 5 days, how much of the time has p Rarely or not at all Occasionally Frequently Almost constantly Unable to answer | oain made it hard for you to sleep at night?" | | | |
| J0520. | Pain Ir | nterference with Therapy Activities | | | | |
| Enter Code | 0. 1. 2. 3. | dent: "Over the past 5 days, how often have you limited Does not apply - I have not received rehabilitation th Rarely or not at all Occasionally Frequently | | sessions due to pain?" | | |
| | 4 | Almost constantly | | | | |



8. Unable to answer

| esident | | | Identifier | Date | | |
|--------------|-------------|--|--|------------------------------------|--|--|
| Section | on . | J - Health Conditions | | | | |
| Pain A | \ ss | sessment Interview - Continued | 1 | | | |
| J0530. | Pai | in Interference with Day-to-Day Activities | | | | |
| Enter Code | | sk resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) ecause of pain?" | | | | |
| | | Rarely or not at all Occasionally Frequently Almost constantly Unable to answer | | | | |
| J0600. | Pai | in Intensity - Administer ONLY ONE of the following pair | n intensity questions (A or B) | | | |
| Enter Rating | A. | 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 Code | В. | Enter two-digit response. Enter 99 if unable to answer. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale) | | | | |
| | | Mild Moderate Severe Very severe, horrible Unable to answer | | , | | |
| J0700. | Sho | ould the Staff Assessment for Pain be Condu | cted? | | | |
| Enter Code | | No (J0410 = 1 thru 4) → Skip to J1100, Shortness of Yes (J0410 = 9) → Continue to J0800, Indicators of | | | | |
| | | sment for Pain. | | | | |
| J0800. | | licators of Pain or Possible Pain in the last 5 days | 3 | | | |
| \downarrow | Che | eck all that apply | | | | |
| | A. | Non-verbal sounds (e.g., crying, whining, gasping, moar | ning, or groaning) | | | |
| | B. | Vocal complaints of pain (e.g., that hurts, ouch, stop) | | | | |
| | C. | Facial expressions (e.g., grimaces, winces, wrinkled fore | ehead, furrowed brow, clenched teeth or jaw) | | | |
| | D. | Protective body movements or postures (e.g., bracing, during movement) | guarding, rubbing or massaging a body part/area | a, clutching or holding a body par | | |
| | Z. | None of these signs observed or documented \rightarrow If \mbox{ch} | ecked, skip to J1100, Shortness of Breath (dyspn | ea) | | |
| J0850. | Fre | Frequency of Indicator of Pain or Possible Pain in the last 5 days | | | | |
| Enter Code | Fred | Frequency with which resident complains or shows evidence of pain or possible pain | | | | |
| Ш | | Indicators of pain or possible pain observed 1 to 2 Indicators of pain or possible pain observed 3 to 4 Indicators of pain or possible pain observed daily | | | | |



| Resident | Identifier | Date |
|--------------------|--|--------------------------------|
| Section | tion J - Health Conditions | |
| | r Health Conditions D. Shortness of Breath (dyspnea) | |
| \downarrow | 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 | |
| J1300. | 0. Current Tobacco Use | |
| Enter Code | 0. No 1. Yes | |
| J1400. | 0. Prognosis | |
| Enter Code | documentation) | nonths? (Requires physician |
| | 0. No 1. Yes | |
| J1550. | 0. Problem Conditions | |
| ↓ | Check all that apply | |
| | A. Fever | |
| | B. Vomiting | |
| | C. Dehydrated | |
| | D. Internal bleeding | |
| | Z. None of the above | |
| J1700. Complete | 0. Fall History on Admission/Entry or Reentry ete only if A0310A = 01 or A0310E = 1 | |
| Enter Code | A. Did the resident have a fall any time in the last month prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine | |
| Enter Code | B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine | |
| Enter Code | C. Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry 0. No 1. Yes 9. Unable to determine | ý? |
| | Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Sched ever is more recent | uled PPS), |
| Enter Code | recent? | eduled PPS), whichever is more |
| | 0. No → Skip to J2000, Prior Surgery 1. Ves → Continue to J1000, Number of Falls Since Admission/Entry or Reentry or Prior Assessment | at (ORDA or Schodulad DDS) |

| Resident | | Identifier _ | | Date |
|---------------------------------|--------|---|---|------------------------------------|
| Section | n . | J - Health Conditions | | |
| J1900. more rece | | umber of Falls Since Admission/Entry or Reentry or Prio | r Assessment (OBRA or Sch | eduled PPS), whichever is |
| Coding: 0. None 1. One 2. Two o | r mo | ore | | |
| Enter Code | s in E | n Boxes | | |
| | A. | No injury - no evidence of any injury is noted on physical assessment by the resident; no change in the resident's behavior is noted after the | by the nurse or primary care clinician | ; no complaints of pain or injury |
| | В. | Injury (except major) - skin tears, abrasions, lacerations, superficial b the resident to complain of pain | ruises, hematomas and sprains; or a | ny fall-related injury that causes |
| | C. | Major injury - bone fractures, joint dislocations, closed head injuries w | ith altered consciousness, subdural h | nematoma |
| J2000. | Prio | ior Surgery - Complete only if A0310B = 01 | | |
| Enter Code | Did | d the resident have major surgery during the 100 days prior to admissio | n? | |
| Ш | | 0. No1. Yes8. Unknown | | |
| J2100. | Rec | ecent Surgery Requiring Active SNF Care - Complete only if A0310B = | 01 or if state requires completion with | an OBRA assessment |
| Enter Code | Did t | d the resident have a major surgical procedure during the prior inpatient h 0. No 1. Yes 8. Unknown | ospital stay that requires active care | during the SNF stay? |
| | | | | |

| esident | Ider | tifier | Date |
|--------------|--|--|---|
| Sectio | on J - Health Conditions | | |
| Surgica | al Procedures - Complete only if J2100 = 1 | | |
| \downarrow | Check all that apply | | |
| Major Joi | int Replacement | | |
| | J2300. Knee Replacement - partial or total J2310. Hip Replacement - partial or total J2320. Ankle Replacement - partial or total J2330. Shoulder Replacement - partial or total | | |
| Spinal Su | urgery | | |
| | J2400. Involving the spinal cord or major spinal nerves J2410. Involving fusion of spinal bones J2420. Involving lamina, discs, or facets J2499. Other major spinal surgery | | |
| Other Ort | thopedic Surgery | | |
| | J2500. Repair fractures of the shoulder (including clavicle and scap J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not J2520. Repair but not replace joints J2530. Repair other bones (such as hand, foot, jaw) J2599. Other major orthopedic surgery | · · · · · · · · · · · · · · · · · · · | |
| Neurologi | gical Surgery | | |
| | J2600. Involving the brain, surrounding tissue or blood vessels (J2610. Involving the peripheral or autonomic nervous system - o J2620. Insertion or removal of spinal or brain neurostimulators, 6 J2699. Other major neurological surgery | pen or percutaneous | , |
| Cardiopul | ılmonary Surgery | | |
| | J2700. Involving the heart or major blood vessels - open or percui J2710. Involving the respiratory system, including lungs, bronch J2799. Other major cardiopulmonary surgery | | r endoscopic |
| Genitouri | inary Surgery | | |
| | J2800. Involving genital systems (such as prostate, testes, ovaries, J2810. Involving the kidneys, ureters, adrenal glands, or bladder nephrostomies or urostomies) J2899. Other major genitourinary surgery | • • • | removal of |
| Other Maj | jor Surgery | | |
| | J2900. Involving tendons, ligaments, or muscles J2910. Involving the gastrointestinal tract or abdominal contents pancreas, or spleen - open or laparoscopic (including creation) | n or removal of ostomies or percutaneous f | ary tree, gall bladder, liver, eeding tubes, or hernia repair) |
| | J2920. Involving the endocrine organs (such as thyroid, parathyroid J2930. Involving the breast J2940. Repair of deep ulcers, internal brachytherapy, bone marrous J5000. Other major surgery not listed above | | |

| Resident | | | Identifier | | D |)ate | |
|---|--|--|---|---------------------|-------------------------|---------------------|-----------------|
| Secti | ion | K. | - Swallowing/Nutritional Status | | | | |
| | | | wing Disorder s of possible swallowing disorder | | | | |
| • | | • | nat apply | | | | |
| | | | ss of liquids/solids from mouth when eating or drinking | | | | |
| | | | | | | | |
| | | | ughing or choking during meals or when swallowing medications | | | | |
| | D. | | mplaints of difficulty or pain with swallowing | | | | |
| <u>_</u> _ | Z. | | ne of the above | | | | |
| K0200 | . He | | and Weight - While measuring, if the number is X.1 - X.4 round down | ; X.5 or greater ro | ound up | | |
| Pounds |] | А. В. | Weight (in pounds). Base weight on most recent measure in last 30 days practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.) | | | according to sta | ndard facility |
| K0300 | . We | eiah | Loss | | | | |
| Enter Code | Los | 0. 1. | Yes, on physician-prescribed weight-loss regimen | ; | | | |
| | | 2. | , | | | | |
| K0310 | . We | eigh | : Gain | | | | |
| Enter Code | Ga | 0. | 5% or more in the last month or gain of 10% or more in last 6 months No or unknown Yes, on physician-prescribed weight-gain regimen Yes, not on physician-prescribed weight-gain regimen | ; | | | |
| | | | onal Approaches | | | | |
| | | | owing nutritional approaches that apply | | | | |
| Asse 2. Whil Perfo Only 3. Whil Perfo 4. At D | le Not ormed check le a Re ormed Discha | nt per a Re white c colu eside white rge | le NOT a resident of this facility and within the last 7 days Imn 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If re | esident last enter | red 7 or more da | ys ago, leave c | olumn 2 blank |
| | | | | 1. | 2. | 3. | 4. |
| | | | | On Admission | While Not a Resident | While a Resident | At Discharge |
| | | | | 7101111001011 | ↓ Check all | | 2.00.101.90 |
| A. Pare | entera | / V fa | eeding | | | | |
| | | | e.g., nasogastric or abdominal (PEG)) | | | | |
| C. Mec | hanic | ally a | Itered diet - require change in texture of food or liquids (e.g., pureed liquids) | | | | |
| D. Ther | rapeut | ic di | et (e.g., low salt, diabetic, low cholesterol) | | | | |
| 7. None | e of th | e ab | ove | П | П | | П |

| Resident | Identi | ifier | Date | | | | | |
|----------|---|--|-------------------------------|--|--|--|--|--|
| Sec | Section K - Swallowing/Nutritional Status | | | | | | | |
| K071 | 10. Percent Intake by Artificial Route - Complete K0710 only if C | column 2 and/or Column 3 are checked for h | (0520A and/or K0520B | | | | | |
| 2. 3. | While a Resident Performed while a resident of this facility and within the last During Entire 7 Days Performed during the entire last 7 days | t 7 days 2. While a Resident | 3. During Entire 7 Days | | | | | |
| | | 1 | Enter Codes↓ | | | | | |
| A. | Proportion of total calories the resident received through parenteral of 1. 25% or less 2. 26-50% 3. 51% or more | or tube feeding | | | | | | |
| В. | Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more | | | | | | | |

| Section | Section L - Oral/Dental Status | | | | |
|--------------|--------------------------------|---|--|--|--|
| L0200. | De | ental | | | |
| \downarrow | Ch | eck all that apply | | | |
| | A. | Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose) | | | |
| | B. | No natural teeth or tooth fragment(s) (edentulous) | | | |
| | C. | Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn) | | | |
| | D. | Obvious or likely cavity or broken natural teeth | | | |
| | E. | Inflamed or bleeding gums or loose natural teeth | | | |
| | F. | Mouth or facial pain, discomfort or difficulty with chewing | | | |
| | G. | Unable to examine | | | |
| | Z. | None of the above were present | | | |

| Section | n | IVI · | - Skin Conditions |
|--------------|------------|---------------------|---|
| | | Re | port based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage |
| M0100. | Det | term | ination of Pressure Ulcer/Injury Risk |
| \downarrow | Che | ck al | l that apply |
| | A. | Res | ident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device |
| | B. | For | mal assessment instrument/tool (e.g., Braden, Norton, or other) |
| | C. | Clin | ical assessment |
| | Z . | _ | e of the above |
| M0150. | Ris | k of | Pressure Ulcers/Injuries |
| Enter Code | ls th | his re | sident at risk of developing pressure ulcers/injuries? |
| Ш | | 0. 1. | No Yes |
| M0210. | Un | | ed Pressure Ulcers/Injuries |
| Enter Code | Doe | s thi | s resident have one or more unhealed pressure ulcers/injuries? |
| | | 0. 1. | No → Skip to M1030, Number of Venous and Arterial Ulcers Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| M0300. | Cu | rren | t Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| Enter Number | A. | Sta visib | ge 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a ble blanching; in dark skin tones only it may appear with persistent blue or purple hues |
| | | 1. | Number of Stage 1 pressure injuries |
| Enter Number | B. | | ge 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present in intact or open/ruptured blister |
| | | 1. | Number of Stage 2 pressure ulcers - If $0 \rightarrow$ Skip to M0300C, Stage 3 |
| Enter Number | | 2. | Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | C. | | ge 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but s not obscure the depth of tissue loss. May include undermining and tunneling |
| | | 1. | Number of Stage 3 pressure ulcers - If 0 \rightarrow Skip to M0300D, Stage 4 |
| Enter Number | | 2. | Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | D. | | ge 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound. Often includes undermining and tunneling |
| Ш | | 1. | Number of Stage 4 pressure ulcers - If 0 \rightarrow Skip to M0300E, Unstageable - Non-removable dressing/device |
| Enter Number | | 2. | Number of https://example.com/these-stage-4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| M0300 c | ont | inue | ed on next page |
| | | | |

Identifier

Resident

| Resident | | | Identifier | Date |
|--------------|-----|---|------------------------------------|--|
| Section | n | M - Skin Conditions | | |
| M0300. | Cu | rrent Number of Unhealed Pressure Ulcer | s/Injuries at Each Stage - C | continued |
| Enter Number | E. | Unstageable - Non-removable dressing/device: Kr | nown but not stageable due to non | -removable dressing/device |
| Enter Number | | Number of unstageable pressure ulcers/injur Slough and/or eschar | ries due to non-removable dress | ing/device - If $0 \rightarrow \text{Skip}$ to M0300F, Unstageable - |
| Liner Name | | 2. Number of these unstageable pressure ulcer were noted at the time of admission/entry or reel | | n admission/entry or reentry - enter how many |
| Enter Number | F. | Unstageable - Slough and/or eschar: Known but no | ot stageable due to coverage of wo | ound bed by slough and/or eschar |
| Enter Number | | Number of unstageable pressure ulcers due unstageable - Deep tissue injury | to coverage of wound bed by sle | ough and/or eschar - If $0 \rightarrow \text{Skip to M0300G}$, |
| Enter Number | | 2. Number of <u>these</u> unstageable pressure ulcerat the time of admission/entry or reentry | s that were present upon admis | sion/entry or reentry - enter how many were noted |
| | G. | Unstageable - Deep tissue injury: | | |
| Enter Number | | Number of unstageable pressure injuries pre Ulcers | esenting as deep tissue injury - l | f 0 \rightarrow Skip to M1030, Number of Venous and Arteria |
| Enter Number | | 2. Number of <u>these</u> unstageable pressure injuri at the time of admission/entry or reentry | ies that were present upon admi | ssion/entry or reentry - enter how many were noted |
| M1030. | Nu | mber of Venous and Arterial Ulcers | | |
| Enter Number | Ent | er the total number of venous and arterial ulcers pr | resent | |
| M1040. | Oth | ner Ulcers, Wounds and Skin Problems | | |
| \downarrow | Che | eck all that apply | | |
| | Foo | ot Problems | | |
| | A. | Infection of the foot (e.g., cellulitis, purulent drainage | re) | |
| | B. | Diabetic foot ulcer(s) | | |
| | C. | Other open lesion(s) on the foot | | |
| | Oth | er Problems | | |
| | D. | Open lesion(s) other than ulcers, rashes, cuts (e.g | g., cancer lesion) | |
| | E. | Surgical wound(s) | | |
| | F. | Burn(s) (second or third degree) | | |
| | G. | Skin tear(s) | | |
| | Н. | Moisture Associated Skin Damage (MASD) (e.g., ir | ncontinence-associated dermatitis | [IAD], perspiration, drainage) |
| | Nor | ne of the Above | | |
| | Z. | None of the above were present | | |

| Resident | | ldentifier | | Date |
|--------------|-----|--|----------------|------|
| Section | on | M - Skin Conditions | | |
| M1200. | Ski | in and Ulcer/Injury Treatments | | |
| \downarrow | Che | eck all that apply | | |
| | A. | Pressure reducing device for chair | | |
| | В. | Pressure reducing device for bed | | |
| | C. | Turning/repositioning program | | |
| | D. | Nutrition or hydration intervention to manage skin problems | | |
| | E. | Pressure ulcer/injury care | | |
| | F. | Surgical wound care | | |
| | G. | Application of nonsurgical dressings (with or without topical medications) other | r than to feet | |
| | Н. | Applications of ointments/medications other than to feet | | |
| | I. | Application of dressings to feet (with or without topical medications) | | |
| | 7 | None of the above were provided | | |

| esident _ | | Identifier | Date | | | |
|------------|--|--|-------------------------|---------------------|--|--|
| Sect | ion | N - Medications | | | | |
| N030 |). In | jections | | | | |
| Enter Days | Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication | | | | | |
| N035 | 0350. Insulin | | | | | |
| Enter Days | A. | Insulin injections - Record the number of days that insulin injections were received during the reentry if less than 7 days Orders for insulin - Record the number of days the physician (or authorized assistant or prainsulin orders during the last 7 days or since admission/entry or reentry if less than 7 days | · | · | | |
| N041 | 5. Hi | gh-Risk Drug Classes: Use and Indication | | | | |
| 2. | or ree | ing If the resident is taking any medications by pharmacological classification, not how it is used, during intry if less than 7 days Ition noted Imn 1 is checked, check if there is an indication noted for all medications in the drug class | the last 7 days or sinc | e admission/entry | | |
| | | | 1. Is taking | 2. Indication noted | | |
| | | | ↓ Check all | that apply↓ | | |
| A. | Antip | sychotic | | | | |
| | Antia | • | | | | |
| | | epressant | | | | |
| | Hypno | | | | | |
| | | pagulant (e.g., warfarin, heparin, or low-molecular weight heparin) | | | | |
| | Antibi | | | | | |
| | Diure | | Ц | Щ | | |
| | Opioi | | | | | |
| | | atelet glycemic (including insulin) | | | | |
| | | of the above | | | | |
| - | .10116 | | | | | |

| esident | | | ldentifier | Date |
|-------------|-----|------------------|--|-----------------------------------|
| Section | n | N - | Medications | |
| N0450. | Ant | ipsy | chotic Medication Review | |
| Enter Code | A. | | the resident receive antipsychotic medications since admission/entry or reentry or the prior OBI e recent? | RA assessment, whichever is |
| Ш | | 0. | \mbox{No} - Antipsychotics were not received \rightarrow Skip N0450B, N0450C, N0450D, and N0450E | |
| | | 1. | $\textbf{Yes} \text{ -} \text{Antipsychotics were received on a routine basis only} \rightarrow \text{Continue to N0450B, Has a GDR been a substitution of the continue to N0450B}.$ | attempted? |
| | | 2. | $\textbf{Yes} \text{ -} \text{Antipsychotics were received on a PRN basis only} \rightarrow \text{Continue to N0450B, Has a GDR been attraction}.$ | empted? |
| Enter Code | В. | 3. Has | Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR b a gradual dose reduction (GDR) been attempted? | een attempted? |
| Eliter Code | | 0. | No → Skip to N0450D, Physician documented GDR as clinically contraindicated | |
| | | 1. | Yes → Continue to N0450C, Date of last attempted GDR | |
| | C. | | e of last attempted GDR: Day Year | |
| Enter Code | D. | Phy | sician documented GDR as clinically contraindicated | |
| | | 0. | \mbox{No} - GDR has not been documented by a physician as clinically contraindicated \rightarrow Skip N0450E, Date clinically contraindicated | physician documented GDR as |
| | | 1. | $\textbf{Yes} \text{ - GDR has been documented by a physician as clinically contraindicated} \rightarrow \textbf{Continue to N0450E}, \\ \textbf{GDR as clinically contraindicated}$ | Date physician documented |
| | E. | | e physician documented GDR as clinically contraindicated: | |
| N2001. | Dru | ıg R | egimen Review - Complete only if A0310B = 01 | |
| Enter Code | Did | a co | mplete drug regimen review identify potential clinically significant medication issues? | |
| | | 0. 1. 9. | No - No issues found during review Yes - Issues found during review NA - Resident is not taking any medications | |
| N2003. | Ме | dica | tion Follow-up - Complete only if N2001 = 1 | |
| Enter Code | | | acility contact a physician (or physician-designee) by midnight of the next calendar day and con ended actions in response to the identified potential clinically significant medication issues? No Yes | iplete prescribed/ |
| N2005. | Ме | dica | tion Intervention - Complete only if A0310H = 1 | |
| Enter Code | | ndar | acility contact and complete physician (or physician-designee) prescribed/recommended actions day each time potential clinically significant medication issues were identified since the admiss | |
| | | 0. 1. 9. | No Yes NA - There were no potential clinically significant medication issues identified since admission or reside | ent is not taking any medications |

| Resident | Identifier | | Date | | | | |
|---|--------------------------|--------------------|------------------------|--------------------|--|--|--|
| Section O - Special Treatments, Procedures, and Programs O0110. Special Treatments, Procedures, and Programs | | | | | | | |
| Check all of the following treatments, procedures, and prog | rams that were performed | | | | | | |
| a. On Admission Assessment period is days 1 through 3 of the SNF PF b. While a Resident Performed while a resident of this facility and within | | a. On Admission | b. While a Resident | c. At Discharge | | | |
| At Discharge Assessment period is the last 3 days of the SNF PPS | Stay ending on A2400C | ↓ | Check all that apply ↓ | ļ | | | |
| Cancer Treatments | | | | | | | |
| A1. Chemotherapy | | | | | | | |
| A2. IV | | | | | | | |
| A3. Oral | | | | | | | |
| A10. Other | | | | | | | |
| B1. Radiation | | | | | | | |
| Respiratory Treatments | | <u>_</u> | _ | _ | | | |
| C1. Oxygen therapy | | <u> </u> | | | | | |
| C2. Continuous | | | | | | | |
| C3. Intermittent | | | | | | | |
| C4. High-concentration | | | <u> </u> | | | | |
| D1. Suctioning | | | | | | | |
| D2. Scheduled | | | | | | | |
| D3. As needed | | | | | | | |
| E1. Tracheostomy care | Lau\ | | | | | | |
| F1. Invasive Mechanical Ventilator (ventilator or respira G1. Non-invasive Mechanical Ventilator | lor) | | | | | | |
| G2. BiPAP | | | | | | | |
| G3. CPAP | | | | | | | |
| Other | | | | | | | |
| H1. IV Medications | | | П | П | | | |
| H2. Vasoactive medications | | | | | | | |
| H3. Antibiotics | | | | | | | |
| H4. Anticoagulant | | | | | | | |
| H10. Other | | | | | | | |
| I1. Transfusions | | | | | | | |
| O0110 continued on next page | | | | | | | |
| | | | | | | | |

| Section O - Special Treatments, Procedures, and Programs O0110. Special Treatments, Procedures, and Programs - Continued Check all of the following treatments, procedures, and programs that were performed a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A24008 b. While a Resident Performed while a resident of this facility and within the Isst 14 days c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C J. Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C J. Discharge J. Hemodialysis J. Performed idialysis J. Performed dialysis KI. Hospice care MI. Isolation or quarantine for active infectious disease (does not include standard bodylfluid precautions) O1. IV Access J. Performed dialysis J. Performed Accession of RAI manual for current influenza vaccination season and reporting period A. Central (e.g., PICC, tunneled, port) None of the above O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season? A. Did the resident receive the influenza vaccine not received, state reason 1. Yes — Continue to O0250B, Date influenza vaccine received B. Date influenza vaccine received, state reason: C. If influenza vaccine not received, state reason: 1. Resident not in this facility during his year's influenza vaccination season 2. Received outside of this facility Not eligible - medical contrandication 4. Offered and declined Not offered 5. Influenza vaccine not received, state reason: 1. Yes — Skip to O0250B, Therapies B. If Pneumococcal vaccination up to date? 0. No — Confinue to O0300B, If Pneumococcal vaccination up to date? 1. Not eligible - medical contrandication 2. Offered and declined Not offered Not offered 1. Not eligible - medical contrandication 2. Offered and declined Not offered Not offered Not offered and declined | Residen | nt | Identifier | | Date | |
|--|---------------|-----------------------|--|---------------------------|--------------------------|------------|
| a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B White a Resident Performed white a resident of this facility and within the last 14 days Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C JI. Dialysis J3. Hemodialysis J3. Peritoneal dialysis K1. Hospice care M1. Isolation or quarantine for active infectious disease (does not include standard bodyffluid precautions) O1. IV Access O2. Peripheral O3. Midlline O4. Central (e.g., PICC, tunneled, port) None of the above C1. None of the above AD bid the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? O. No — Skip to O0250C, if influenza vaccine received. state reason 1. Yes — Confinue to O0250B, Date influenza vaccine received B. Date influenza vaccine received, state reason: 1. Resident not in this facility during this year's influenza vaccination season? CRESIDED OF STATE OF S | | | • | nd Program | S | |
| Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B b. While a Resident Performed while a resident of this facility and within the last 14 days c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C J1. Dialysis J2. Hemodialysis J3. Peritoneal dialysis While a Resident While a Resident Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C J1. Dialysis J2. Hemodialysis J3. Peritoneal dialysis While a Resident Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C While a Resident Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C While a Resident Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C While a Resident Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C While a Resident Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C While a Resident correction in Check all that apply While a Resident apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C Check all that apply Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C Check all that apply Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C Check all that apply Check all that apply Check all that apply Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C Check all that apply Check all th | Chec | ck all of t | the following treatments, procedures, and programs that were performed | | | |
| Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C J1. Dialysis J2. Hemodialysis J3. Peritoneal dialysis W1. Hospice care M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) O1. IV Access O2. Peripheral O3. Midline O4. Central (e.g., PICC, tunneled, port) None of the Above Z1. None of the Above Z2. None of the above O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period Enner Coop B. Date influenza vaccine received the influenza vaccine in this facility for this year's influenza vaccination season? C. If influenza vaccine received — Complete date and skip to 00300A, is the resident's Pneumococcal vaccination up to date? Warner Coop In Resident not in this facility during this year's influenza vaccination season 1. Resident not in this facility during this year's influenza vaccination season 1. Resident not in this facility of this facility and influenza vaccine due to a declared shortage Not offered 6. Inability to obtain influenza vaccine due to a declared shortage None of the above O3000. Pneumococcal Vaccine A. Is the resident's Pneumococcal vaccination up to date? None of the above D3000. Pneumococcal Vaccine I. Yes — Sibje to 0400, 17 repaises B. If Pneumococcal vaccine not received, state reason: 1. Yes — Sibje to 0400, 17 repaises B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined Not offered 3. Is the resident's Pneumococcal vaccine not received, state reason: 1. Yes — Sibje to 0400, 17 repaises B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined O2060. O107 repaises | b. V | Assessm While a f | ent period is days 1 through 3 of the SNF PPS Stay starting with A2400B Resident | | | |
| J2. Hemodialysis J3. Peritoneal dialysis W1. Hospice care M1. Isolation or quarantine for active infectious disease (does not include standard bodyffluid precautions) O1. IV Access O2. Peripheral O3. Midline O4. Central (e.g., PICC, tunneled, port) None of the Above O250. 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? 1. Yes → Continue to O0250b, Date influenza vaccine received, state reason 1. Yes → Continue to O0250b, Date influenza vaccination season C. If influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? 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 D0300. Pneumococcal Vaccine Coston → Continue to O0300B, If Pneumococcal vaccine not received, state reason: 1. Yes → Skip to O0400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 1. Yes → Skip to O0400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not eligible - medical contraindication 2. Offered and declined 3. Not eligible - medical contraindication 2. Offered and declined 3. Not eligible - medical contraindication 2. Offered and declined 3. Not eligible - medical contraindication 4. State reason: 1. Not eligible - medical contraindication 2. Offered and declined | | | | ↓ | Check all that apply ↓ | ↓ |
| J3. Peritoneal dialysis | J1. D | Dialysis | | | | |
| M1. Isolation or quarantine for active infectious disease (does not include standard bodyfluid precautions) O1. IV Access O2. Peripheral O3. Midline O4. Central (e.g., PICC, tunneled, port) None of the Above Z1. None of the above O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period Enter Code A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? 0. No → Skip to 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? C5. 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 C0300. 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 00400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | J | I2. Hen | nodialysis | | | |
| M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) O1. IV Access O2. Peripheral O3. Midline O4. Central (eg., PICC, tunneled, port) None of the Above Z1. None of the above O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period Enter Core A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? O. No → Skip to O0250C, If influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date influenza vaccine received B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? □ 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 5. Not offered 6. Inability to obtain influenza vaccine due to a declared shortage 9. None of the above O0300. Pneumococcal Vaccine A. Is the resident's Pneumococcal vaccination up to date? O. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason: 1. Yes → Skip to O0400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | J | I3. Peri | toneal dialysis | | | |
| Dots | | • | | | | |
| O2. Peripheral □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ | M1. Is | solation ody/fluid | or quarantine for active infectious disease (does not include standard precautions) | | | |
| O3. Midline | O1. I | V Acces | s | | | |
| O4. Central (e.g., PICC, tunneled, port) None of the Above Z1. None of the above □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□ | C | D2. Peri | pheral | | | |
| None of the Above Z1. None of the above | C | D3. Mid | line | | | |
| 21. None of the above | | | | | | |
| Double | None | of the A | Above | | | |
| 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? | | | | | | |
| No → Skip to 00250C, If influenza vaccine not received, state reason 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? | O02 | 250. lr | nfluenza Vaccine - Refer to current version of RAI manual for current infl | uenza vaccination seas | son and reporting period | |
| C. If influenza vaccine not received, state reason: 1. Resident not in this facility during this year's influenza vaccination season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain influenza vaccine due to a declared shortage 9. None of the above O0300. Pneumococcal Vaccine 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 B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | Enter C | Code A | 0. No \rightarrow Skip to O0250C, If influenza vaccine not received, state reasons | | ation season? | |
| 1. Resident not in this facility during this year's influenza vaccination season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain influenza vaccine due to a declared shortage 9. None of the above O0300. Pneumococcal Vaccine Enter Code A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | | В | | ι, Is the resident's Pneι | imococcal vaccination u | p to date? |
| 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 B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | | Code | Resident not in this facility during this year's influenza vaccination Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | season | | |
| 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined | O030 | 00. P | neumococcal Vaccine | | | |
| 1. Not eligible - medical contraindication 2. Offered and declined | Enter C | Code A | 0. $\operatorname{\textbf{No}} \rightarrow \operatorname{Continue}$ to O0300B, If Pneumococcal vaccine not received, | state reason | | |
| | Enter C | Code B | Not eligible - medical contraindication Offered and declined | | | |

| Section O - | • | ial Treatments, Procedures, and Programs | |
|--|-----------|---|------|
| | | 01 (complete O0400D2 when required by state) | |
| Complete only union? | | eech-Language Pathology and Audiology Services | |
| Enter Number of Minutes | 1. | | те |
| 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 in the last 7 days | |
| 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 o residents in the last 7 days | of |
| | If the | $\textbf{sum of individual, concurrent, and group minutes is zero,} \rightarrow \textbf{skip to O0400A5}, \textbf{Therapy start date}$ | |
| Enter Number of Minutes | 3A. | . Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatme sessions in the last 7 days | ent |
| 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 | |
| | | Month Day Year | |
| | 6. | Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes therapy is ongoing | s if |
| | | Month Day Year | |
| Fater North on of Minoton | B. Oc | cupational Therapy | |
| Enter Number of Minutes 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 days | е |
| | 2. | Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days | |
| Enter Number of Minutes | 3. | Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group o residents in the last 7 days | of |
| Fater North on of Minoton | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date | |
| Enter Number of Minutes Enter Number of Days | 3A. | . Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatme sessions in the last 7 days | ent |
| Line 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 | |
| | | Month Day Year | |
| | 6. | Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes therapy is ongoing | s if |
| | | Month Day Year | |
| O0400 continued | on next | • | |
| MDS 3.0 Nursing Hom | ne Compre | ehensive (NC) Version 1.18.11 Effective 10/01/2023 Page 46 of | 58 |

| Resident | Identifier Date |
|---|---|
| Section O - | Special Treatments, Procedures, and Programs |
| O0400. Therapie | · |
| Complete only when A | 0310B = 01 (complete O0400D2 when required by state) |
| Enter Number of Minutes | C. Physical Therapy |
| | Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days |
| Enter Number of Minutes | 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days |
| Enter Number of Minutes | Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days |
| Enter Number of Minutes | If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date |
| | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days |
| Enter Number of Days | 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 |
| | |
| | Month Day Year |
| | 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 |
| Enter Number of Minutes | D. Respiratory Therapy |
| Enter Number of Minutes Enter Number of Days | Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy |
| Little Number of Days | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| Falsa Nambara (Missian | E. Psychological Therapy (by any licensed mental health professional) |
| Enter Number of Minutes Enter Number of Days | Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational 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 Minutes | F. Recreational Therapy (includes recreational and music therapy) |
| Enter Number of Days | Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy |
| | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| O0420. Distinct | Calendar Days of Therapy |
| Complete only when A | 0310B = 01 |
| 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 in the past 7 days. |
| | |

| Resident | | Identifier | Date |
|-------------------------|----------|--|---|
| Section O - S | Speci | al Treatments, Procedures, and Programs | |
| O0425. Part A Th | nerapies | | |
| Complete only if A0310 |)H = 1 | | |
| Enter Number of Minutes | A. Spe | eech-Language Pathology and Audiology Services | |
| | 1. | Individual minutes - record the total number of minutes this therapy was administered to the start date of the resident's most recent Medicare Part A stay (A2400B) | the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered to with one other resident since the start date of the resident's most recent Medicare Part A | o the resident concurrently a stay (A2400B) |
| Enter Number of Minutes | 3. | Group minutes - record the total number of minutes this therapy was administered to the residents since the start date of the resident's most recent Medicare Part A stay (A2400B) | resident as part of a group of |
| | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupati | onal Therapy |
| Enter Number of Minutes | 4. | Co-treatment minutes - record the total number of minutes this therapy was administered sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) | |
| Enter Number of Days | 5. | Days - record the number of days this therapy was administered for at least 15 minutes resident's most recent Medicare Part A stay (A2400B) | a day since the start date of the |
| | B. Occ | cupational Therapy | |
| Enter Number of Minutes | | Individual minutes - record the total number of minutes this therapy was administered to the start date of the resident's most recent Medicare Part A stay (A2400B) | the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered to with one other resident since the start date of the resident's most recent Medicare Part A | |
| Enter Number of Minutes | 3. | Group minutes - record the total number of minutes this therapy was administered to the 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 sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) | |
| Enter Number of Days | 5. | Days - record the number of days this therapy was administered for at least 15 minutes resident's most recent Medicare Part A stay (A2400B) | a day since the start date of the |
| | C. Phy | sical Therapy | |
| Enter Number of Minutes | - | Individual minutes - record the total number of minutes this therapy was administered to the start date of the resident's most recent Medicare Part A stay (A2400B) | the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered to with one other resident since the start date of the resident's most recent Medicare Part A | o the resident concurrently stay (A2400B) |
| Enter Number of Minutes | 3. | Group minutes - record the total number of minutes this therapy was administered to the residents since the start date of the resident's most recent Medicare Part A stay (A2400B) | resident as part of a group of |
| | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Ca | alendar Days of Part A Therapy |
| Enter Number of Minutes | 4. | Co-treatment minutes - record the total number of minutes this therapy was administered sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) | |
| Enter Number of Days | 5. | Days - record the number of days this therapy was administered for at least 15 minutes resident's most recent Medicare Part A stay (A2400B) | a day since the start date of the |
| | | | |

| esident | | Identifier | Date |
|-------------------------|----------------------|--|---|
| Section | n | O - Special Treatments, Procedures, and Programs | |
| O0430. | Dis | tinct Calendar Days of Part A Therapy | |
| Complete | only | if A0310H = 1 | |
| Enter Number | of Day | Record the number of calendar days that the resident received Speech-Language Patholog Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the Part A stay (A2400B) | gy and Audiology Services, e resident's most recent Medicare |
| O0500. | Res | storative Nursing Programs | |
| Record the none or less | num s thai | ber of days each of the following restorative programs was performed (for at least 15 minutes a day) n 15 minutes daily) | in the last 7 calendar days (enter 0 if |
| Number of Days | Tec | chnique | |
| | Α. | Range of motion (passive) | |
| | В. | Range of motion (active) | |
| | C. | Splint or brace assistance | |
| Number of Days | Tra | ining and Skill Practice In: | |
| | D. | Bed mobility | |
| | <u>E.</u> | Transfer | |
| | F | Walking | |
| | G. | Dressing and/or grooming | |
| | Н. | Eating and/or swallowing | |
| | l | Amputation/prostheses care | |
| | J. | Communication | |

| esident | | Ide | ntifier | Date |
|------------------|---------------|--|---|---|
| Sec | tic | on P - Restraints and Alarms | | |
| P010 | 00. | Physical Restraints | | |
| Physi individ | cal r dual | restraints are any manual method or physical or mechanical device, m I cannot remove easily which restricts freedom of movement or normal | aterial or equipme access to one's b | nt attached or adjacent to the resident's body that the ody |
| 1. | No Us | ot used sed less than daily sed daily | | |
| Enter (| Code | les in Boxes | | |
| | Use | ed in Bed | | |
| | Α. | Bed rail | | _ |
| | В. | Trunk restraint | | |
| | C. | Limb restraint | | - |
| | D. | Other | | |
| | Use | ed in Chair or Out of Bed | | |
| | Ε. | Trunk restraint | | - |
| | F. | Limb restraint | | - |
| _ | G. | Chair prevents rising | | - |
| | H. | Other | | |
| P020 | 00. | Alarms | | |
| An ala | arm i | is any physical or electronic device that monitors resident movement a | nd alerts the staff | when movement is detected |
| 1. | Not Use | t used ed less than daily ed daily | | |
| Enter (| Code | les in Boxes | | |
| | Α. | Bed alarm | | |
| | В. | Chair alarm | | |
| | C. | Floor mat alarm | | |
| | D. | Motion sensor alarm | | |
| | Ε. | Wander/elopement alarm | | |
| | F. | Other alarm | | |
| | | | | |

| Resident | | Identifier | Date |
|--------------|--------|--|--|
| Section | on | Q - Participation in Assessment and Goal Setting | |
| Q0110. | Pa | rticipation in Assessment and Goal Setting | |
| Identify all | l acti | ve participants in the assessment process | |
| \downarrow | Ch | eck all that apply | |
| | A. | Resident | |
| | В. | Family | |
| | C. | Significant other | |
| | D. | Legal guardian | |
| | E. | Other legally authorized representative | |
| | Z. | None of the above | |
| Q0310. | Re | sident's Overall Goal | |
| Complete | only | rif A0310E = 1 | |
| Enter Code | Α. | Resident's overall goal for discharge established during the assessment process 1. Discharge to the community 2. Remain in this facility 3. Discharge to another facility/institution 9. Unknown or uncertain | |
| Enter Code | B. | Indicate information source for Q0310A 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | |
| Q0400. | Di | scharge Plan | |
| Enter Code | A. | Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes → Skip to Q0610, Referral | |
| | | sident's Documented Preference to Avoid Being Asked Question Q0500B rif A0310A = 02, 06, or 99 | |
| Enter Code | Do | es resident's clinical record document a request that this question (Q0500B) be asked only on a comp 0. No 1. Yes → Skip to Q0610, Referral | rehensive assessment? |
| Q0500. | Re | turn to Community | |
| Enter Code | B. | Ask the resident (or family or significant other or guardian or legally authorized representative only if resid respond): "Do you want to talk to someone about the possibility of leaving this facility and returning the community?" 0. No 1. Yes 9. Unknown or uncertain | ent is unable to understand or to live and receive services in |
| Enter Code | C. | Indicate information source for Q0500B 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | |



| Resident | | | Identifier | Date |
|------------|----------------------------------|--|---------------------------------|--|
| Section | n Q | - Participation in Asses | sment and Goal Se | etting |
| Q0550. | Resid | dent's Preference to Avoid Being Ask | ed Question Q0500B | |
| Enter Code | A. D re | espond) want to be asked about returning to th No - then document in resident's clinical reco Yes | e community on all assessments? | Intative only if resident is unable to understand or (Rather than on comprehensive assessments alone) omprehensive assessment |
| Enter Code | C. In | ndicate information source for Q0550A | | |
| Ш | 1. 2. 3. 4. 5. 9. | Significant other Legal guardian Other legally authorized representative | | |
| Q0610. | Refer | rral | | |
| Enter Code | A. H 0. 1. | | Agency (LCA)? | |
| | | on Referral to Local Contact Agency | (LCA) Not Made | |
| Complete | • | | | |
| Enter Code | 1. 2. 3. 4. 5. | Referral not wantedDischarge date 3 or fewer months away | 1 | |

| Resident | | | Identifier | Date |
|-------------|----|--|---------------------------------------|-------------------------------|
| Section | n | V - Care Area Assessment (CAA | A) Summary | |
| | | ms From the Most Recent Prior OBRA or Sched if A0310E = 0 and if the following is true for the prior assess i | | |
| Enter Code | A. | Prior Assessment Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive asses 06. Significant correction to prior quarterly assessment 99. None of the above | , , , , , , , , , , , , , , , , , , , | |
| Enter Code | B. | Prior Assessment PPS Reason for Assessment (A0310B 01. 5-day scheduled assessment 08. IPA - Interim Payment Assessment 99. None of the above | value from prior assessment) | |
| | C. | Prior Assessment Reference Date (A2300 value from Month Day Year | om prior assessment) | |
| Enter Score | D. | Prior Assessment Brief Interview for Mental S | atus (BIMS) Summary Score (C0500 v | value from prior assessment) |
| Enter Score | E. | Prior Assessment Resident Mood Interview (Passessment) | HQ-2 to 9©) Total Severity Score (D0 | 160 value from prior |
| Enter Score | F. | Prior Assessment Staff Assessment of Reside assesment) | nt Mood (PHQ-9-OV) Total Severity | Score (D0600 value from prior |

| Resident | | ldentifier | Date |
|--|---|--|---|
| Section V - Care Area Assess | sment (CA | - | |
| V0200. CAAs and Care Planning | | | |
| Check column A if Care Area is triggered. For each triggered Care Area, indicate whether problem(s) identified in your assessment of the RAI (MDS and CAA(s)). Check column B if the Indicate in the Location and Date of CAA Document include information on the complicating factors, | care area. The <u>Care</u> triggered care area is mentation column wh | Planning Decision column must addressed in the care plan. ere information related to the control of the control | n of current care plan is necessary to address the st be completed within 7 days of completing the CAA can be found. CAA documentation should e area. |
| A. CAA Results | | | |
| Care Area | A. Care Area Triggered | B. Care Planning Decision | Location and Date of CAA documentation |
| | ↓ Check a | ll that apply↓ | |
| 01. Delirium | | | |
| 02. Cognitive Loss/Dementia | | | |
| 03. Visual Function | | | |
| 04. Communication | | | |
| 05. ADL Functional/Rehabilitation Potential | | | |
| 06. Urinary Incontinence and Indwelling Catheter | | | |
| 07. Psychosocial Well-Being | | | |
| 08. Mood State | | | |
| 09. Behavioral Symptoms | | | |
| 10. Activities | | | |
| 11. Falls | | | |
| 12. Nutritional Status | | | |

2. Date

2. Date

Month

Month

Day

Day

B. Signature of RN Coordinator for CAA Process and Date Signed

C. Signature of Person Completing Care Plan Decision and Date Signed

13. Feeding Tube

15. Dental Care

19. Pain

16. Pressure Ulcer

1. Signature

1. Signature

17. Psychotropic Drug Use18. Physical Restraints

14. Dehydration/Fluid Maintenance

20. Return to Community Referral

Year

Year

| Resident | | Identifier | Date |
|--------------------------|---|--|--|
| Section | on X - Correction Request | | |
| Identific section, re | te Section X only if A0050 = 2 or 3 cation of Record to be Modified/Inactivated - The folloproduce the information EXACTLY as it appeared on the existing nation is necessary to locate the existing record in the National M | erroneous record, even if the information is | nt record that is in error. In this incorrect. |
| X0150. | Type of Provider (A0200 on existing record to be modified/in | nactivated) | |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | Name of Resident (A0500 on existing record to be modified | /inactivated) | |
| | A. First name: | | |
| | | | |
| | C. Last name: | | |
| | | | |
| X0300. | Gender (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | 1. Male | | |
| | 2. Female | | |
| X0400. | Birth Date (A0900 on existing record to be modified/inactivate | d) | |
| | Month Day Year | | |
| X0500. | Social Security Number (A0600A on existing record to be | modified/inactivated) | |
| | | , | |
| | | | |
| X0600. | Type of Assessment (A0310 on existing record to be modified to be | fied/inactivated) | |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive asses 06. Significant correction to prior quarterly assessment 99. None of the above | | |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A St | | |
| | 08. IPA - Interim Payment Assessment Not PPS Assessment | | |
| | 99. None of the above | | |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |

| Resident | | Identifier Date |
|--------------|-------|--|
| Section | n | X - Correction Request |
| X0700. | Da | te on existing record to be modified/inactivated - Complete one only |
| | A. | Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 |
| | | Month Day Year |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 |
| | | Month Day Year |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 |
| | | Month Day Year |
| Correct | ion . | Attestation Section - Complete this section to explain and attest to the modification/inactivation request |
| | Со | rrection Number |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one |
| X0900. | Re | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) |
| | Che | ck 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. | Re | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) |
| ↓ | Che | ck all that apply |
| <u>.</u> | | Event did not occur |
| | Z. | Other error requiring inactivation If "Other" checked, please specify: |
| X1100. | RN | Assessment Coordinator Attestation of Completion |
| | Α. | Attesting individual's first name: |
| | | |
| | | |
| | B. | Attesting individual's last name: |
| | | |
| | C. | Attesting individual's title: |
| | D. | Signature |
| | E. | Attestation date |
| | | Month Day Year |

| Resident | | Identifier | Date |
|-----------|---|------------|------|
| Section | Z - Assessment Administration | | |
| Z0100. M | ledicare Part A Billing | | |
| А | Medicare Part A HIPPS code: | | |
| В | . Version code: | | |
| | | | |
| Z0200. S | tate Medicaid Billing (if required by the state) | | |
| Α | . Case Mix group: | | |
| | | | |
| В | . Version code: | | |
| | | | |
| Z0250. A | lternate State Medicaid Billing (if required by the | state) | |
| Α | . Case Mix group: | | |
| | | | |
| В | . Version code: | | |
| | | | |
| Z0300. Ir | nsurance Billing | | |
| | Billing code: | | |
| | | | |
| В | . Billing version: | | |
| | | | |
| | | | |

| I certify that the accompanying information accurately refle of this information on the dates specified. To the best of my requirements. I understand that this information is used as from federal funds. I further understand that payment of su conditioned on the accuracy and truthfulness of this inform civil, and/or administrative penalties for submitting false information. | r knowledge, this information was coll a basis for ensuring that residents re ch federal funds and continued partic ation, and that I may be personally su | lected in accordance with applicable I eceive appropriate and quality care, ar cipation in the government-funded hea ubject to or may subject my organizati | Medicare and Medicaid nd as a basis for payment alth care programs is on to substantial criminal. |
|---|---|--|--|
| Signature | Title | Sections | Date Section Completed |
| A. | | | |
| В. | | | |
| C. | | | |
| D. | | | |
| E | | | |
| F | | | |
| G. | | | |
| Н. | | | |
| I. | | | |
| J. | | | |
| K. | | | |
| L. | | | |
| | | | |
| Z0500. Signature of RN Assessment Coor | dinator Verifying Assessmer | nt Completion | |
| A. Signature: | | B. Date RN Assessment Co assessment as complete | |
| | | Month Day | Year |
| | | | |

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Section Z - Assessment Administration

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

| Resident | 1.1 | D-1- |
|----------|------------|------|
| Resident | Identitier | Date |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Quarterly (NQ) Item Set

| Section | on A - Identification Information |
|------------|--|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): B. CMS Certification Number (CCN): C. State Provider Number: |
| | |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment Not PPS Assessment |
| | 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

| Resident | Identifier | | Date |
|------------|---|--|--------------------------------|
| Section | on A - Identification Information | | |
| A0310. | Type of Assessment - Continued | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |
| A0410. | Unit Certification or Licensure Designation | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS dat Unit is neither Medicare nor Medicaid certified but MDS data Unit is Medicare and/or Medicaid certified | a is not required by the State i is required by the State | |
| A0500. | Legal Name of Resident | | |
| | A. First name: C. Last name: | | 3. Middle initial: 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 recipier | ıt | |
| | | | |
| A0800. | Gender | | |
| Enter Code | 1. Male 2. Female | | |
| A0900. | Birth Date | | |
| | Month Day Year | | |

| Resident | | Identifier Date |
|--------------|--------|--|
| Section | on. | A - Identification Information |
| A1005. | Eth | nnicity |
| Are you o | f Hisp | panic, Latino/a, or Spanish origin? |
| \downarrow | Che | eck all that apply |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin |
| | В. | Yes, Mexican, Mexican American, Chicano/a |
| | C. | Yes, Puerto Rican |
| | D. | Yes, Cuban |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| A1010. | | |
| What is y | | |
| <u> </u> | Che | eck all that apply |
| | A. | White |
| | B. | Black or African American |
| | C. | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | H. | Korean |
| | I. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1110. | | nguage |
| | Α. | What is your preferred language? |
| Entor Codo | | |
| Enter Code | В. | Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No |
| | | 1. Yes 9. Unable to determine |



| Resident | | Identifier Date | | | |
|---------------|--|--|--|--|--|
| Section | on | A - Identification Information | | | |
| A1200. | Ма | rital Status | | | |
| Enter Code | | Never married Married Widowed Separated Divorced | | | |
| Has lack | of tra | ansportation (from NACHC©) nsportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? if A0310B = 01 or A0310G = 1 and A0310H = 1 | | | |
| \ | Che | eck all that apply | | | |
| | A. | Yes, it has kept me from medical appointments or from getting my medications | | | |
| | В. | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need | | | |
| | C. | No | | | |
| | X. | Resident unable to respond | | | |
| | Y. | Resident declines to respond | | | |
| and its resou | rces a | ssociation of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute part or whole without written consent from NACHC. | | | |
| A1300. | Op | tional Resident Items | | | |
| | A. | Medical record number: | | | |
| | | | | | |
| | В. | Room number: | | | |
| | | | | | |
| | C. Name by which resident prefers to be addressed: | | | | |
| | | | | | |
| | D. | Lifetime occupation(s) - put "/" between two occupations: | | | |
| | | | | | |
| | | | | | |

| Resident | | Identifier | Date | |
|--|---|--|--------------------|--|
| Section A - Identification Information | | | | |
| Most Recent A A1600. Entry | Admission/Entry or Reentry into this Facility Date | | | |
| | Month Day Year | | | |
| A1700. Type | of Entry | | | |
| | dmission eentry | | | |
| A1805. Entere | ed From | | | |
| 02. Nu 03. Sk 04. Sh 05. Lo 06. In 07. In 08. Int 09. Ho 10. Ho 11. Cr 12. Ho | ome/Community (e.g., private home/apt., board/care, assisted sidential care arrangements) sursing Home (long-term care facility) stilled Nursing Facility (SNF, swing beds) nort-Term General Hospital (acute hospital, IPPS) ong-Term Care Hospital (LTCH) patient Rehabilitation Facility (IRF, free standing facility opatient Psychiatric Facility (psychiatric hospital or unit) termediate Care Facility (ID/DD facility) ospice (home/non-institutional) ospice (institutional facility) ritical Access Hospital (CAH) ome under care of organized home health service organized | or unit) | r | |
| A1900. Admis | ssion Date (Date this episode of care in this f | acility began) | | |
| | Month Day Year | | | |
| A2000. Disch Complete only if A | arge Date 0310F = 10, 11, or 12 | | | |
| | Month Day Year | | | |
| A2105. Disch Complete only if A | arge Status 0310F = 10, 11, or 12 | | | |
| 02. Nu 03. Sk 04. Si 05. Lo 06. Inp 07. In 08. Int 09. Ho 11. Cr 12. Ho 13. De | ome/Community (e.g., private home/apt., board/care, assist rangements) → Skip to A2123, Provision of Current Recordursing Home (long-term care facility) (silled Nursing Facility (SNF, swing beds) (hort-Term General Hospital (acute hospital, IPPS) (brog-Term Care Hospital (LTCH) (patient Rehabilitation Facility (IRF, free standing facility (patient Psychiatric Facility (psychiatric hospital or unit) (termediate Care Facility (ID/DD facility) (pspice (home/non-institutional) (pspice (institutional facility) (Titical Access Hospital (CAH) (CA | nciled Medication List to Resident at Discharge or unit) | r residential care | |

| esident | | Identifier Date |
|--------------------|--------|---|
| Section | n. | A - Identification Information |
| | | ovision of Current Reconciled Medication List to Subsequent Provider at Discharge if A0310H = 1 and A2105 = 02-12 |
| Enter Code | At th | ne time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? No - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction Yes - Current reconciled medication list provided to the subsequent provider |
| Indicate th | ne rou | ute of Current Reconciled Medication List Transmission to Subsequent Provider ute(s) of transmission of the current reconciled medication list to the subsequent provider. if A2121 = 1 |
| Ţ | Che | eck all that apply Route of Transmission |
| | A. | Electronic Health Record |
| | B. | Health Information Exchange |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | E. | Other methods (e.g., texting, email, CDs) |
| | | ovision of Current Reconciled Medication List to Resident at Discharge if A0310H = 1 and A2105 = 01, 99 |
| Enter Code | At th | he time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? |
| Ш | | No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction Yes - Current reconciled medication list provided to the resident, family and/or caregiver |
| Indicate th | ne rou | ute of Current Reconciled Medication List Transmission to Resident ute(s) of transmission of the current reconciled medication list to the resident/family/caregiver. if A2123 = 1 |
| ↓ Cł | eck | all that apply Route of Transmission |
| | Α. | Electronic Health Record (e.g., electronic access to patient portal) |
| | В. | Health Information Exchange |
| | C. | |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | Ε. | Other methods (e.g., texting, email, CDs) |
| A2200. Complete | Pre | evious Assessment Reference Date for Significant Correction if A0310A = 05 or 06 |
| | | Month Day Year |

| Resident | Identifier Date | |
|--|---|----|
| Section | on A - Identification Information | |
| 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 | |
| | C. End date of most recent Medicare stay - Enter dashes if stay is ongoing: Month | |
| | | |
| | | |
| Look | back period for all items is 7 days unless another time frame is indicate | ed |
| _ | back period for all items is 7 days unless another time frame is indicated on B - Hearing, Speech, and Vision | ed |
| _ | on B - Hearing, Speech, and Vision | ed |
| Section | on B - Hearing, Speech, and Vision | ed |
| Section B0100. | on B - Hearing, Speech, and Vision Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing | ed |
| Section B0100. | on B - Hearing, Speech, and Vision Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities | ed |
| Section B0100. Enter Code B0200. | On B - Hearing, Speech, and Vision Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities Hearing Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly 3. Highly impaired - absence of useful hearing Hearing Aid | ed |
| Sections B0100. Enter Code B0200. Enter Code | On B - Hearing, Speech, and Vision Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities Hearing Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly 3. Highly impaired - absence of useful hearing | ed |
| B0100. Enter Code B0200. Enter Code B0300. | On B - Hearing, Speech, and Vision Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities Hearing Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly 3. Highly impaired - absence of useful hearing Hearing Aid Hearing aid or other hearing appliance used in completing B0200, Hearing 0. No | ed |

| Resident | | Identifier | Date |
|----------------|---|---|--|
| Section | on B - Hearing, Speech, and | l Vision | |
| B0700. | Makes Self Understood | | |
| Enter Code | Ability to express ideas and wants, consider both 0. Understood 1. Usually understood - difficulty communic 2. Sometimes understood - ability is limited 3. Rarely/never understood | cating some words or finishing thoug | hts but is able if prompted or given time |
| B0800. | Ability To Understand Others | | |
| Enter Code | Understanding verbal content, however able (with 0. Understands - clear comprehension 1. Usually understands - misses some par 2. Sometimes understands - responds add 3. Rarely/never understands | t/intent of message but comprehenc | |
| B1000. | Vision | | |
| Enter Code | Ability to see in adequate light (with glasses or of 0. Adequate - sees fine detail, such as regulated - sees large print, but not regulated - sees large print, but not regulated - limited vision; not Highly impaired - object identification in 6. Severely impaired - no vision or sees on | llar print in newspapers/books ar print in newspapers/books able to see newspaper headlines be question, but eyes appear to follow o | objects |
| B1200. | Corrective Lenses | | |
| Enter Code | Orrective lenses (contacts, glasses, or magnify 0. No 1. Yes | ring glass) used in completing B100 | 0, Vision |
| | Health Literacy only if A0310B = 01 or A0310G = 1 and A0310H = 1 | | |
| Enter Code | How often do you need to have someone help you we pharmacy? O. Never Rarely Sometimes Always Resident declines to respond Resident unable to respond | | |
| rne Sinaie lie | em Literacy Screener is licensed under a Creative Common | is Announon-NonCommercial 4.0 Interna | MONALLICENSE. |

| Resident | | Identifier | Date |
|-------------|---|--|-------------------------------------|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C0200-C conduct interview with all residents | 0500) be Conducted? | |
| Enter Code | No (resident is rarely/never understood) → Skip to and com Yes → Continue to C0200, Repetition of Three Words | plete C0700-C1000, Staff Assessment for Me | ental Status |
| Brief Int | erview for Mental Status (BIMS) | | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to remember The words are: sock , blue , and bed . Now tell me the three wo Number of words repeated after first attempt | · | three. |
| Ш | 0. None 1. One 2. Two | | |
| | Three After the resident's first attempt, repeat the words using cues ("so the words up to two more times. | ck, something to wear; blue, a color; bed, a p | iece of furniture"). You may repeat |
| C0300. | $\textbf{Temporal Orientation} \ (\text{orientation to year, month, and day})$ | | |
| 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 the If unable to remember a word, give cue (something to wear; a col 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 Enter 99 if the resident was unable to complete the interview | | |



| esident | | lde | entifier | Date | | | | |
|---|--|--|--|---------------------------------|--|--|--|--|
| Section | n | C - Cognitive Patterns | | | | | | |
| C0600. | Sh | ould the Staff Assessment for Mental Status (C07 | 00 - C1000) be Conducted? | | | | | |
| Enter Code | 0. 1. | No (resident was able to complete Brief Interview for Mental St Yes (resident was unable to complete Brief Interview for Menta | | | | | | |
| Staff Assessment for Mental Status | | | | | | | | |
| Do not cor | not conduct if Brief Interview for Mental Status (C0200-C0500) was completed | | | | | | | |
| C0700. | | ort-term Memory OK | | | | | | |
| Enter Code | See 0. 1. | ems or appears to recall after 5 minutes Memory OK Memory problem | | | | | | |
| C0800. | Lo | ng-term Memory OK | | | | | | |
| Enter Code | Sec 0. 1. | ems or appears to recall long past Memory OK Memory problem | | | | | | |
| C0900. | Memory/Recall Ability | | | | | | | |
| \downarrow | Che | eck all that the resident was normally able to recall | | | | | | |
| | A. | Current season | | | | | | |
| | В. | Location of own room | | | | | | |
| | C. | Staff names and faces | | | | | | |
| | D. | That they are in a nursing home/hospital swing bed | | | | | | |
| | Z. | None of the above were recalled | | | | | | |
| C1000. | Со | ognitive Skills for Daily Decision Making | | | | | | |
| Enter Code | Ma 0. 1. 2. 3. | Ide decisions regarding tasks of daily life Independent - decisions consistent/reasonable Modified independence - some difficulty in new situations only Moderately impaired - decisions poor; cues/supervision requir Severely impaired - never/rarely made decisions | | | | | | |
| Delirium C1310. Signs and Symptoms of Delirium (from CAM©) | | | | | | | | |
| | | • | and reviewing medical record | | | | | |
| Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record A. Acute Onset Mental Status Change | | | | | | | | |
| Enter Code | | there evidence of an acute change in mental status from the re No Yes | esident's baseline? | | | | | |
| Coding: 0. Behavior not present 1. Behavior continuously present, does not fluctuate 2. Behavior present, fluctuates (comes and goes, changes in severity) | | | | | | | | |
| Enter Code in Boxes | S | | | | | | | |
| | В. | Inattention - Did the resident have difficulty focusing attention, what was being said? | for example, being easily distractible or having | ng difficulty keeping track of | | | | |
| | C. | | zed or incoherent (rambling or irrelevant convit)? | versation, unclear or illogical | | | | |
| | D. | Altered Level of Consciousness - Did the resident have altered vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being asked questions, but stuporous - very difficult to arouse and keep aroused for the integration of the in | ed level of consciousness, as indicated by an | y of the following criteria? | | | | |

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

| eside | nt | Identifier | Date | | | | | |
|---|---|--|--------------------------|-----------|--|--|--|--|
| Se | ction | D - Mood | | | | | | |
| D0 | 100. S | ould Resident Mood Interview be Conducted? - Attempt to conduct interview with all | residents | | | | | |
| Enter | No (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV) 1. Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©) | | | | | | | |
| D0 | 150. R | sident Mood Interview (PHQ-2 to 9©) | | | | | | |
| If sy If ye Rea | 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. | Sympt | om Frequency | 1. | 2. | | | | |
| | | ver or 1 day 6 days (several days) | Symptom | Symptom | | | | |
| | 2. 7- | 1 days (half or more of the days) | Presence | Frequency | | | | |
| | 3. 12 | .14 days (nearly every day) | ↓ Enter Scores in Boxes↓ | | | | | |
| Α. | Little i | nterest or pleasure in doing things | | | | | | |
| B. | Feelin | down, depressed, or hopeless | | | | | | |
| If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue. | | | | | | | | |
| C. | Troub | e falling or staying asleep, or sleeping too much | | | | | | |
| D. | Feelin | tired or having little energy | | | | | | |
| E. | | opetite or overeating | | | | | | |
| F. | Feelin family | bad about yourself - or that you are a failure or have let yourself or your down | | | | | | |
| G. | Troub televis | e concentrating on things, such as reading the newspaper or watching ion | | | | | | |
| 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 | | | | | | | | |
| l. | Thoug | hts that you would be better off dead, or of hurting yourself in some way | | | | | | |
| D0160. Total Severity Score | | | | | | | | |
| Enter | — A | d scores for all frequency responses in Column 2, Symptom Frequency. Total score must be better 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required item | etween 00 and 27. | | | | | |



| Resident | | Identifier | Date | |
|--|--|--------------------------------------|------------------|-----------|
| Sectio | n D - Mood | | | |
| | Staff Assessment of Resident Mood (PHQ-9-OV*) duct if Resident Mood Interview (D0150-D0160) was completed | | | |
| If symptom Then move 1. Sym l 0. | last 2 weeks, did the resident have any of the foll is present, enter 1 (yes) in column 1, Symptom Presence. to column 2, Symptom Frequency, and indicate symptom frequentom Presence No (enter 0 in column 2) Yes (enter 0-3 in column 2) | | s? | |
| | otom Frequency | | 1. | 2. |
| | Never or 1 day | | Symptom | Symptom |
| | 2-6 days (several days) | | Presence | Frequency |
| | 7-11 days (half or more of the days) 12-14 days (nearly every day) | | ↓ Enter Scores i | |
| | nterest or pleasure in doing things | | Line ocores ii | T Boxes↓ |
| B. Feelin | g or appearing down, depressed, or hopeless | | | |
| C. Troub | e falling or staying asleep, or sleeping too much | | | |
| D. Feelin | g tired or having little energy | | | |
| E. Poor a | ppetite or overeating | | | |
| F. Indica | ting that they feel bad about self, are a failure, or have let se | lf or family down | | |
| G. Troub | e concentrating on things, such as reading the newspaper of | or watching television | | |
| | g or speaking so slowly that other people have noticed. Or t so fidgety or restless that they have been moving around a | | | |
| I. States | that life isn't worth living, wishes for death, or attempts to h | narm self | | |
| J. Being | short-tempered, easily annoyed | | | |
| D0600. | Total Severity Score | | | |
| Enter Score | Add scores for all frequency responses in Column 2, Sympto | m Frequency. Total score must be bei | tween 00 and 30. | |
| D0700. | Social Isolation | | | |
| Enter Code | How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | | | |
| | | | | |



| Resident | | lde | entifier | Date |
|---------------------------|----------------|--|---|---|
| Section | on | E - Behavior | | |
| E0100. | Pot | tential Indicators of Psychosis | | |
| ↓ Ch | eck | all that apply | | |
| | A. | Hallucinations (perceptual experiences in the absence of real | external sensory stimuli) | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, contr | rary to reality) | |
| | Z. | None of the above | | |
| Behavio | oral | Symptoms | | |
| E0200. | Bel | havioral Symptom - Presence & Frequency | | |
| Note pres | ence | e of symptoms and their frequency | | |
| 1. Be 2. Be | havio havio | or not exhibited or of this type occurred 1 to 3 days or of this type occurred 4 to 6 days, but less than daily or of this type occurred daily | | |
| Enter Code | A. | Physical behavioral symptoms directed toward others (e.g. | ., hitting, kicking, pushing, scratching, grabbir | ng, abusing others sexually) |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g., t | hreatening others, screaming at others, cursi | ng at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e.grummaging, public sexual acts, disrobing in public, throwing or disruptive sounds) | g., physical symptoms such as hitting or scrat smearing food or bodily wastes, or verbal/voo | ching self, pacing, cal symptoms like screaming, |
| E0800. | Rej | jection of Care - Presence & Frequency | | |
| Enter Code | goa | I the resident reject evaluation or care (e.g., bloodwork, taking als for health and well-being? Do not include behaviors that havident or family), and determined to be consistent with resident val 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 that 3. Behavior of this type occurred daily | ve already been addressed (é.g., by discussi lues, preferences, or goals. | |
| E0900. | Wa | andering - Presence & Frequency | | |
| Enter Code | Has | the resident wandered? Behavior not exhibited Behavior of this type occurred 1 to 3 days Behavior of this type occurred 4 to 6 days, but less that Behavior of this type occurred daily | n daily | |

| Section | n | GG - Functional Abilities and Goals |
|--|----------------------------|---|
| exacerbati | on, o | rior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, r injury if A0310B = 01 |
| withou 2. Neede person | t an a ed So n to co | nt - Resident completed all the activities by themself, with or assistive device, with no assistance from a helper. me Help - Resident needed partial assistance from another complete any activities. - A helper completed all the activities for the resident. 8. Unknown. 9. Not Applicable. |
| nter Codes | s in E | Boxes |
| | A. | Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation or injury. |
| | В. | Indoor Mobility (Ambulation): Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. |
| | C. | Stairs: Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. |
| | D. | Functional Cognition: Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury. |
| | | fior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury if A0310B = 01 |
| ↓ Ch | eck a | all that apply |
| | A. | Manual wheelchair |
| | В. | Motorized wheelchair and/or scooter |
| | C. | Mechanical lift |
| | D. | Walker |
| | E. | Orthotics/Prosthetics |
| | Z. | None of the above |
| | | ınctional Limitation in Range of Motion |
| | limita | ation that interfered with daily functions or placed resident at risk of injury in the last 7 days |
| Coding: 0. No impair 1. Impair 2. Impair | men | nent t on one side t on both sides |
| inter Code | s in E | Boxes |
| | A. | Upper extremity (shoulder, elbow, wrist, hand) |
| GG0120 | | Lower extremity (hip, knee, ankle, foot) obility Devices |
| | | ere normally used in the last 7 days |
| $\;\;\; \; \; \; \; \; \; \; \; \; \; \; \; \; \; \; \; \; $ | | Cane/crutch |
| | B. | Walker |
| | C. | Wheelchair (manual or electric) |
| | D. | Limb prosthesis |
| | Z. | None of the above were used |

Resident _

| sident | | | Identifier Date |
|--|--|--|---|
| Sectio | n GG | - Fı | unctional Abilities and Goals - Admission |
| Complete | column 1 w | hen / | sessment period is the first 3 days of the stay) A0310A = 01. Complete columns 1 and 2 when A0310B = 01. begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| t the star | t of the stay | / (adr | performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted nission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use o ermissible to code end of SNF PPS stay (discharge) goal(s). |
| amount of a Activities m 06. Ind. 05. Set 04. Sup con 03. Par the 02. Sub effo 01. Dep requ f activity v 07. Res 09. Not 10. Not | assistance pay be compependent - cup or clean or clean or clean or clean of | orovide leted Reside -up a r touc ity. As te as exima elper reside empte ed - Not due f | rmance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to ed. with or without assistive devices. ent completes the activity by themself with no assistance from a helper. ssistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. hing assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident is istance may be provided throughout the activity or intermittently. sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is ent to complete the activity. Ind. code reason: attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. o environmental limitations (e.g., lack of equipment, weather constraints) o medical condition or safety concerns |
| 1. mission formance | 2. Discharge Goal | | |
| nter Codes ↓ | in Boxes | A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| | | В. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| | | C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| | | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) Does not include transferring in/out of tub/shower. |
| | | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| | | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| | | H. | Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. |
| | | I. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |

| Resident | Identifier Date | | | | | |
|--|---|--|--|--|--|--|
| Section GG - Functional Abilities and Goals - Admission | | | | | | |
| GG0170. Mobility (Assessment period is the first 3 days of the stay) Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01. When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600. | | | | | | |
| at the start of the stay (adm | erformance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted ission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of rmissible to code end of SNF PPS stay (discharge) goal(s). | | | | | |
| amount of assistance provide Activities may be completed with the completed with the completes activity. Associated assistance provided the completes activity. Associated assistance assis | nt completes the activity by themself with no assistance from a helper. sistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. sistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident istance may be provided throughout the activity or intermittently. sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is not to complete the activity. I, code reason: attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. environmental limitations (e.g., lack of equipment, weather constraints) | | | | | |
| 1. 2. Admission Discharge Performance Goal Enter Codes in Boxes | medical condition or safety concerns | | | | | |
| | Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. | | | | | |
| В. | Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. | | | | | |
| c. | Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. | | | | | |
| D. | Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. | | | | | |
| E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). | | | | | |
| F. | Toilet transfer: The ability to get on and off a toilet or commode. | | | | | |
| FF. | Tub/shower transfer: The ability to get in and out of a tub/shower. | | | | | |
| G. | Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. | | | | | |
| I. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) | | | | | |
| J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. | | | | | |
| К. | Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. | | | | | |

| Resident | Identifier Date |
|---|--|
| Section GG - F | unctional Abilities and Goals - Admission |
| Complete column 1 when | sessment period is the first 3 days of the stay) A0310A = 01. Complete columns 1 and 2 when A0310B = 01. y begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| at the start of the stay (ad | performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted mission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of permissible to code end of SNF PPS stay (discharge) goal(s). |
| amount of assistance provid Activities may be completed 06. Independent - Resi 05. Setup or clean-up a 04. Supervision or tou completes activity. A 03. Partial/moderate as the effort. 02. Substantial/maxim effort. 01. Dependent - Helper required for the resid 16. Resident refused 09. Not applicable - Not 10. Not attempted due | with or without assistive devices. dent completes the activity by themself with no assistance from a helper. dent completes the activity by themself with no assistance from a helper. desistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. Ching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident assistance may be provided throughout the activity or intermittently. Sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is lent to complete the activity. |
| 1. 2. Admission Discharge Performance Goal Enter Codes in Boxes L. | Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| M. | 1 step (curb): The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object |
| N. | 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or $88 \rightarrow \text{Skip}$ to GG0170P, Picking up object |
| O. | 12 steps: The ability to go up and down 12 steps with or without a rail. |
| P. | Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| | Q1. Does the resident use a wheelchair and/or scooter? |
| | No → Skip to GG0130, Self Care (Discharge) Yes → Continue to GG0170R, Wheel 50 feet with two turns |
| R. | Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized |
| s. | Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | SS1. Indicate the type of wheelchair or scooter used. |
| | 1. Manual 2. Motorized |

| Resident _ | | Identifier Date |
|--|---|--|
| Sect | ion | GG - Functional Abilities and Goals - Discharge |
| Comple When A | ete colu NO310G | elf-Care (Assessment period is the last 3 days of the stay) umn 3 when A0310F = 10 or 11 or when A0310H = 1. is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. ischarge assessments, the stay ends on A2000. |
| | | dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end ode the reason. |
| amount Activitie 06. 05. 04. 03. 02. 01. If activition 07. 09. 10. | and Qui of assi es may Indepe Setup of Superv comple Partial/ the effo Substa effort. Depender required ity was Reside Not app Not atti | rality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to stance provided. be completed with or without assistive devices. ndent - Resident completes the activity by themself with no assistance from a helper. or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. rision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident tes activity. Assistance may be provided throughout the activity or intermittently. Impoderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half ort. Intial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the dent - 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 d for the resident to complete the activity. not attempted, code reason: int refused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. empted due to environmental limitations (e.g., lack of equipment, weather constraints) empted due to medical condition or safety concerns |
| 3. Dischar Performa Enter Code | ance | res |
| Ĺ |] A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| |] B. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| |] C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| |] E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| |] F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| |] H. | Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. |
| |] I. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |
| | | |

| Identifier Date Date |
|---|
| GG - Functional Abilities and Goals - Discharge |
| Iobility (Assessment period is the last 3 days of the stay) umn 3 when A0310F = 10 or 11 or when A0310H = 1. is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. ischarge assessments, the stay ends on A2000. |
| dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the en ode the reason. |
| pality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to istance provided. be completed with or without assistive devices. Indent - Resident completes the activity by themself with no assistance from a helper. Or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. Indent - Resident completes activity. Assistance as resident activity. Indent - Resident completes activity. Assistance as resident the activity. Assistance may be provided throughout the activity or intermittently. Indent - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than have. Intial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the dent - 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 d for the resident to complete the activity. Into attempted, code reason: Interfused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Interfused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Interfused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Interfused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Interfused plicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. |
| Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. |
| Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| Toilet transfer: The ability to get on and off a toilet or commode. |
| Tub/shower transfer: The ability to get in and out of a tub/shower. |
| Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. |
| Walk 10 feet: 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) |
| Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
| |

| esident | | Identifier | Date |
|---|--|---|---|
| Section | GG - Functional Abilities | s and Goals - Discharge | |
| Complete col When A03100 | Mobility (Assessment period is the last 3 days lumn 3 when A0310F = 10 or 11 or when A0316 is not = 2 and A0310H = 1 and A2400C minus Discharge assessments, the stay ends on A2000 | IOH = 1. A2400B is greater than 2 and A2105 is not | = 04, the stay ends on A2400C. |
| | ident's usual performance at the end of the s ode the reason. | tay for each activity using the 6-point sca | ale. If an activity was not attempted at the end |
| amount of ass Activities may 06. Indepe 05. Setup 04. Super comple 03. Partia the eff 02. Subst effort. 01. Deper require If activity was 07. Reside 09. Not as 10. Not at | ort. | mself with no assistance from a helper. ans up; resident completes activity. Helper a es verbal cues and/or touching/steadying an hout the activity or intermittently. AN HALF the effort. Helper lifts, holds, or su E THAN HALF the effort. Helper lifts or hold loes none of the effort to complete the activit ot perform this activity prior to the current illing., lack of equipment, weather constraints) | assists only prior to or following the activity. d/or contact guard assistance as resident apports trunk or limbs, but provides less than half as trunk or limbs and provides more than half the ty. Or, the assistance of 2 or more helpers is |
| 3. Discharge Performance Enter Codes in Bo | | bility to walk 10 feet on uneven or sloping su | urfaces (indoor or outdoor), such as turf or gravel. |
| M. | 1 step (curb): The ability to go up and down of the first light of the | a curb and/or up and down one step. or 88 → Skip to GG0170P, Picking up obje | ct |
| N. | 4 steps: The ability to go up and down four st If discharge performance is coded 07, 09, 10, | teps with or without a rail. or 88 → Skip to GG0170P, Picking up obje | ct |
| 0. | 12 steps: The ability to go up and down 12 st | teps with or without a rail. | |
| P. | Picking up object: The ability to bend/stoop | from a standing position to pick up a small o | bject, such as a spoon, from the floor. |
| | Q3. Does the resident use a wheelchair at 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, W | | |
| R. | Wheel 50 feet with two turns: Once seated | in wheelchair/scooter, the ability to wheel at | least 50 feet and make two turns. |
| | RR3. Indicate the type of wheelchair or sc 1. Manual 2. Motorized | ooter used. | |
| S. | Wheel 150 feet: Once seated in wheelchair/s | scooter, the ability to wheel at least 150 feet | in a corridor or similar space. |
| | SS3. Indicate the type of wheelchair or sc | ooter used. | |
| | 1. Manual 2. Motorized | | |
| | | | |

| esident | | Identifier Date | |
|---|--|--|-----------------------------------|
| Secti | on (| GG - Functional Abilities and Goals - OBRA/Interim | |
| Complet | e colu | celf-Care (Assessment period is the ARD plus 2 previous calendar days) Solumn 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. | |
| Code the | resid | ident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason. | |
| Safety an amount of Activities 06. In 05. S 04. S 07. P 09. N 10. N | of assist may be needed to be n | relative of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according sistance provided. If helper assistance is required because resident's performance is unsafe or of poor quality, score according sistance provided. If helper assistance is required because resident's performance is unsafe or of poor quality, score according sistance resident completes with or without assistive devices. If no crean-up assistance is relieved to the provided verbal cues and/or touching/steadying and/or contact guard assistance as resident etes activity. Assistance may be provided throughout the activity or intermittently. If moderate assistance is represented throughout the effort. Helper lifts, holds, or supports trunk or limbs, but provides less the fort. It antial/maximal assistance is represented by the effort of the effort. Helper lifts or holds trunk or limbs and provides more than the resident to complete the activity. Or, the assistance of 2 or more helper end for the resident to complete the activity. If no definition is not attempted, code reason: If the provided is required by the provided because resident to the current illness, exacerbation, or injury the provided of the equirement of the equirement, weather constraints the provided by the provided condition or safety concerns. | ty. It han half half the |
| 5. OBRA/Into Performa nter Codes | nce | oxes | |
| <u> </u> | A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is before the resident. | placed |
| | В. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures in from the mouth, and manage denture soaking and rinsing with use of equipment. | nto and |
| | C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. managing an ostomy, include wiping the opening but not managing equipment. | lf |
| | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does include transferring in/out of tub/shower. | s not |
| | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. | |
| | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. | |
| | Н. | Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe n including fasteners, if applicable. | nobility; |
| | l. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying fa hands (excludes baths, showers, and oral hygiene). | ace and |
| | | | |

| esident | | Identifier | Date |
|--|---|---|---|
| Sectio | n (| GG - Functional Abilities and Goals - OBF | RA/Interim |
| | | obility (Assessment period is the ARD plus 2 previous calendar days) | |
| • | | lumn 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. | |
| | resid | ident's usual performance for each activity using the 6-point scale. If an acti | vity was not attempted, code the reason. |
| amount of Activities no 06. Ind 05. Set 04. Su cor 03. Pai the 02. Su effc 01. De required for activity 07. Re 09. No 10. No | assismay by leper tup o pervimpleto rtial/restrict. pend puired was resider tatte | uality of Performance - If helper assistance is required because resident's performance provided. be completed with or without assistive devices. endent - Resident completes the activity by themself with no assistance from a heat or clean-up assistance - Helper sets up or cleans up; resident completes activity vision or touching assistance - Helper provides verbal cues and/or touching/steptes activity. Assistance may be provided throughout the activity or intermittently. I/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, hort. antial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts addent - Helper does ALL of the effort. Resident does none of the effort to complete and for the resident to complete the activity. Is not attempted, code reason: ent refused opplicable - Not attempted and the resident did not perform this activity prior to the tempted due to environmental limitations (e.g., lack of equipment, weather contempted due to medical condition or safety concerns | elper. y. Helper assists only prior to or following the activity. eadying and/or contact guard assistance as resident olds, or supports trunk or limbs, but provides less than half ifts or holds trunk or limbs and provides more than half the e the activity. Or, the assistance of 2 or more helpers is current illness, exacerbation, or injury |
| 5. OBRA/Inter Performand nter Codes in | се | YAS | |
| J J | | Roll left and right: The ability to roll from lying on back to left and right side, ar | nd return to lying on back on the bed. |
| | B. | Sit to lying: The ability to move from sitting on side of bed to lying flat on the be | ed. |
| | C. | Lying to sitting on side of bed: The ability to move from lying on the back to s | sitting on the side of the bed and with no back support. |
| | D. | Sit to stand: The ability to come to a standing position from sitting in a chair, w | heelchair, or on the side of the bed. |
| | E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair | r (or wheelchair). |
| | F. | Toilet transfer: The ability to get on and off a toilet or commode. | |
| | FF. | . Tub/shower transfer: The ability to get in and out of a tub/shower. | |
| | I. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corrected 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheeld | dor, or similar space. If performance in the last 7 days is shair and/or scooter? |
| | J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet | and make two turns. |
| | K. | Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor | or similar space. |
| | | | |

| esident | Identif | ier | Date | |
|--|--|--|---|--|
| Section | n GG - Functional Abilities and Goals | s - OBRA/Interim | | |
| | Mobility (Assessment period is the ARD plus 2 previous calendar da | | | |
| • | olumn 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B | | | |
| | sident's usual performance for each activity using the 6-point sca | ile. If an activity was not attempted, co | ode the reason. | |
| amount of a Activities ma 06. Inde 05. Setu 04. Super comp 03. Partitle 6 02. Subseffor 01. Depo | stantial/maximal assistance - Helper does MORE THAN HALF the ef | nce from a helper. Ince from a helper assists only prior to the contact guard Ince from the from a helper lifts, holds, or supports trunk or limbs and Ince front. Helper lifts or holds trunk or limbs and | o or following the activity. d assistance as resident nbs, but provides less than half nd provides more than half the | |
| 07. Resi 09. Not a 10. Not a 88. Not a | If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns | | | |
| 5. OBRA/Interim Performance | | | | |
| Enter Codes in E ↓ | Boxes | | | |
| | 5. Does the resident use a wheelchair and/or scooter? | | | |
| | 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns | | | |
| R | Wheel 50 feet with two turns: Once seated in wheelchair/scoot | er, the ability to wheel at least 50 feet an | id make two turns. | |
| R | R5. Indicate the type of wheelchair or scooter used. | | | |
| | 1. Manual 2. Motorized | | | |
| S | . Wheel 150 feet: Once seated in wheelchair/scooter, the ability to | o wheel at least 150 feet in a corridor or | similar space. | |
| S | S5. Indicate the type of wheelchair or scooter used. | | | |
| | 1. Manual 2. Motorized | | | |
| | | | | |

| Resident | | Identifier | Date | |
|--------------|---|--|---|--|
| Section | on H - Bladder and Bowel | | | |
| H0100. | Appliances | | | |
| \downarrow | Check all that apply | | | |
| | A. Indwelling catheter (including suprapubic catheter ar | d nephrostomy tube) | | |
| | B. External catheter | | | |
| | C. Ostomy (including urostomy, ileostomy, and colostom | y) | | |
| | D. Intermittent catheterization | | | |
| | Z. None of the above | | | |
| H0200. | Urinary Toileting Program | | | |
| Enter Code | A. Has a trial of a toileting program (e.g., scheduled to or reentry or since urinary incontinence was noted in the scheduled to the scheduled to the scheduled to the scheduled triangle of t | nis facility? gram or trial | der training) been attempted on admission/entry | |
| Enter Code | 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? No Yes | | | |
| H0300. | Urinary Continence | | | |
| Enter Code | Urinary continence - Select the one category that best des 0. Always continent 1. Occasionally incontinent (less than 7 episodes 2. Frequently incontinent (7 or more episodes of a 3. Always incontinent (no episodes of continent volumes) 9. Not rated, resident had a catheter (indwelling, continent) | of incontinence) rinary incontinence, but at least one editing) | • | |
| H0400. | Bowel Continence | | | |
| Enter Code | Bowel continence - Select the one category that best descontinent Always continent Occasionally incontinent (one episode of bowe prequently incontinent (2 or more episodes of base) Always incontinent (no episodes of continent both processes) Not rated, resident had an ostomy or did not have | incontinence) lowel incontinence, but at least one convel movements) | , | |
| H0500. | Bowel Toileting Program | | | |
| Enter Code | Is a toileting program currently being used to manage t 0. No 1. Yes | he resident's bowel continence? | | |

| esident | | Identifier | Date | |
|--------------------|--|----------------------------|--------------------------|--|
| Section | on I - Active Diagnoses | | | |
| I0020. Complete | Indicate the resident's primary medical condition only if A0310B = 01 or if state requires completion with an OBRA a | | | |
| Enter Code | Indicate the resident's primary medical condition category the 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions 10020B. ICD Code | at best describes the prim | ary reason for admission | |

| Resident | | Identifier | Date |
|------------|--|---|------------------------------------|
| Section | on I - Active Diagnoses | | |
| | Diagnoses in the last 7 days - Check all that apply s listed in parentheses are provided as examples and should not | | |
| Cancer | | | |
| | I0100. Cancer (with or without metastasis) | | |
| Heart/Circ | culation | | |
| | 10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and s 10400. Coronary Artery Disease (CAD) (e.g., angina, myocar 10600. Heart Failure (e.g., congestive heart failure (CHF) and 10700. Hypertension 10800. Orthostatic Hypotension 10900. Peripheral Vascular Disease (PVD) or Peripheral Art. | dial infarction, and atherosclerotic heart disease pulmonary edema) | (ASHD)) |
| Gastroint | testinal | | |
| | I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory | Bowel Disease | |
| Genitouri | • | 201101 2100000 | |
| | I1500. Renal Insufficiency, Renal Failure, or End-Stage Ren I1550. Neurogenic Bladder I1650. Obstructive Uropathy | al Disease (ESRD) | |
| Infections | S | | |
| | I1700. Multidrug-Resistant Organism (MDRO) I2000. Pneumonia I2100. Septicemia I2200. Tuberculosis I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) I2500. Wound Infection (other than foot) | | |
| Metabolio | · · · · · · · · · · · · · · · · · · · | | |
| | I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, neph I3100. Hyponatremia I3200. Hyperkalemia I3300. Hyperlipidemia (e.g., hypercholesterolemia) | ropathy, and neuropathy) | |
| Musculos | skeletal | | |
| | I3900. Hip Fracture - any hip fracture that has a relationship to the trochanter and femoral neck) I4000. Other Fracture | current status, treatments, monitoring (e.g., sub- | capital fractures, and fractures o |
| Neurolog | | | |
| | I4200. Alzheimer's Disease I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebrovascular Accident (CVA), Transient Ischemic I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, as Pick's disease; and dementia related to stroke, Parkinson's of I4900. Hemiplegia or Hemiparesis I5000. Paraplegia I5100. Quadriplegia | vascular or multi-infarct dementia; mixed demen | tia; frontotemporal dementia such |
| | I5200. Multiple Sclerosis (MS) | | |
| | I5250. Huntington's Disease | | |
| | I5300. Parkinson's Disease I5350. Tourette's Syndrome | | |
| | • | | |
| ineurolog | ical continued on next page | | |

| Resident | | Identifier | Date | |
|----------|---|---------------------------------------|---|--|
| Secti | on I - Active Diagnoses | | | |
| | Diagnoses in the last 7 days - Check all that apply es listed in parentheses are provided as examples and should not be | e considered as all-inclusive lists | | |
| Neurolo | gical - Continued | | | |
| | I5400. Seizure Disorder or Epilepsy I5500. Traumatic Brain Injury (TBI) | | | |
| Nutritio | nal | | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | | |
| Psychia | tric/Mood Disorder | | | |
| | I5700. Anxiety Disorder I5800. Depression (other than bipolar) I5900. Bipolar Disorder I5950. Psychotic Disorder (other than schizophrenia) I6000. Schizophrenia (e.g., schizoaffective and schizophreniform I6100. Post Traumatic Stress Disorder (PTSD) | n disorders) | | |
| Pulmon | ary | | | |
| | I6200. Asthma, Chronic Obstructive Pulmonary Disease (COI diseases such as asbestosis) I6300. Respiratory Failure | PD), or Chronic Lung Disease (e. | g., chronic bronchitis and restrictive lung | |
| Other | | | | |
| | 18000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the decim | nal for the code in the appropriate b | DOX. | |
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| Resident | Identifier Date |
|------------|---|
| Section | n J - Health Conditions |
| J0100. | Pain Management - Complete for all residents, regardless of current pain level |
| At any tim | in the last 5 days, has the resident: |
| Enter Code | A. Received scheduled pain medication regimen? |
| | 0. No 1. Yes |
| Enter Code | B. Received PRN pain medications OR was offered and declined? |
| | 0. No 1. Yes |
| Enter Code | C. Received non-medication intervention for pain? |
| Eller Code | 0. No |
| Ш | 1. Yes |
| J0200. | Should Pain Assessment Interview be Conducted? |
| | 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 |
| | Yes → Continue to J0300, Pain Presence |
| | |
| Pain As | sessment Interview |
| J0300. | Pain Presence |
| Enter Code | Ask resident: "Have you had pain or hurting at any time in the last 5 days?" |
| | 0. No \rightarrow Skip to J1100, Shortness of Breath |
| | 1. Yes → Continue to J0410, Pain Frequency |
| 10440 | 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain |
| J0410. | Pain Frequency |
| Enter Code | Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" |
| | 1. Rarely or not at all |
| | 2. Occasionally3. Frequently |
| | 4. Almost constantly |
| | 9. Unable to answer |
| J0510. | Pain Effect on Sleep |
| Enter Code | Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" |
| | 1. Rarely or not at all |
| | Occasionally Frequently |
| | 4. Almost constantly |
| | 8. Unable to answer |
| J0520. | Pain Interference with Therapy Activities |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" |
| | Does not apply - I have not received rehabilitation therapy in the past 5 days |
| | Rarely or not at all Occasionally |
| | 3. Frequently |
| | 4. Almost constantly |
| | 8. Unable to answer |



| Resident | Identifier Date |
|--------------|--|
| Section | on J - Health Conditions |
| Pain As | sessment Interview - Continued |
| J0530. | Pain Interference with Day-to-Day Activities |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" |
| | Rarely or not at all Occasionally Frequently Almost constantly Unable to answer |
| J0600. | Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B) |
| Enter Rating | A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale) |
| Enter Code | Enter two-digit response. Enter 99 if unable to answer. B. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale) |
| | Mild Moderate Severe Very severe, horrible Unable to answer |
| 10700 | |
| J0700. | Should the Staff Assessment for Pain be Conducted? |
| Enter Code | No (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) Yes (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain |
| Staff As | sessment for Pain |
| J0800. | Indicators of Pain or Possible Pain in the last 5 days |
| \downarrow | 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, winces, 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 |
| | Indicators of pain or possible pain observed 3 to 4 days Indicators of pain or possible pain observed daily |



| Resident | | Identifier Date |
|--------------------|----|--|
| Section | n | J - Health Conditions |
| | | th Conditions ortness of Breath (dyspnea) |
| \downarrow | Ch | eck 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. | Pr | ognosis |
| Enter Code | | es the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician cumentation) |
| | | 0. No 1. Yes |
| J1550. | Pr | oblem Conditions |
| \downarrow | Ch | eck all that apply |
| | A. | Fever |
| | В. | Vomiting |
| | C. | Dehydrated |
| | D. | Internal bleeding |
| | Z. | None of the above |
| J1700. Complete | | II History on Admission/Entry or Reentry if A0310A = 01 or A0310E = 1 |
| Enter Code | A. | Did the resident have a fall any time in the last month prior to admission/entry or reentry? 0. No 1. Yes |
| Enter Code | В. | 9. Unable to determine Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? 0. No 1. Yes |
| Enter Code | C. | 9. Unable to determine Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine |
| J1800. | | y Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), chever is more recent |
| Enter Code | | s the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more ent? 0. No → Skip to J2000, Prior Surgery 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) |

| esident | | | Identifier | Date |
|---------------------------------|--------|--|--|--|
| Section | on . | J - Health Conditions | | |
| J1900. | Num | ber of Falls Since Admission/Entry or Re | eentry or Prior Assessment (OBRA or Sch | eduled PPS), whichever is more recent |
| Coding: 0. None 1. One 2. Two o | or mor | e | | |
| nter Code ↓ | s in B | oxes | | |
| | A. | No injury - no evidence of any injury is not by the resident; no change in the resident's | ted on physical assessment by the nurse or p behavior is noted after the fall | rimary care clinician; no complaints of pain or injury |
| | | Injury (except major) - skin tears, abrasior the resident to complain of pain | ns, lacerations, superficial bruises, hematoma | as and sprains; or any fall-related injury that causes |
| | C. | Major injury - bone fractures, joint dislocat | tions, closed head injuries with altered consci | ousness, subdural hematoma |
| J2000. | Prior | Surgery - Complete only if A0310B = 01 | | |
| Enter Code | | he resident have major surgery during the 1 0. No 1. Yes 8. Unknown | 100 days prior to admission? | |
| J2100. | Rece | nt Surgery Requiring Active SNF Care - | Complete only if A0310B = 01 or if state requ | ires completion with an OBRA assessment |
| Enter Code | | he resident have a major surgical procedure 0. No 1. Yes | e during the prior inpatient hospital stay that r | requires active care during the SNF stay? |

8. Unknown

| esident | lder | ntifier | Date |
|--------------|--|---|---|
| Sectio | on J - Health Conditions | | |
| Surgica | al Procedures - Complete only if J2100 = 1 | | |
| \downarrow | Check all that apply | | |
| Major Joi | int Replacement | | |
| | J2300. Knee Replacement - partial or total J2310. Hip Replacement - partial or total J2320. Ankle Replacement - partial or total J2330. Shoulder Replacement - partial or total | | |
| Spinal Su | urgery | | |
| | J2400. Involving the spinal cord or major spinal nerves J2410. Involving fusion of spinal bones J2420. Involving lamina, discs, or facets J2499. Other major spinal surgery | | |
| Other Ort | thopedic Surgery | | |
| | J2500. Repair fractures of the shoulder (including clavicle and scap J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not J2520. Repair but not replace joints J2530. Repair other bones (such as hand, foot, jaw) J2599. Other major orthopedic surgery | | |
| Neurologi | gical Surgery | | |
| | J2600. Involving the brain, surrounding tissue or blood vessels (J2610. Involving the peripheral or autonomic nervous system - o J2620. Insertion or removal of spinal or brain neurostimulators, e J2699. Other major neurological surgery | pen or percutaneous | , |
| Cardiopul | ılmonary Surgery | | |
| | J2700. Involving the heart or major blood vessels - open or percut J2710. Involving the respiratory system, including lungs, bronch J2799. Other major cardiopulmonary surgery | | r endoscopic |
| Genitouri | inary Surgery | | |
| | J2800. Involving genital systems (such as prostate, testes, ovaries, J2810. Involving the kidneys, ureters, adrenal glands, or bladder nephrostomies or urostomies) J2899. Other major genitourinary surgery | • , | removal of |
| Other Maj | jor Surgery | | |
| | J2900. Involving tendons, ligaments, or muscles J2910. Involving the gastrointestinal tract or abdominal contents pancreas, or spleen - open or laparoscopic (including creation) | on or removal of ostomies or percutaneous for | ary tree, gall bladder, liver, eeding tubes, or hernia repair) |
| | J2920. Involving the endocrine organs (such as thyroid, parathyroid J2930. Involving the breast J2940. Repair of deep ulcers, internal brachytherapy, bone marro J5000. Other major surgery not listed above | | |

| Resident | | | | ldentifier | | D | ate | |
|---|---|--|---|---|-------------------|-------------------------|---------------------|-----------------|
| Sect | tion | K. | Swallowing/Nutritional | Status | | | | |
| | | | wing Disorder s of possible swallowing disorder | | | | | |
| July | • | • | Il that apply | | | | | |
| | | | s of liquids/solids from mouth when eating | or drinking | | | | |
| | | | ding food in mouth/cheeks or residual food | | | | | |
| | C. | | ighing or choking during meals or when sw | | | | | |
| | D. | | nplaints of difficulty or pain with swallowing | | | | | |
| | Z. | | ne of the above | | | | | |
| K020 | 0. He | ight | and Weight - While measuring, if the numb | per is X.1 - X.4 round down; X | X.5 or greater ro | ound up | | |
| Inches | | A. | Height (in inches). Record most recent height | t measure since the most rec | cent admission/e | entry or reentry | | |
| Pounds | | В. | Weight (in pounds). Base weight on most rec practice (e.g., in a.m. after voiding, before me | | measure weigh | t consistently, a | ccording to sta | ndard facility |
| K030 | 0. W | eight | Loss | | | | | |
| Enter Cod | le Lo | ss of | 5% or more in the last month or loss of 10% | or more in last 6 months | | | | |
| | | 0. 1. 2. | No or unknown Yes, on physician-prescribed weight-loss regi Yes, not on physician-prescribed weight-loss | | | | | |
| K031 | 0. W | eight | Gain | | | | | |
| Enter Cod | e Ga | in of | 5% or more in the last month or gain of $10%$ | or more in last 6 months | | | | |
| | | 0. | No or unknown | | | | | |
| | | 1. 2. | Yes, on physician-prescribed weight-gain reg Yes, not on physician-prescribed weight-gain | | | | | |
| K052 | 0. Nu | itriti | onal Approaches | J | | | | |
| | | | wing nutritional approaches that apply | | | | | |
| As. 2. Wh Pe On 3. Wh Pe | nile Not rformed aly chec nile a R | nt per a Re while k colu eside | e NOT a resident of this facility and within th mn 2 if resident entered (admission or reentry) | ne <i>last 7 days</i> IN THE LAST 7 DAYS. If res | sident last enter | ed 7 or more da | ys ago, leave c | olumn 2 blank. |
| | | | iod is the last 3 days of the SNF PPS Stay end | ling on A2400C | | | | |
| | | | | | 1. | 2. | 3. | 4. |
| | | | | | On Admission | While Not a Resident | While a Resident | At Discharge |
| | | | | | | ↓ Check all | that apply↓ | |
| A. Pa | rentera | I/IV f | eeding | | | | | |
| B. Fe | eding t | ube (| e.g., nasogastric or abdominal (PEG)) | | | | | |
| C. Me | echanic od, thick | ally a ened | Itered diet - require change in texture of food of liquids) | or liquids (e.g., pureed | | | | |
| D. Th | erapeu | tic di | et (e.g., low salt, diabetic, low cholesterol) | | | | | |
| 7. No | ne of t | he ah | ove | | | | | |

| Resident | lde | entifier | Date | |
|--------------------------|--|------------------------------------|---------------------------|-------------------------|
| Section | on K - Swallowing/Nutritional Status | . | | |
| K0710. | Percent Intake by Artificial Route - Complete K0710 only i | f Column 2 and/or Column 3 are che | ecked for K0520A and | or K0520B |
| Ρε 3. D ι | hile a Resident erformed while a resident of this facility and within the la uring Entire 7 Days erformed during the entire last 7 days | | 2. While a Resident | 3. During Entire 7 Days |
| A. Pro 1. 2. 3. | oportion of total calories the resident received through parentera 25% or less 26-50% 51% or more | l or tube feeding | ↓ Enter Code | es ↓ |
| B. Av o 1. 2. | erage fluid intake per day by IV or tube feeding 500 cc/day or less 501 cc/day or more | | | |
| | | | | |
| Section | on L - Oral/Dental Status | | | |
| L0200. | Dental | | | |
| \downarrow | Check all that apply | | | |
| | A. Broken or loosely fitting full or partial denture (chipped, cra | cked, uncleanable, or loose) | | |
| | F. Mouth or facial pain, discomfort or difficulty with chewing | | | |
| | | | | |
| Section | on M - Skin Conditions | | | |
| | Report based on highest stage of exi do not "reve | - | at their worst | , |
| M0100. | Determination of Pressure Ulcer/Injury Risk | | | |
| ↓ | Check all that apply | | | |
| | A. Resident has a pressure ulcer/injury, a scar over bony pror | minence, or a non-removable dres | sing/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/Injuries | | | |
| Enter Code | Is this resident at risk of developing pressure ulcers/injuries? 0. No 1. Yes | | | |
| M0210. | Unhealed Pressure Ulcers/Injuries | | | |
| Enter Code | Does this resident have one or more unhealed pressure ulcers/ No → Skip to M1030, Number of Venous and Arterial Ulce Yes → Continue to M0300, Current Number of Unhealed | ers | age | |

| Section | on | M - Skin Conditions |
|--------------|----|---|
| M0300. | Cu | rent Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| Enter Number | A. | Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones only it may appear with persistent blue or purple hues |
| | | 1. Number of Stage 1 pressure injuries |
| 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 prese as an intact or open/ruptured blister |
| | | 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 |
| Enter Number | | Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | C. | Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling |
| | | 1. Number of Stage 3 pressure ulcers - If $0 \rightarrow \text{Skip}$ to M0300D, Stage 4 |
| Enter Number | | 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling |
| | | 1. Number of Stage 4 pressure ulcers - If $0 \rightarrow \text{Skip}$ to M0300E, Unstageable - Non-removable dressing/device |
| Enter Number | | 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | E. | Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device |
| Enter Number | | 1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If $0 \rightarrow$ Skip to M0300F, Unstageable Slough and/or eschar |
| Enter Number | | 2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | F. | Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar |
| | | Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury |
| Enter Number | | 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| | G. | Unstageable - Deep tissue injury: |
| Enter Number | | Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterior |
| Enter Number | | 2. Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were not at the time of admission/entry or reentry |
| | | |

| | | Identifier | Date | | |
|-----|--|--|--|--|--|
| n | M - Skin Conditions | | | | |
| Nu | mber of Venous and Arterial Ulcers | | | | |
| Ent | ter the total number of venous and arterial ulcers present | | | | |
| Otl | her Ulcers, Wounds and Skin Problems | | | | |
| Che | eck all that apply | | | | |
| F | Foot Problems | | | | |
| A. | Infection of the foot (e.g., cellulitis, purulent drainage) | | | | |
| В. | Diabetic foot ulcer(s) | | | | |
| C. | Other open lesion(s) on the foot | | | | |
| C | Other Problems | | | | |
| D. | Open lesion(s) other than ulcers, rashes, cuts (e.g., cance | er lesion) | | | |
| E. | Surgical wound(s) | | | | |
| F. | Burn(s) (second or third degree) | | | | |
| G. | Skin tear(s) | | | | |
| H. | H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) | | | | |
| N | lone of the Above | | | | |
| Z. | None of the above were present | | | | |
| Ski | in and Ulcer/Injury Treatments | | | | |
| Che | eck all that apply | | | | |
| A. | Pressure reducing device for chair | | | | |
| B. | Pressure reducing device for bed | | | | |
| C. | Turning/repositioning program | | | | |
| D. | Nutrition or hydration intervention to manage skin problem | ns | | | |
| E. | Pressure ulcer/injury care | | | | |
| F. | Surgical wound care | | | | |
| G. | Application of nonsurgical dressings (with or without topic | al medications) other than to feet | | | |
| H. | Applications of ointments/medications other than to feet | | | | |
| l. | • , , | dications) | | | |
| Z. | None of the above were provided | | | | |
| | Nu Enti Otti Che F. G. H. Sk Che A. B. C. D. E. F. G. H. I. | Enter the total number of venous and arterial ulcers present Other Ulcers, Wounds and Skin Problems Check all that apply Foot Problems A. Infection of the foot (e.g., cellulitis, purulent drainage) B. Diabetic foot ulcer(s) C. Other open lesion(s) on the foot Other Problems D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancelle. Surgical wound(s) F. Burn(s) (second or third degree) G. Skin tear(s) H. Moisture Associated Skin Damage (MASD) (e.g., incontinelle None of the Above Z. None of the above were present Skin and Ulcer/Injury Treatments Check all that apply A. Pressure reducing device for chair B. Pressure reducing device for bed C. Turning/repositioning program D. Nutrition or hydration intervention to manage skin problem E. Pressure ulcer/injury care F. Surgical wound care G. Application of nonsurgical dressings (with or without topical medications of ointments/medications other than to feet I. Application of dressings to feet (with or without topical medications of ointments/medications other than to feet | Enter the total number of venous and Arterial Ulcers Enter the total number of venous and arterial ulcers present Other Ulcers, Wounds and Skin Problems Check all that apply Foot Problems A. Infection of the foot (e.g., cellulitis, purulent drainage) B. Diabetic foot ulcer(s) C. Other open lesion(s) on the foot Other Problems D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) E. Surgical wound(s) F. Burn(s) (second or third degree) G. Skin tear(s) H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, on None of the Above Z. None of the Above Z. None of the above were present Skin and Ulcer/Injury Treatments Check all that apply A. Pressure reducing device for bed C. Turning/repositioning program D. Nutrition or hydration intervention to manage skin problems E. Pressure ulcer/injury care F. Surgical wound care G. Application of nonsurgical dressings (with or without topical medications) other than to feet H. Application of dressings to feet (with or without topical medications) | | |

| esident | | Identifier | Date | |
|-----------|------------|---|------------------------|----------------------|
| | | N - Medications | | |
| Enter Day | 1/6/ | ford the number of days that injections of any type were received during the last 7 days or since as s. If $0 \rightarrow Skip$ to N0415, High-Risk Drug Classes: Use and Indication | admission/entry or re | entry if less than 7 |
| N035 | 0. Ins | ulin | | |
| Enter Day | A . | Insulin injections - Record the number of days that insulin injections were received during the reentry if less than 7 days | last 7 days or since | admission/entry or |
| Enter Day | в. | Orders for insulin - Record the number of days the physician (or authorized assistant or practinsulin orders during the last 7 days or since admission/entry or reentry if less than 7 days | titioner) changed th | ne resident's |
| N041 | 5. Hig | h-Risk Drug Classes: Use and Indication | | |
| 1. 2. | or reent | g f the resident is taking any medications by pharmacological classification, not how it is used, during the ry if less than 7 days on noted on 1 is checked, check if there is an indication noted for all medications in the drug class | ne last 7 days or sinc | ee admission/entry |
| | | | 1. | 2. |
| | | | Is taking | Indication noted |
| | | | ↓ Check all | that apply↓ |
| A. | Antips | ychotic | | |
| B. | Antian | riety | | |
| C. | Antide | pressant | | |
| D. | Hypnot | ic | | |
| E. | | agulant (e.g., warfarin, heparin, or low-molecular weight heparin) | | |
| F. | Antibio | | | |
| G. | Diureti | | | |
| H. | Opioid | | | |
| I. | Antipla | | | |
| J. | | ycemic (including insulin) | | |
| Z. | None o | f the above | | |
| | | | | |

| esident | | | Identifier Date |
|------------|------------|------------------|---|
| Section | n | N - | Medications |
| N0450. | An | tips | chotic Medication Review |
| Enter Code | A. | | the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is e recent? |
| | | 0. | \mbox{No} - Antipsychotics were not received \rightarrow Skip N0450B, N0450C, N0450D, and N0450E |
| | | 1. | $\textbf{Yes} \text{ -} \text{Antipsychotics were received on a routine basis only} \rightarrow \text{Continue to N0450B, Has a GDR been attempted?}$ |
| | | 2. | $\textbf{Yes} \text{ -} \text{Antipsychotics were received on a PRN basis only} \rightarrow \text{Continue to N0450B, Has a GDR been attempted?}$ |
| Enter Code | В. | 3. Has | Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted? a gradual dose reduction (GDR) been attempted? |
| | | 0. | No → Skip to N0450D, Physician documented GDR as clinically contraindicated |
| | | 1. | $Yes \rightarrow Continue to N0450C$, Date of last attempted GDR |
| | C. | Dat | e of last attempted GDR: |
| | | L N | onth Day Year |
| Enter Code | D. | Phy | sician documented GDR as clinically contraindicated |
| Ш | | 0. | ${f No}$ - GDR has not been documented by a physician as clinically contraindicated $ ightarrow$ Skip N0450E, Date physician documented GDR as clinically contraindicated |
| | | 1. | $\textbf{Yes} - \text{GDR has been documented by a physician as clinically contraindicated} \rightarrow \text{Continue to N0450E}, \text{Date physician documented GDR as clinically contraindicated}$ |
| | E. | Dat | physician documented GDR as clinically contraindicated: |
| | | N | onth Day Year |
| N2001. | | _ | egimen Review - Complete only if A0310B = 01 |
| Enter Code | Did | a co | mplete drug regimen review identify potential clinically significant medication issues? |
| | | 0. 1. | No - No issues found during review Yes - Issues found during review |
| | | 9. | NA - Resident is not taking any medications |
| N2003. | Ме | dica | tion Follow-up - Complete only if N2001 = 1 |
| Enter Code | Did rec | the f | acility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ ended actions in response to the identified potential clinically significant medication issues? |
| ш | | 0. 1. | No Yes |
| N2005. | Me | | tion Intervention - Complete only if A0310H = 1 |
| Enter Code | | | acility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next day each time potential clinically significant medication issues were identified since the admission? |
| Ш | | 0. 1. | No Yes |
| | | 9. | NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications |

| | Section O - Special Treatments, Procedures, and Programs O0110. Special Treatments, Procedures, and Programs | | | | | |
|---------------------|--|--------------------|------------------------|--------------------|--|--|
| Check all of the fo | ollowing treatments, procedures, and programs that were performed | | | | | |
| b. While a Res | period is days 1 through 3 of the SNF PPS Stay starting with A2400B | a. On Admission | b. While a Resident | c. At Discharge | | |
| c. At Discharg | | | Check all that apply | | | |
| _ | period is the last 3 days of the SNF PPS Stay ending on A2400C | \downarrow | ↓ ↓ | \downarrow | | |
| Cancer Treatmer | nts | | | | | |
| A1. Chemothera | ару | | | | | |
| A2. IV | | | | | | |
| A3. Oral | | | | | | |
| A10. Other | • | | | | | |
| B1. Radiation | | | | | | |
| Respiratory Trea | atments | | | | | |
| C1. Oxygen the | rapy | | | | | |
| C2. Continu | uous | | | | | |
| C3. Intermi | ttent | | | | | |
| C4. High-co | oncentration | | | | | |
| D1. Suctioning | | | | | | |
| D2. Schedu | ıled | | | | | |
| D3. As nee | ded | | | | | |
| E1. Tracheostor | my care | | | | | |
| F1. Invasive Me | chanical Ventilator (ventilator or respirator) | | | | | |
| G1. Non-invasiv | re Mechanical Ventilator | | | | | |
| G2. BiPAP | | | | | | |
| G3. CPAP | | | | | | |
| Other | | | | | | |
| H1. IV Medication | ons | | | | | |
| H2. Vasoac | tive medications | | | | | |
| H3. Antibio | tics | | | | | |
| H4. Anticoa | | | | | | |
| H10. Other | | | | | | |
| I1. Transfusion | | | | | | |
| O0110 continu | ed on next page | | | | | |
| | | | | | | |

Resident ___

| Reside | ent | | Identifier | | Date | |
|--------|---------|---------------------|--|--------------------------|--------------------------|--------------------|
| | | | O - Special Treatments, Procedures, and Programs - Continued | nd Program | S | |
| Che | eck all | of the | e following treatments, procedures, and programs that were performed | | | |
| b. | While | smer a Re | sion It period is days 1 through 3 of the SNF PPS Stay starting with A2400B sident while a resident of this facility and within the last 14 days | a. On Admission | b. While a Resident | c. At Discharge |
| C. | At Dis | schar | • | \downarrow | Check all that apply ↓ | \downarrow |
| J1. | Dialys | sis | | | | |
| | J2. F | lemo | dialysis | | | |
| | J3. F | Perito | neal dialysis | | | |
| K1. | Hospi | ice ca | are | | | |
| M1. | | | r quarantine for active infectious disease nclude standard body/fluid precautions) | | | |
| 01. | IV Ac | cess | | | | |
| | O2. F | Peripl | neral | | | |
| | O3. N | Midlin | e | | | |
| | O4. C | Centra | al (e.g., PICC, tunneled, port) | | | |
| Non | e of th | e Ab | ove | | | |
| Z1. | None | of th | e above | | | |
| 00 | 250. | Infl | luenza Vaccine - Refer to current version of RAI manual for current influ | uenza vaccination sea | son and reporting period | |
| Enter | r Code | A. | Did the resident receive the influenza vaccine <i>in this facility</i> for this to No → Skip to O0250C, If influenza vaccine not received, state reason. Yes → Continue to O0250B, Date influenza vaccine received | | ation season? | |
| | | B. | Date influenza vaccine received → Complete date and skip to O0300A Month Day Year | , Is the resident's Pnet | umococcal vaccination u | p to date? |
| | | C. | If influenza vaccine not received, state reason: | | | |
| Enter | r Code | | Resident not in this facility during this year's influenza vaccination Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | season | | |
| 003 | 300. | Pn | eumococcal Vaccine | | | |
| Enter | r Code | A. | Is the resident's Pneumococcal vaccination up to date? | | | |
| L | | | No → Continue to O0300B, If Pneumococcal vaccine not received, s Yes → Skip to O0400, Therapies | state reason | | |
| Ento | r Code | В. | If Pneumococcal vaccine not received, state reason: | | | |
| Entel | Code | | Not eligible - medical contraindication Offered and declined Not offered | | | |

| Resident | | Identifier Date |
|---|------------|---|
| Section O - | Speci | ial Treatments, Procedures, and Programs |
| O0400. Therapi | _ | |
| Complete only when | A0310B = (| 01 (complete O0400D2 when required by state) |
| | A. Sp | eech-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 days |
| 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 in the last 7 days |
| 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 in the last 7 days |
| | If the | sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0400A5, Therapy start date |
| Enter Number of Minutes | 3A | . Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days |
| Enter Number of Days | 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 |
| | | Month Day Year |
| | 6. | Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes it therapy is ongoing |
| | | Month Day Year |
| Enter Number of Minutes | B. Oc | cupational Therapy |
| | 1. | Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days |
| Enter Number of Minutes | 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 | $\textbf{sum of individual, concurrent, and group minutes is zero,} \rightarrow \textbf{skip to O0400B5}, \textbf{Therapy start date}$ |
| Enter Number of Minutes Enter Number of Days | 3A | . Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days |
| The Hamber of Baye | 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 |
| | | Month Day Year |
| | 6. | Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes it therapy is ongoing |
| | | Month Day Year |
| O0400 continued | on next | |
| MDS 3.0 Nursing Hor | ne Quarte | rly (NQ) Version 1.18.11 Effective 10/01/2023 Page 41 of 51 |

| | Identifier Date |
|-------------------------|--|
| Section O - S | pecial Treatments, Procedures, and Programs - Continued |
| Complete only when A | 110B = 01 (complete O0400D2 when required by state) |
| | C. Physical Therapy |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days |
| Enter Number of Minutes | Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days |
| Enter Number of Minutes | 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, \rightarrow skip to O0400C5, Therapy start date |
| Enter Number of Minutes | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatmen sessions in the last 7 days |
| 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 |
| | Month Day Year |
| | 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes therapy is ongoing |
| | Month Day Year |
| | D. Respiratory Therapy |
| Enter Number of Days | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| | E. Psychological Therapy (by any licensed mental health professional) |
| Enter Number of Days | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| O0420. Distinct C | alendar Days of Therapy |
| Complete only when A | 110B = 01 |
| 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 in the past 7 days. |

| Resident | Identifier | Date |
|--------------------------|--|--|
| Section O - | Special Treatments, Procedures, and Programs | 3 |
| O0425. Part A T | herapies | |
| Complete only if A031 | 10H = 1 | |
| Enter Number of Minutes | A. Speech-Language Pathology and Audiology Services | |
| | Individual minutes - record the total number of minutes this therapy was admir the start date of the resident's most recent Medicare Part A stay (A2400B) | nistered to the resident individually since |
| Enter Number of Minutes | Concurrent minutes - record the total number of minutes this therapy was adm with one other resident since the start date of the resident's most recent Medic | |
| Enter Number of Minutes | Group minutes - record the total number of minutes this therapy was administed residents since the start date of the resident's most recent Medicare Part A stay | |
| Enter Number of Minutes | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0425B | , Occupational Therapy |
| | Co-treatment minutes - record the total number of minutes this therapy was ac sessions since the start date of the resident's most recent Medicare Part A stay | Iministered to the resident in co-treatment (A2400B) |
| Enter Number of Days | Days - record the number of days this therapy was administered for at least 1s resident's most recent Medicare Part A stay (A2400B) | 5 minutes a day since the start date of the |
| | B. Occupational Therapy | |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was admir | nistered to the resident individually since |
| Enter Number of Minutes | the start date of the resident's most recent Medicare Part A stay (A2400B) | instelled to the resident individually since |
| Enter Number of Minutes | Concurrent minutes - record the total number of minutes this therapy was adm with one other resident since the start date of the resident's most recent Medic | |
| Lines Nambol of Williams | Group minutes - record the total number of minutes this therapy was administeresidents since the start date of the resident's most recent Medicare Part A stay | |
| | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to 004250 | c, Physical Therapy |
| Enter Number of Minutes | 4. Co-treatment minutes - record the total number of minutes this therapy was ac sessions since the start date of the resident's most recent Medicare Part A stay | |
| Enter Number of Days | Days - record the number of days this therapy was administered for at least 1st resident's most recent Medicare Part A stay (A2400B) | 5 minutes a day since the start date of the |
| 5 . N. J. (Nr.) | C. Physical Therapy | |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was admir the start date of the resident's most recent Medicare Part A stay (A2400B) | nistered to the resident individually since |
| Enter Number of Minutes | 2. Concurrent minutes - record the total number of minutes this therapy was adm with one other resident since the start date of the resident's most recent Medic | ninistered to the resident concurrently care Part A stay (A2400B) |
| Enter Number of Minutes | 3. Group minutes - record the total number of minutes this therapy was administer residents since the start date of the resident's most recent Medicare Part A stay | |
| | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0430, | Distinct Calendar Days of Part A Therapy |
| Enter Number of Minutes | Co-treatment minutes - record the total number of minutes this therapy was ac sessions since the start date of the resident's most recent Medicare Part A stay | |
| Enter Number of Days | Days - record the number of days this therapy was administered for at least 1s resident's most recent Medicare Part A stay (A2400B) | 5 minutes a day since the start date of the |
| | | |

| esident | | Identifier | Date |
|-------------------------|-----------------------|---|--------------------------------|
| Section | n (| O - Special Treatments, Procedures, and Programs | |
| O0430. | Dist | inct 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 Autional Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most (A2400B) | |
| O0500. | Res | torative Nursing Programs | |
| Record the none or less | numb s than | per of days each of the following restorative programs was performed (for at least 15 minutes a day) in the la 15 minutes daily) | st 7 calendar days (enter 0 if |
| Number of Days | Tec | hnique | |
| | Α. | Range of motion (passive) | |
| | В. | Range of motion (active) | |
| | C. | Splint or brace assistance | |
| Number of Days | Trai | ning and Skill Practice In: | |
| | D. | Bed mobility | |
| | E. | Transfer | |
| | F. | Walking | |
| | G. | Dressing and/or grooming | |
| | Н. | Eating and/or swallowing | |
| | l. | Amputation/prostheses care | |
| | J. | Communication | |

| esident | | | Identifier | Date |
|-------------------|------------------|---|--|--|
| Sect | io | n P - Restraints and Alarms | | |
| P010 |). F | Physical Restraints | | |
| Physic individual | al res ual ca | straints are any manual method or physical or mechanical device annot remove easily which restricts freedom of movement or nor | material or equipment attached or nal access to one's body | adjacent to the resident's body that the |
| 1. | Not Use | used d less than daily d daily | | |
| nter C | odes | in Boxes | | |
| ↓ | Use | d in Bed | | |
| | Α. | Bed rail | | |
| | В. | Trunk restraint | | |
| ╛ | C. | Limb restraint | | |
| | D. | Other | | |
| _ | Use | d in Chair or Out of Bed | | |
| ╛ | Ε | Trunk restraint | | |
| ╡ | F | Limb restraint | | |
| ╡ | G. | Chair prevents rising | | |
| | | Other | | |
| | | Alarms | | |
| An alai | m is | any physical or electronic device that monitors resident moveme | nt and alerts the staff when movem | ent is detected |
| 1. U | Not u Jsed | ised less than daily daily | | |
| Enter C ↓ | odes | in Boxes | | |
| | Α. | Bed alarm | | |
| | В. | Chair alarm | | |
| | C. | Floor mat alarm | | |
| | D. | Motion sensor alarm | | |
| | E. | Wander/elopement alarm | | |
| Ī | F. | Other alarm | | |
| | | | | |

| Resident | | Identifier | Date |
|-------------|--------|--|--|
| Section | on | Q - Participation in Assessment and Goal Setting | |
| Q0110. | Pa | rticipation in Assessment and Goal Setting | |
| Identify al | l acti | ive participants in the assessment process | |
| ↓ | Ch | eck all that apply | |
| | A. | Resident | |
| | B. | Family | |
| | C. | Significant other | |
| | D. | Legal guardian | |
| | E. | Other legally authorized representative | |
| | Z. | None of the above | |
| Q0310. | Re | esident's Overall Goal | |
| Complete | only | r if A0310E = 1 | |
| Enter Code | A. | Resident's overall goal for discharge established during the assessment process 1. Discharge to the community 2. Remain in this facility 3. Discharge to another facility/institution 9. Unknown or uncertain | |
| Enter Code | B. | Indicate information source for Q0310A 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | |
| Q0400. | Dis | scharge Plan | |
| Enter Code | A. | Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes → Skip to Q0610, Referral | |
| | | esident's Documented Preference to Avoid Being Asked Question Q0500B v if A0310A = 02, 06, or 99 | |
| Enter Code | Do | es resident's clinical record document a request that this question (Q0500B) be asked only on a comp 0. No 1. Yes → Skip to Q0610, Referral | rehensive assessment? |
| Q0500. | Re | eturn to Community | |
| Enter Code | B. | Ask the resident (or family or significant other or guardian or legally authorized representative only if residence respond): "Do you want to talk to someone about the possibility of leaving this facility and returning the community?" 0. No 1. Yes 9. Unknown or uncertain | ent is unable to understand or to live and receive services in |
| Enter Code | C. | Indicate information source for Q0500B 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally authorized representative 9. None of the above | |



| esident | | Identifier | Date |
|------------|---|--|--|
| Section | on Q - Participa | tion in Assessment and Goal Se | etting |
| Q0550. | Resident's Preference | to Avoid Being Asked Question Q0500B | |
| Enter Code | A. Does resident (or fami spond) want to be ask | ly or significant other or guardian or legally authorized represe ed about returning to the community on all assessments? | ntative only if resident is unable to understand or re- (Rather than on comprehensive assessments alone) |
| | No - then docume Yes Information not a | nt in resident's clinical record and ask again only on the next covailable | omprehensive assessment |
| Enter Code | C. Indicate information s 1. Resident 2. Family 3. Significant other 4. Legal guardian 5. Other legally aut 9. None of the abov | norized representative | |
| Q0610. | Referral | | |
| Enter Code | A. Has a referral been m 0. No 1. Yes | ade to the Local Contact Agency (LCA)? | |
| Q0620. | Reason Referral to Lo | cal Contact Agency (LCA) Not Made | |
| Complete | only if Q0610 = 0 | | |
| Enter Code | | sly made | |

| Resident | | | | | | _ Identifier _ | | Date | |
|--------------------------|---------------|---|--|--|----------------------------|-----------------|--------------------|--|-------------------|
| Section | n 2 | X - Correcti | on Red | quest | | | | | |
| Identific section, re | atio produ | ection X only if A n of Record to b uce the information EX is necessary to local | e Modified KACTLY as it | /Inactiva | n the existin | ig erroneous i | ecord, even if the | ting assessment record that is e information is incorrect. | in error. In this |
| X0150. | Тур | e of Provider (A0 | 200 on existi | ng record to | be modified | l/inactivated) | | | |
| Enter Code | Тур | e of provider 1. Nursing home 2. Swing Bed | (SNF/NF) | | | | | | |
| X0200. | Nan | ne of Resident (A | 0500 on exis | ting record | to be modifi | ed/inactivated |) | | |
| | A. | First name: | | | | _ | | | |
| | | | | | | | | | |
| | C. | Last name: | | | | | | | |
| | | | | | | | $\Box\Box$ | | |
| X0300. | Ger | nder (A0800 on exist | ting record to | be modified | l/inactivated |) | | | |
| Enter Code | | 1. Male 2. Female | J | | | , | | | |
| X0400. | Birt | h Date (A0900 on e | existing record | d to be mod | ified/inactiva | ited) | | | |
| | | Month Day |]-[| Year | | | | | |
| X0500. | Soc | ial Security Nun | nber (A0600 | A on existin | g record to | oe modified/in | activated) | | |
| | | <u> </u> | [| | | | | | |
| X0600. | Тур | e of Assessmen | t (A0310 on e | existing reco | ord to be mo | dified/inactiva | ted) | | |
| Enter Code | A. | Federal OBRA Reas 01. Admission ass 02. Quarterly revie 03. Annual assess 04. Significant cha 05. Significant con 06. Significant con 99. None of the ab | sessment (receive assessment ange in staturection to prection to p | quired by dant s assessment for compre | ent e hensive as | | | | |
| Enter Code | B. | PPS Assessment PPS Scheduled Ass 01. 5-day scheduled PPS Unscheduled Assessment | d assessmen Assessment | t <u>for a Medic</u> | | | | | |
| | | 08. IPA - Interim PaNot PPS Assessme99. None of the ab | nt | smem | | | | | |
| Enter Code | F. | Entry/discharge rep 01. Entry tracking 10. Discharge ass 11. Discharge ass 12. Death in facilit 99. None of the ab | record essment- retu essment- ret u y tracking red | rn anticipa | | | | | |
| Enter Code | | Is this a SNF Part A 0. No 1. Yes | PPS Discha | rge Assess | sment? | | | | |

| Resident | | Identifier Date | | | | | |
|--------------|----------------|--|--|--|--|--|--|
| Section | n | X - Correction Request | | | | | |
| X0700. | Da | te on existing record to be modified/inactivated - Complete one only | | | | | |
| | A. | Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 | | | | | |
| | | Month Day Year | | | | | |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 | | | | | |
| | Month Day Year | | | | | | |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 | | | | | |
| | | Month Day Year | | | | | |
| Correcti | on . | Attestation Section - Complete this section to explain and attest to the modification/inactivation request | | | | | |
| | Со | rrection Number | | | | | |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one | | | | | |
| X0900. | Re | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | | | |
| ↓ | Che | eck 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. | Re | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | | | |
| \downarrow | Che | eck 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: | | | | | |
| | | | | | | | |
| | В. | Attesting individual's last name: | | | | | |
| | υ. | Attesting individual's last name. | | | | | |
| | | | | | | | |
| | C. | Attesting individual's title: | | | | | |
| | D. | Signature | | | | | |
| | E. | Attestation date | | | | | |
| | | Month Day Year | | | | | |

| Resident | | Identifier Date |
|----------------|----------|---|
| Section | n | Z - Assessment Administration |
| Z0100. | Ме | edicare Part A Billing |
| | A. | Medicare Part A HIPPS code: |
| | | Version code: |
| Z 0200. | | ate Medicaid Billing (if required by the state) |
| | A. | Case Mix group: |
| | B. | Version code: |
| Z0250. | Alt | ternate State Medicaid Billing (if required by the state) |
| | A. B. | Case Mix group: Version code: |
| Z0300. | Ins | surance Billing |
| | A. | Billing code: |
| | B. | Billing version: |

| Z0400. Signature of Persons Complet | _ | • • | |
|---|---|---|---|
| I certify that the accompanying information accurately of this information on the dates specified. To the best requirements. I understand that this information is use from federal funds. I further understand that payment conditioned on the accuracy and truthfulness of this in civil, and/or administrative penalties for submitting false. | of my knowledge, this information was colled as a basis for ensuring that residents reconstructed of such federal funds and continued particinformation, and that I may be personally susse information. I also certify that I am authors | ected in accordance with applicable ceive appropriate and quality care, a ipation in the government-funded he ibject to or may subject my organiza | Medicare and Medicaid and as a basis for payment ealth care programs is ation to substantial criminal. |
| Signature | Title | Sections | Date Section Completed |
| А. | | | |
| В. | | | |
| <u>C</u> . | | | |
| D. | | | |
| E | | | |
| <u>F.</u> | | | |
| G. | | | |
| Н. | | | |
| <u>I.</u> | | | |
| <u>J.</u> | | | |
| <u>K.</u> | | | |
| Z0500 Signature of DN Assessment (| Saudinatas Vasifisina Aasaaman | at Completion | |
| Z0500. Signature of RN Assessment C A. Signature: | Coordinator verifying Assessmen | B. Date RN Assessment C | Coordinator signed |
| A. Oighature. | | assessment as comple | |
| | | <u> </u> | |
| | | Month Day | Year |
| | | | |
| | | | |
| | | | |

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Section Z - Assessment Administration

| Resident | Identifier | Data |
|----------|------------|--------|
| RESIDEDI | Identitier | Date . |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Discharge (ND) Item Set

| Section | on A - Identification Information |
|------------|---|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): |
| | B. CMS Certification Number (CCN): |
| | |
| | C. State Provider Number: |
| | |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment |
| | PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment |
| | Not PPS Assessment 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

A0310 continued on next page

| Resident | | Identifier | | Date |
|------------|--|---|----------|--------------------------|
| Section | on A - Identification Information | | | |
| A0310. | Type of Assessment - Continued | | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | | |
| A0410. | Unit Certification or Licensure Designation | | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and Unit is neither Medicare nor Medicaid certified but I Unit is Medicare and/or Medicaid certified | MDS data is not required by the State MDS data is required by the State | | |
| A0500. | Legal Name of Resident | | | |
| | A. First name: C. Last name: | | B. D. | Middle initial: Suffix: |
| A0600. | Social Security and Medicare Numbers | | | |
| | A. Social Security Number: B. Medicare number: | | | |
| A0700. | Medicaid Number - Enter "+" if pending, "N" if not a N | Medicaid recipient | | |
| | | | | |
| A0800. | Gender | | | |
| Enter Code | 1. Male 2. Female | | | |
| A0900. | Birth Date | | | |
| | Month Day Year | | | |

| Resident | | Identifier Date |
|------------|--------|---|
| Section | n. | A - Identification Information |
| A1005. | Eth | nnicity |
| Are you of | f Hisp | panic, Latino/a, or Spanish origin? |
| | Che | eck all that apply |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin |
| | B. | Yes, Mexican, Mexican American, Chicano/a |
| | C. | Yes, Puerto Rican |
| | D. | Yes, Cuban |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| A1010. | | |
| What is yo | | |
| | Che | eck all that apply |
| | A. | White |
| | B. | Black or African American |
| | C. | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | H. | Korean |
| | I. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1110. | | nguage |
| | A. | What is your preferred language? |
| F | | |
| Enter Code | B. | Do you need or want an interpreter to communicate with a doctor or health care staff? |
| | | 1. Yes 9. Unable to determine |

| Resident | | | ldentifier | Date |
|-------------------|---------|--|---|---|
| Section | on / | A - Identification Inform | ation | |
| A1200. | Mar | ital Status | | |
| Enter Code | | Never married Married Widowed Separated Divorced | | |
| Has lack of | of tran | nsportation (from NACHC©) sportation kept you from medical appointmen f A0310B = 01 or A0310G = 1 and A0310H = | | gs needed for daily living? |
| ↓ | Che | ck all that apply | | |
| | A. | Yes, it has kept me from medical appointmen | its or from getting my medications | |
| | B. | Yes, it has kept me from non-medical meetin | gs, appointments, work, or from getting | things that I need |
| | C. | No | | |
| | X. | Resident unable to respond | | |
| | Y. | Resident declines to respond | | |
| and its resour | ces ar | | | Organizations, Oregon Primary Care Association. PRAPARE, and authorized recipients. Do not publish, copy, or distribute |
| A1300. | Opt | ional Resident Items | | |
| | A. | Medical record number: | | |
| | | | | |
| | B. | Room number: | _ | |
| | | | ┙. | |
| | C. | Name by which resident prefers to be ad | dressed: | |
| | _ | | | |
| | D. | Lifetime occupation(s) - put "/" between two | o occupations: | |
| | | | | |
| Most Re A1600. | | t Admission/Entry or Reentry into t ry Date | his Facility | |
| | | Month Day Year |] | |
| A1700. | Тур | e of Entry | | |
| Enter Code | | Admission Reentry | | |

| Resident | Iden | tifier | Date |
|------------|---|--|----------------------------------|
| Section | on A - Identification Information | | |
| A1805. | Entered From | | |
| Enter Code | Home/Community (e.g., private home/apt., board/care, assisted residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or under the Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health service organization | nit) | er |
| A1900. | Admission Date (Date this episode of care in this faci | lity began) | |
| | Month Day Year | | |
| | Discharge Date only if A0310F = 10, 11, or 12 | | |
| | Month Day Year | | |
| | Discharge Status only if A0310F = 10, 11, or 12 | | |
| Enter Code | O1. Home/Community (e.g., private home/apt., board/care, assisted arrangements) → Skip to A2123, Provision of Current Reconcile O2. Nursing Home (long-term care facility) O3. Skilled Nursing Facility (SNF, swing beds) O4. Short-Term General Hospital (acute hospital, IPPS) O5. Long-Term Care Hospital (LTCH) O6. Inpatient Rehabilitation Facility (IRF, free standing facility or under the properties of the p | d Medication List to Resident at Discharge nit) | er residential care |
| | Provision of Current Reconciled Medication List to Su only if A0310H = 1 and A2105 = 02-12 | ıbsequent Provider at Discharge |) |
| Enter Code | At the time of discharge to another provider, did your facility provide the | e resident's current reconciled medication | list to the subsequent provider? |
| | No - Current reconciled medication list not provided to the s Yes - Current reconciled medication list provided to the substitute | | essment Reference Date |
| | | | |

| Resident | | Identifier Date |
|-------------|--------|---|
| Section | n . | A - Identification Information |
| Indicate th | ne rou | ute of Current Reconciled Medication List Transmission to Subsequent Provider ate(s) of transmission of the current reconciled medication list to the subsequent provider. if A2121 = 1 |
| \ | Che | ck all that apply Route of Transmission |
| | A. | Electronic Health Record |
| | B. | Health Information Exchange |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | E. | Other methods (e.g., texting, email, CDs) |
| | | vision of Current Reconciled Medication List to Resident at Discharge if A0310H = 1 and A2105 = 01, 99 |
| Enter Code | At th | ne time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 0. No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver |
| Indicate th | ne rou | ute of Current Reconciled Medication List Transmission to Resident ute(s) of transmission of the current reconciled medication list to the resident/family/caregiver. if A2123 = 1 |
| ↓ Ch | eck | all that apply |
| | | Route of Transmission |
| | A. | Electronic Health Record (e.g., electronic access to patient portal) |
| | B. | Health Information Exchange |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | | Other methods (e.g., texting, email, CDs) |
| A2300. | Ass | sessment Reference Date |
| | Ob | servation end date: Month Day Year |
| A2400. | Me | dicare Stay |
| Enter Code | Α. | Has the resident had a Medicare-covered stay since the most recent entry? No → Skip to B0100, Comatose Yes → Continue to A2400B, Start date of most recent Medicare stay |
| | B. | Start date of most recent Medicare stay: Day |
| | C. | End date of most recent Medicare stay - Enter dashes if stay is ongoing: Month Day Year |

| resident | | Identifier | Date | |
|------------|---|-----------------------------------|---------------------------------------|--------------|
| Look | back period for all items is 7 | 7 days unless and | other time frame is | s indicated |
| Section | on B - Hearing, Speech, and \ | / ision | | |
| B0100. | Comatose | | | |
| Enter Code | Persistent vegetative state/no discernible consciou 0. No → Continue to B1300, Health Literacy 1. Yes → Skip to GG0130, Self-Care | ısness | | |
| | Health Literacy only if A0310B = 01 or A0310G = 1 and A0310H = 1 | | | |
| Enter Code | How often do you need to have someone help you whe pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often | en you read instructions, pamphle | ts, or other written material from yo | ur doctor or |

4. Always
7. Resident declines to respond
8. Resident unable to respond
The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

| Resident | lde | ntifier | Date |
|-------------|---|--|-----------------------------------|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C0200-C050) = 2 skip to C0700. Otherwise, attempt to conduct interview with all res | | |
| Enter Code | No (resident is rarely/never understood) → Skip to and continue to C0200, Repetition of Three Words | nplete C0700-C1000, Staff Assessment for | Mental Status |
| Brief I | 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. Pleather words are: sock, blue, and bed. Now tell me the three words. | • | nree. |
| | 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, the words up to two more times. | something to wear; blue, a color; bed, a pie | ce of furniture"). You may repeat |
| 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 to If unable to remember a word, give cue (something to wear; a color; a 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 | | |



| Resident | | | Identifier | Date |
|---------------|------------|--|--|---|
| Section | on C | - Cognitive Patterns | | |
| | Should | d the Staff Assessment for Mental | l Status (C0700 - C1000) be Co | onducted? |
| Enter Code | 0. 1. | No (resident was able to complete Brief Ir Yes (resident was unable to complete Brief) | | |
| Staff As | sessm | ent for Mental Status | | |
| Do not co | nduct if B | rief Interview for Mental Status (C0200-C05 | 000) was completed | |
| C0700. | Short- | term Memory OK | | |
| Enter Code | | or appears to recall after 5 minutes Memory OK Memory problem | | |
| C1000. | Cognit | ive Skills for Daily Decision Maki | ng | |
| Enter Code | 0. 1. | ecisions regarding tasks of daily life Independent - decisions consistent/reasc Modified independence - some difficulty Moderately impaired - decisions poor; co Severely impaired - never/rarely made d | in new situations only ues/supervision required | |
| Deliriun | n | | | |
| C1310. | Signs | and Symptoms of Delirium (from | CAM©) | |
| Code afte | er comple | ting Brief Interview for Mental Status or Sta | aff Assessment, and reviewing medical | record |
| A. Acut | e Onset | Mental Status Change | | |
| Enter Code | | evidence of an acute change in mental s No Yes | status from the resident's baseline? | |
| 1. B e | ehavior c | ot present ontinuously present, does not fluctuate resent, fluctuates (comes and goes, chang | ges in severity) | |
| Enter Code | es | · · · · · · · · · · · · · · · · · · · | · | |
| ↓ ↓ | | | | |
| | | ttention - Did the resident have difficulty for at was being said? | cusing attention, for example, being ea | sily distractible or having difficulty keeping track of |
| | C. Dis | <u> </u> | | nbling or irrelevant conversation, unclear or illogical |
| | D. Alt | ered Level of Consciousness - Did the re- vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being a stuporous - very difficult to arouse and keep a comatose - could not be aroused | n sked questions, but responded to voice or t | ess, as indicated by any of the following criteria? |

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

| Reside | nt | Identifier | Date | |
|--|---|---|------------------------|-------------------|
| Se | ction D - Mood | | | |
| D0 | 100. Should Resident Mood Interview be Conducted? | | | |
| If A | 310G = 2 Skip to D0700. Otherwise, attempt to conduct interview with a | l residents | | |
| Enter | No (resident is rarely/never understood) → Skip to and Yes → Continue to D0150, Resident Mood Interview (F | | sment of Resident Mo | od (PHQ-9-OV) |
| D0 | 150. Resident Mood Interview (PHQ-2 to 9©) | | | |
| If sy If ye Rea | to resident: "Over the last 2 weeks, have you been bothed imptom is present, enter 1 (yes) in column 1, Symptom Presence. It is in column 1, then ask the resident: "About how often have you been been and show the resident a card with the symptom frequency choices. Ind Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank) | othered by this?" | | |
| 2. | Symptom Frequency | | 1. | 2. |
| | 0. Never or 1 day1. 2-6 days (several days) | | Symptom Presence | Symptom Frequency |
| 2. 7-11 days (half or more of the days)3. 12-14 days (nearly every day) | | | ↓ Enter Scores | |
| | | | | |
| A. | Little interest or pleasure in doing things | | | |
| В. | Feeling down, depressed, or hopeless | | | |
| If b | oth D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D015 | 0B2 are coded 0 or 1, END the PHQ | interview; otherwise | e, continue. |
| C. | Trouble falling or staying asleep, or sleeping too much | 1 | | |
| D. | Feeling tired or having little energy | | | |
| E. | Poor appetite or overeating | | | |
| F. | Feeling bad about yourself - or that you are a failure or family down | have let yourself or your | | |
| G. | Trouble concentrating on things, such as reading the relevision | newspaper or watching | | |
| H. | Moving or speaking so slowly that other people could opposite - being so fidgety or restless that you have be more than usual | | | |
| l. | Thoughts that you would be better off dead, or of hurti | ng yourself in some way | | |
| | 160. Total Severity Score | | | |
| Enter | Add scores for all frequency responses in Column 2, Sympton Enter 99 if unable to complete interview (i.e., Symptom Frequency | m Frequency. Total score must be bet y is blank for 3 or more required items | ween 00 and 27. s). | |



| Resider | t | Identifier | Date | |
|--------------|---|---|------------------|-----------|
| Se | ction D - Mood | | | |
| | 00. Staff Assessment of Resident Mood (PHQ-9-OV*) ot conduct if Resident Mood Interview (D0150-D0160) was completed | | | |
| If sy The | the last 2 weeks, did the resident have any of the following prob nptom is present, enter 1 (yes) in column 1, Symptom Presence. move to column 2, Symptom Frequency, and indicate symptom frequ Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) | | | |
| 2. | Symptom Frequency | | 1. | 2. |
| | 0. Never or 1 day | | Symptom | Symptom |
| | 2-6 days (several days) 7-11 days (half or more of the days) | | Presence | Frequency |
| | 3. 12-14 days (nearly every day) | | | |
| | o. 12 14 days (notify story day) | | ↓ Enter Scores | in Boxes↓ |
| Α. | Little interest or pleasure in doing things | | | |
| В. | Feeling or appearing down, depressed, or hopeless | | | |
| C. | Trouble falling or staying asleep, or sleeping too much | | | |
| D. | Feeling tired or having little energy | | | |
| Ε. | Poor appetite or overeating | | | |
| F. | Indicating that they feel bad about self, are a failure, or have let s | elf or family down | | |
| G. | Trouble concentrating on things, such as reading the newspaper | or watching television | | |
| H. | Moving or speaking so slowly that other people have noticed. Or being so fidgety or restless that they have been moving around a | the opposite - a lot more than usual | | |
| I. | States that life isn't worth living, wishes for death, or attempts to | harm self | | |
| J. | Being short-tempered, easily annoyed | | | |
| D06 | 00. Total Severity Score | | | |
| Enter S | Add scores for all frequency responses in Column 2, Sympton | tom Frequency. Total score must be be | tween 00 and 30. | |
| D07 | 00. Social Isolation | | | |
| Enter (| How often do you feel lonely or isolated from those around you? 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | | | |
| | | | | |



| Resident | | | Identifier | Date |
|---------------------------|----------------|---|--|---|
| Section | on l | E - Behavior | | |
| E0100. | Pot | ential Indicators of Psychosis | | |
| ↓ Cł | neck a | all that apply | | |
| | A. | Hallucinations (perceptual experiences in the absence of re | eal external sensory stimuli) | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, co | ntrary to reality) | |
| | Z. | None of the above | | |
| Behavio | oral | Symptoms | | |
| E0200. | Bel | navioral Symptom - Presence & Frequency | | |
| | sence | of symptoms and their frequency | | |
| 1. Be 2. Be | havio havio | or not exhibited or of this type occurred 1 to 3 days or of this type occurred 4 to 6 days, but less than daily or of this type occurred daily | | |
| Enter Code | A. | Physical behavioral symptoms directed toward others (e | e.g., hitting, kicking, pushing, scratching, grabbi | ng, abusing others sexually) |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g | ., threatening others, screaming at others, curs | ing at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (rummaging, public sexual acts, disrobing in public, throwing disruptive sounds) | e.g., physical symptoms such as hitting or scra or smearing food or bodily wastes, or verbal/vo | tching self, pacing, cal symptoms like screaming, |
| E0800. | Rej | ection of Care - Presence & Frequency | | |
| Enter Code | goa | the resident reject evaluation or care (e.g., bloodwork, taking for health and well-being? Do not include behaviors that be dent or family), and determined to be consistent with resident to the consistent with resident with | nave already been addressed (e.g., by discussi values, preferences, or goals. | sary to achieve the resident's on or care planning with the |
| E0900. | Wa | ndering - Presence & Frequency | | |
| Enter Code | Has | the resident wandered? 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less the second | nan daily | |

| Resident | | Identifier Date |
|--|--|--|
| Section | n (| GG - Functional Abilities and Goals - Discharge |
| Complete When A03 | colu 10G | elf-Care (Assessment period is the last 3 days of the stay) mn 3 when A0310F = 10 or 11 or when A0310H = 1. s not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. scharge assessments, the stay ends on A2000. |
| | | ent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end le the reason. |
| amount of Activities notes of the Activities of the O5. See O4. Su cor O3. Part the O2. Su efform of the O7. Re O9. No 10. No 88. No | d Qui assiss may the tup of tu | ality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to tance provided. e completed with or without assistive devices. Ident - Resident completes the activity by themself with no assistance from a helper. r clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. sion or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident as activity. Assistance may be provided throughout the activity or intermittently. moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half to the network of the effort. Resident does none of the effort. Helper lifts or holds trunk or limbs and provides more than half the network of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is for the resident to complete the activity. Interfused licable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Interfused licable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Impeted due to environmental limitations (e.g., lack of equipment, weather constraints) |
| 3. Discharge Performance | е | |
| Enter Codes in | n Box | es e |
| | Α. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| | B. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| | C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| | Н. | 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. |
| | I. | Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). |
| | | |

| esident | Identifier | Date |
|---|---|--|
| Section | GG - Functional Abilities and Goals - [| Discharge |
| When A0310G | lobility (Assessment period is the last 3 days of the stay) umn 3 when A0310F = 10 or 11 or when A0310H = 1. is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 are ischarge assessments, the stay ends on A2000. | nd A2105 is not = 04, the stay ends on A2400C. |
| | dent's usual performance at the end of the stay for each activity using ode the reason. | the 6-point scale. If an activity was not attempted at the en |
| amount of assis Activities may 1 06. Indepe 05. Setup of the efform of the efform of the effort. 01. Dependence of the effort of the effort. If activity was of the effort of the effort. If activity was of the effort of the effort. Not applied of the effort of the effort of the effort. If activity was of the effort | antial/maximal assistance - Helper does MORE THAN HALF the effort. He dent - Helper does ALL of the effort. Resident does none of the effort to cord for the resident to complete the activity. | m a helper. activity. Helper assists only prior to or following the activity. ing/steadying and/or contact guard assistance as resident ently. lifts, holds, or supports trunk or limbs, but provides less than hal elper lifts or holds trunk or limbs and provides more than half the mplete the activity. Or, the assistance of 2 or more helpers is to the current illness, exacerbation, or injury. |
| 3. Discharge Performance | yes | |
| A. | Roll left and right: The ability to roll from lying on back to left and right si | ide, and return to lying on back on the bed. |
| В. | Sit to lying: The ability to move from sitting on side of bed to lying flat on | the bed. |
| C. | Lying to sitting on side of bed: The ability to move from lying on the basupport. | ck to sitting on the side of the bed and with no back |
| D. | Sit to stand: The ability to come to a standing position from sitting in a ch | nair, wheelchair, or on the side of the bed. |
| E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a | a chair (or wheelchair). |
| F. | Toilet transfer: The ability to get on and off a toilet or commode. | |
| FF. | Tub/shower transfer: The ability to get in and out of a tub/shower. | |
| G. | Car transfer: The ability to transfer in and out of a car or van on the pass door or fasten seat belt. | enger side. Does not include the ability to open/close |
| I. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) | , corridor, or similar space. If discharge performance |
| J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 5 | 0 feet and make two turns. |
| K. | Walk 150 feet: Once standing, the ability to walk at least 150 feet in a con- | rridor or similar space. |

| Resident | ldentifier | Date | | | |
|--|---|---|--|--|--|
| Section GG - Functional | Abilities and Goals - Discharge |) | | | |
| Complete column 3 when A0310F = 10 or 11 When A0310G is not = 2 and A0310H = 1 and | GG0170. Mobility (Assessment period is the last 3 days of the stay) Complete column 3 when A0310F = 10 or 11 or when A0310H = 1. When A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000. | | | | |
| Code the resident's usual performance at the of the stay, code the reason. | ne end of the stay for each activity using the 6-point sca | ale. If an activity was not attempted at the end | | | |
| amount of assistance provided. Activities may be completed with or without as 06. Independent - Resident completes the 05. Setup or clean-up assistance - Helpe 04. Supervision or touching assistance completes activity. Assistance may be p 03. Partial/moderate assistance - Helper the effort. 02. Substantial/maximal assistance - He effort. 01. Dependent - Helper does ALL of the effort. 06. If activity was not attempted, code reason: 07. Resident refused 09. Not applicable - Not attempted and the 10. Not attempted due to environmental 88. Not attempted due to medical conditions. | activity by themself with no assistance from a helper. Fr sets up or cleans up; resident completes activity. Helper a Helper provides verbal cues and/or touching/steadying and provided throughout the activity or intermittently. In does LESS THAN HALF the effort. Helper lifts, holds, or su Iper does MORE THAN HALF the effort. Helper lifts or holds If ort. Resident does none of the effort to complete the activity In eresident did not perform this activity prior to the current illr Ilimitations (e.g., lack of equipment, weather constraints) | assists only prior to or following the activity. d/or contact guard assistance as resident pports trunk or limbs, but provides less than half s trunk or limbs and provides more than half the ty. Or, the assistance of 2 or more helpers is | | | |
| Discharge Performance Enter Codes in Boxes L. Walking 10 feet on uneven s | urfaces: The ability to walk 10 feet on uneven or sloping รเ | urfaces (indoor or outdoor), such as turf or gravel. | | | |
| M. 1 step (curb): The ability to go If discharge performance is co | o up and down a curb and/or up and down one step. ded 07, 09, 10, or 88 → Skip to GG0170P, Picking up objec | ct | | | |
| | nd down four steps with or without a rail. ded 07, 09, 10, or 88 → Skip to GG0170P, Picking up obje | ct | | | |
| O. 12 steps: The ability to go up | and down 12 steps with or without a rail. | | | | |
| P. Picking up object: The ability | to bend/stoop from a standing position to pick up a small o | bject, such as a spoon, from the floor. | | | |
| \bigcirc 0. No \rightarrow Skip to H0 | a wheelchair and/or scooter? 100, Appliances to GG0170R, Wheel 50 feet with two turns | | | | |
| | : Once seated in wheelchair/scooter, the ability to wheel at | least 50 feet and make two turns. | | | |
| RR3. Indicate the type of whether the type of type of type of the type of type of the type of type | eelchair or scooter used. | | | | |
| | in wheelchair/scooter, the ability to wheel at least 150 feet i | in a corridor or similar space. | | | |
| SS3. Indicate the type of wh 1. Manual 2. Motorized | eelchair or scooter used. | | | | |

| Resident | | Identifier | Date | |
|--------------|---|--|------|--|
| Section | Section H - Bladder and Bowel | | | |
| H0100. | Appliances | | | |
| \downarrow | Check all that apply | | | |
| | A. Indwelling catheter (including suprapubic catheter a | and nephrostomy tube) | | |
| | B. External catheter | | | |
| | C. Ostomy (including urostomy, ileostomy, and colostor | my) | | |
| | D. Intermittent catheterization | | | |
| | Z. None of the above | | | |
| H0300. | Urinary Continence | | | |
| Enter Code | Urinary continence - Select the one category that best do 0. Always continent 1. Occasionally incontinent (less than 7 episode 2. Frequently incontinent (7 or more episodes of 3. Always incontinent (no episodes of continent of 9. Not rated, resident had a catheter (indwelling, of | es of incontinence) i urinary incontinence, but at least or voiding) | | |
| H0400. | Bowel Continence | | | |
| Enter Code | Occasionally incontinent (2 or more episodes of Always incontinent (no episodes of continent the Always incontinent (no episodes of action and the Always incontinent (no episodes of continent the Not rated, resident had an ostomy or did not have the Always incontinent that an ostomy or did not have the Always incontinent that an ostomy or did not have the Always incontinent that an ostomy or did not have the Always incontinent that an ostomy or did not have the Always incontinent that are the Always inco | rel incontinence) bowel incontinence, but at least one bowel movements) | • | |

| Resident | Identifier | Date |
|---|--|------|
| Section I - Active Diagnosis | | |
| Active Diagnoses in the last 7 days - Check all that apply Diagnoses listed in parentheses are provided as examples and should no | | |
| Heart/Circulation | | |
| ☐ I0900. Peripheral Vascular Disease (PVD) or Peripheral Ar | terial Disease (PAD) | |
| Genitourinary | | |
| ☐ I1550. Neurogenic Bladder ☐ I1650. Obstructive Uropathy | | |
| Infections | | |
| ☐ I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) | | |
| Metabolic | | |
| 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nep | hropathy, and neuropathy) | |
| Neurological | | |
| ☐ I5250. Huntington's Disease ☐ I5350. Tourette's Syndrome | | |
| Nutritional | | |
| ☐ I5600. Malnutrition (protein or calorie) or at risk for malnutrition | on | |
| Psychiatric/Mood Disorder | | |
| □ I5700. Anxiety Disorder □ I5900. Bipolar Disorder □ I5950. Psychotic Disorder (other than schizophrenia) □ I6000. Schizophrenia (e.g., schizoaffective and schizophrenif □ I6100. Post Traumatic Stress Disorder (PTSD) | orm disorders) | |
| Other | | |
| I8000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the dec | cimal for the code in the appropriate box. | |
| Α | | |
| A | | |
| В | | |
| C | | |
| D | | |
| E | | |
| F | | |
| G | | |
| Н | | |
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| ·· | | |

| Resident | Identitier | Date |
|-------------|--|----------------------------------|
| Section | on J - Health Conditions | |
| J0100. | Pain Management - Complete for all residents, regardless of current pain | level |
| At any time | ne in the last 5 days, has the resident: | |
| Enter Code | A. Received scheduled pain medication regimen? 0. No 1. Yes | |
| Enter Code | B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes | |
| Enter Code | C. Received non-medication intervention for pain? 0. No 1. Yes | |
| J0200. | | |
| Enter Code | t is comatose or if A0310G = 2, skip to J1100, Shortness of Breath (dyspnea). Ot 0. No (resident is rarely/never understood) → Skip to and complete J11 1. Yes → Continue to J0300, Pain Presence | |
| | sessment Interview only if A0310G = 1 | |
| | 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 J0410, Pain Frequency 9. Unable to answer → Skip to J1100, Shortness of Breath (dyspnea) | |
| J0410. | Pain Frequency | |
| Enter Code | Ask resident: "How much of the time have you experienced pain or hurting 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 9. Unable to answer | g over the last 5 days?" |
| J0510. | Pain Effect on Sleep | |
| Enter Code | Ask resident: "Over the past 5 days, how much of the time has pain made it 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | hard for you to sleep at night?" |
| J0520. | Pain Interference with Therapy Activities | |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited your particle. 0. Does not apply - I have not received rehabilitation therapy in the 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | |

| esident | | Identifier Date |
|-------------------|-----|--|
| Section | n | J - Health Conditions |
| Pain As | ses | sment Interview - Continued |
| J0530. | Pa | in Interference with Day-to-Day Activities |
| Enter Code | | resident: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) cause of pain?" |
| | | Rarely or not at all Occasionally Frequently Almost constantly Unable to answer |
| J0600. | Pa | in Intensity - Administer ONLY ONE of the following pain intensity questions (A or B) |
| Enter Rating | A. | Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale) |
| | _ | Enter two-digit response. Enter 99 if unable to answer. |
| Enter Code | в. | Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale) 1. Mild 2. Moderate 3. Severe |
| | | 4. Very severe, horrible 9. Unable to answer |
| Other H J1100. | | th Conditions ortness of Breath (dyspnea) |
| \downarrow | Che | eck 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. | Pro | ognosis |
| Enter Code | | es the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician cumentation) |
| | | 0. No1. Yes |

| Resident | | lden | ntifier | Date | |
|---------------------------------|--|---|---|------------------------------------|--|
| Section | n · | J - Health Conditions | | | |
| J1550. | Pro | blem Conditions | | | |
| \downarrow | Che | ck 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? No → Skip to K0200, Height and Weight Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) | | | | |
| J1900. | Nun | nber of Falls Since Admission/Entry or Reentry or Prior Asses | ssment (OBRA or Scheduled PPS), which | ever is more recent | |
| Coding: 0. None 1. One 2. Two o | r mo | re | | | |
| Enter Code | s in l | Boxes | | | |
| | A. | No injury - no evidence of any injury is noted on physical assess by the resident; no change in the resident's behavior is noted after | sment by the nurse or primary care clinician er the fall | ; no complaints of pain or injury | |
| | B. | Injury (except major) - skin tears, abrasions, lacerations, superfithe resident to complain of pain | ficial bruises, hematomas and sprains; or a | ny fall-related injury that causes | |
| | C. | Major injury - bone fractures, joint dislocations, closed head inju | ries with altered consciousness, subdural h | ematoma | |
| | | | | | |

| Residen | t | | ldentifier | [| Date | | |
|---|--|---|--|-------------------------|---------------------|-----------------|--|
| Sec | tion K | - Swallowing/Nutrition | nal Status | | | | |
| K020 | 0. Height | and Weight - While measuring, if the num | ber is X.1 - X.4 round down; X.5 or greate | r round up | | | |
| Inches | A | . Height (in inches). Record most recent | t height measure since admission/entry or | reentry | | | |
| Pounds | | . Weight (in pounds). Base weight on mo practice (e.g., in a.m. after voiding, before | ost recent measure in last 30 days; measu ore meal, with shoes off, etc.) | re weight consistently, | according to sta | indard facility | |
| K03 | 00. Weight | Loss | | | | | |
| Enter C | ode Loss o | f 5% or more in the last month or loss o | f 10% or more in last 6 months | | | | |
| L | 0. 1. 2. | Yes, on physician-prescribed weight-los | · · | | | | |
| K03 | 10. Weight | Gain | | | | | |
| Enter C | Gain of 5% or more in the last month or gain of 10% or more in last 6 months O. No or unknown Yes, on physician-prescribed weight-gain regimen Yes, not on physician-prescribed weight-gain regimen | | | | | | |
| K0520. Nutritional Approaches | | | | | | | |
| | | lowing nutritional approaches that apply | | | | | |
| 3. While a Resident Performed while a resident of this facility and within the last 7 days 4. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | | | | | | | |
| | | | , | | 3. | 4. | |
| | | | | | While a Resident | At Discharge | |
| ↓ Check all tha | | | | | that apply↓ | | |
| A. | Parenteral/IV | feeding | | | | | |
| В. | Feeding tube | (e.g., nasogastric or abdominal (PEG)) | | | | | |
| | Mechanically food, thicken | r altered diet - require change in texture of ed liquids) | f food or liquids (e.g., pureed | | | | |
| D. | Therapeutic | diet (e.g., low salt, diabetic, low cholestero | 1) | | | | |
| Z. | None of the | above | | | | | |
| | | | | | | | |

| Section M - Skin Conditions | | | | | | | |
|-----------------------------|--|---|--|--|--|--|--|
| | Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage | | | | | | |
| M0100. | Det | termination of Pressure Ulcer/Injury Risk | | | | | |
| \ | Che | ck all that apply | | | | | |
| | A. | Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device | | | | | |
| M0210. | Unl | healed Pressure Ulcers/Injuries | | | | | |
| Enter Code | Doe | es this resident have one or more unhealed pressure ulcers/injuries? | | | | | |
| | | No → Skip to N0415, High-Risk Drug Classes: Use and Indication Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | | | | |
| M0300. | Cui | rrent Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | | | | |
| Enter Number | B. | Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister | | | | | |
| | | 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 | | | | | |
| Enter Number | | 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | | |
| Enter Number | C. | Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling | | | | | |
| | | 1. Number of Stage 3 pressure ulcers - If $0 \rightarrow$ Skip to M0300D, Stage 4 | | | | | |
| Enter Number | | 2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | | |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling | | | | | |
| | | 1. Number of Stage 4 pressure ulcers - If $0 \rightarrow$ Skip to M0300E, Unstageable - Non-removable dressing/device | | | | | |
| Enter Number | | 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | | |
| Enter Number | E. | Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device | | | | | |
| Enter Number | | 1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If $0 \rightarrow$ Skip to M0300F, Unstageable - Slough and/or eschar | | | | | |
| | | 2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | | |
| Enter Number | F. | Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar | | | | | |
| | | Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury | | | | | |
| Enter Number | | 2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | | |
| M0300 c | ont | inued on next page | | | | | |
| | | | | | | | |

Identifier

Date

Resident _

| Sect | tion | M - | Skin Conditions | | |
|----------------------------|--|---|--|------------------------------|---------------------|
| M030 | 0. Cu | rrent | Number of Unhealed Pressure Ulcers/Injuries at Each Stage - continued | | |
| | G. | Unst | ageable - Deep tissue injury: | | |
| Enter Numb | oer | | Number of unstageable pressure injuries presenting as deep tissue injury - If 0 \to Skip to and Indication | N0415, High-Risk D | Orug Classes: Use |
| Enter Numb | oer | | Number of these unstageable pressure injuries that were present upon admission/entry of the time of admission/entry or reentry | or reentry - enter ho | w many were noted |
| Soci | tion | N | Medications | | |
| | | | | | |
| N041 | 5. Hi | gh-Ri | sk Drug Classes: Use and Indication | | |
| | or reer | if the reatry if le | esident is taking any medications by pharmacological classification, not how it is used, during the set than 7 days ted checked, check if there is an indication noted for all medications in the drug class | e last 7 days or sinc | e admission/entry |
| | | | | 1. Is taking | 2. Indication noted |
| | | | | ↓ Check all | |
| A. | Antips | ychoti | ; | | |
| B. | Antian | xiety | | П | |
| C. | Antide | | | | |
| D. | Hypno | pressa | nt | | |
| E. | 71. | • | nt | | |
| | Antico | tic agular | nt t (e.g., warfarin, heparin, or low-molecular weight heparin) | | _ |
| F. | Antico Antibio | tic agular otic | | | |
| G. | Antico Antibio Diuret | tic agular otic ic | | | |
| G. H. | Antico Antibio Diuret Opioid | tic agular otic ic | | | |
| G. H. I. | Antibio Diuret Opioid Antipla | tic agular otic ic l atelet | t (e.g., warfarin, heparin, or low-molecular weight heparin) | | |
| G. H. I. J. | Antibio Diureti Opioid Antipla Hypog | tic agular otic ic l atelet | t (e.g., warfarin, heparin, or low-molecular weight heparin) c (including insulin) | | |
| G. H. I. J. Z. | Antico Antibio Diuret Opioid Antipla Hypog None o | tic agular otic ic atelet lycem of the a | t (e.g., warfarin, heparin, or low-molecular weight heparin) c (including insulin) bove | | |
| G. H. I. J. | Antico Antibio Diureti Opioid Antipla Hypog None o | agular otic ic atelet of the a edicat I the fa endar 0. | t (e.g., warfarin, heparin, or low-molecular weight heparin) c (including insulin) | actions by midnighadmission? | nt of the next |

| Reside | nt Identifier | Date | |
|--------|--|------------------------|--------------------|
| | ction O - Special Treatments, Procedures, and Progra 110. Special Treatments, Procedures, and Programs | ms | |
| Che | ck all of the following treatments, procedures, and programs that were performed | | |
| b. | While a Resident Performed while a resident of this facility and within the last 14 days | b. While a Resident | c. At Discharge |
| C. | At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | Chaple all A | hat annly |
| | | Check all t ↓ | nat apply ↓ |
| Can | icer Treatments | | |
| A1. | Chemotherapy | | |
| | A2. IV | | |
| | A3. Oral | | |
| | A10. Other | | |
| B1. | Radiation | | |
| Res | piratory Treatments | | |
| C1. | Oxygen therapy | | |
| | C2. Continuous | | |
| | C3. Intermittent | | |
| | C4. High-concentration | | |
| D1. | Suctioning | | |
| | D2. Scheduled | | |
| | D3. As needed | | |
| E1. | Tracheostomy care | | |
| | Invasive Mechanical Ventilator (ventilator or respirator) | | |
| G1. | Non-invasive Mechanical Ventilator | | |
| | G2. BiPAP | | |
| 041 | G3. CPAP | | |
| Oth | er | | |
| H1. | IV Medications | | |
| | H2. Vasoactive medications | | |
| | H3. Antibiotics | | |
| | H4. Anticoagulant | | |
| | H10. Other | | |
| 11. | | | |
| 001 | 10 continued on next page | | |

| Resident | | Identifier _ | | Date | |
|------------|--------------|---|------------------------------|-------------------------|--------------------|
| | | O - Special Treatments, Procedures, pecial Treatments, Procedures, and Programs - Continue | • | S | |
| Check | all of t | ne following treatments, procedures, and programs that were performed | | | |
| Р | | Resident ed while a resident of this facility and within the last 14 days harge | | b. While a Resident | c. At Discharge |
| | | nent period is the last 3 days of the SNF PPS Stay ending on A2400C | | Check all th | at apply ↓ |
| J1. Dia | llysis | | | | |
| | | odialysis | | | |
| | | oneal dialysis | | | |
| K1. Ho | • | | | | |
| | | or quarantine for active infectious disease include standard body/fluid precautions) | | | |
| 01. IV | Acces | S | | | |
| 02 | . Peri | pheral | | | |
| O3 | . Midl | ine | | | |
| | | ral (e.g., PICC, tunneled, port) | | | |
| None of | f the A | bove | | | |
| | | he above | | | |
| O025 | 0. In | fluenza Vaccine - Refer to current version of RAI manual for current | influenza vaccination seas | on and reporting period | |
| Enter Cod | е А . | Did the resident receive the influenza vaccine in this facility for the | nis year's influenza vaccina | ation season? | |
| Ш | | No → Skip to O0250C, If influenza vaccine not received, state reference. Yes → Continue to O0250B, Date influenza vaccine received. | eason | | |
| | В | • | 00A. Is the resident's Pneu | mococcal vaccination u | o to date? |
| | | Month Day Year | , | | |
| 5 . | C | If influenza vaccine not received, state reason: | | | |
| Enter Cod | e | Resident not in this facility during this year's influenza vaccinat Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | | | |
| O0300 | . Р | neumococcal Vaccine | | | |
| Enter Cod | е А . | | | | |
| Ш | | No → Skip to O0300B, If Pneumococcal vaccine not received, st Yes → Continue to O0425, Part A Therapies | ate reason | | |
| Enter Cod | В | If Pneumococcal vaccine not received, state reason: | | | |
| | - | Not eligible - medical contraindication Offered and declined Not offered | | | |

| Complete only if A0310H = 1 Enter Number of Minutes Enter Number of | Section O - 3 | Special Treatments, Procedures, and Programs |
|--|-------------------------|---|
| Enter Number of Minutes Enter Number of Minut | | |
| Enter Number of Minutes Enter Number of Minut | | A. Speech-Language Pathology and Audiology Services |
| 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) 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 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 unther 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) 8. Occupational Therapy 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) 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident is most recent Medicare Part A stay (A2400B) 3. Group minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident is most recent Medicare Part A stay (A2400B) 6. 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) 8. Days - 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) 8. Days - record the number of Minutes this therapy was administered to the resident individually since | | Individual minutes - record the total number of minutes this therapy was administered to the resident individually since |
| The sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy 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) 8. Occupational Therapy 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) 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) 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) 4. Co-treatment 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) 5. Days - record the number of days 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 to the resident in co-treatment sessions ince 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 to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B) 6. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident indivi | Enter Number of Minutes | 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently |
| ## 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) ## B. Occupational Therapy 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) ## B. Occupational Therapy 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) ## 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) ## Co-treatment minutes - record the total number of minutes this therapy was administered to the resident as part of a group of resident's most recent Medicare Part A stay (A2400B) ## 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) ## 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) ## Co-treatment 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) ## Co-treatment 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) ## Co-treatment minutes - record the total number of minutes this therapy was administered to the resident toncurrently with one other resi | Enter Number of Minutes | |
| 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) 8. Occupational Therapy 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) 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) 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 00425C, Physical Therapy 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) 6. Physical Therapy 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) 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident's most recent Medicare Part A stay (A2400B) 3. Group minutes - record the total number of minutes this therapy was administered to the resident on concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (| Enter Number of Minutes | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0425B, Occupational Therapy |
| Enter Number of Minutes Enter Number of Minu | Enter Number of Days | |
| Individual 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) 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) 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 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 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) C. Physical Therapy 1. Individual 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) 3. Group 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | | 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) |
| Individual 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) 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) 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 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 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) C. Physical Therapy 1. Individual 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) 3. Group 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | | D. Occumentional Thousand |
| the start date of the resident's most recent Medicare Part A stay (A2400B) 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) 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 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 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) C. 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) 3. Group 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | Enter Number of Minutes | B. Occupational Inerapy |
| 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) 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 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 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) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident as part of a group of | Enter Number of Minutes | |
| If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy Lenter Number of Minutes Lenter Number of Days Enter Number of Minutes Lenter Number of Minutes | Enter Number of Minutes | with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| 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 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) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | 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 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) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0425C, Physical Therapy |
| 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 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) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | Enter Number of Minutes | |
| Enter Number of Minutes The start date of the resident's most recent Medicare Part A stay (A2400B) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | Enter Number of Days | sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| 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) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | | 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) |
| the start date of the resident's most recent Medicare Part A stay (A2400B) 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | Enter Number of Minutes | C. Physical Therapy |
| 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) 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of | Enter Number of Minutes | 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) |
| 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) | Enter Number of Minutes | with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | Enter Number of Minutes | 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 | | If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy |
| 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 Days | 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) |

Identifier _____ Date ____

| esident | ldentifier Date |
|--|---|
| | Special Treatments, Procedures, and Programs |
| O0430. Distinct C | Calendar Days of Part A Therapy |
| Complete only if A0310 | H = 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) |
| | Restraints and Alarms |
| Physical restraints are individual cannot remove Coding: 0. Not used 1. Used less the 2. Used daily | any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the ve easily which restricts freedom of movement or normal access to one's body |
| Enter Codes in Boxes | |
| ļ | |
| Used in Bed | |
| A. Bed rail | |
| B. Trunk restr | aint |
| C. Limb restra | int |
| D. Other | |
| Used in Chair o | Out of Bed |
| E. Trunk restr | aint |
| F. Limb restra | int |
| G. Chair preve | ents rising |
| H. Other | |
| | |
| | Participation in Assessment and Goal Setting |
| Q0400. Discharge | |
| 0. N | ve discharge planning already occurring for the resident to return to the community? o es |
| Q0610. Referral | |
| Enter Code A. Has a I | |
| Q0620. Reason R Complete only if Q0610 | Referral to Local Contact Agency (LCA) Not Made |
| Enter Code Indicate real 1. L 2. R 3. R 4. D | ison why referral to LCA was not made CA unknown eferral previously made eferral not wanted ischarge date 3 or fewer months away ischarge date more than 3 months away |

| Resident | | Identifier | Date |
|--------------------------|---|---|--------------------------------------|
| Section | on X - Correction Request | | |
| Identific section, re | te Section X only if A0050 = 2 or 3 cation of Record to be Modified/Inactivated - The folloproduce the information EXACTLY as it appeared on the existing mation is necessary to locate the existing record in the National M | erroneous record, even if the information is inco | ord that is in error. In this rrect. |
| X0150. | Type of Provider (A0200 on existing record to be modified/i | nactivated) | |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | Name of Resident (A0500 on existing record to be modified | l/inactivated) | |
| | A. First name: | | |
| | | | |
| | C. Last name: | | |
| | | | |
| X0300. | Gender (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | 1. Male 2. Female | | |
| X0400. | Birth Date (A0900 on existing record to be modified/inactivated | ed) | |
| | | | |
| | Month Day Year | | |
| X0500. | Social Security Number (A0600A on existing record to be | modified/inactivated) | |
| | | | |
| X0600. | Type of Assessment (A0310 on existing record to be modified to be | fied/inactivated) | |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above | essment t | |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A S 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | | |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |

| Resident | | Identifier Date Date | | | | |
|--------------|---|--|--|--|--|--|
| Section | n | X - Correction Request | | | | |
| X0700. | Dat | te on existing record to be modified/inactivated - Complete one only | | | | |
| | A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 | | | | | |
| | | Month Day Year | | | | |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 | | | | |
| | | Month Day Year | | | | |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 | | | | |
| | | Month Day Year | | | | |
| Correct | ion . | Attestation Section - Complete this section to explain and attest to the modification/inactivation request | | | | |
| X0800. | Co | rrection Number | | | | |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one | | | | |
| X0900. | Rea | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | | |
| \downarrow | Che | ck 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. | Rea | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | | |
| | Che | ck 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: | | | | |
| | | | | | | |
| | В. | Attesting individual's last name: | | | | |
| | Б. | Attesting individual's last fiame. | | | | |
| | | | | | | |
| | C. | Attesting individual's title: | | | | |
| | D. | Signature | | | | |
| | E. | Attestation date | | | | |
| | | Month Day Year | | | | |

| esident | Identifier | Date | |
|---|--|---|---|
| Section Z - Assessment Admin | istration | | |
| Z0300. Insurance Billing | | | |
| A. Billing code: B. Billing version: | | | |
| Section Z - Assessment Admin | istration | | |
| Z0400. Signature of Persons Completing the certify that the accompanying information accurately reflects if this information on the dates specified. To the best of my knequirements. I understand that this information is used as a bom federal funds. I further understand that payment of such conditioned on the accuracy and truthfulness of this informaticity, and/or administrative penalties for submitting false information. | resident assessment information for nowledge, this information was collepasis for ensuring that residents recifederal funds and continued particion, and that I may be personally su | or this resident and that I collected or concepted in accordance with applicable Meseive appropriate and quality care, and pation in the government-funded health bject to or may subject my organization | edicare and Medicaid as a basis for payment n care programs is n to substantial criminal |
| Signature | Title | Sections | Date Section Completed |
| | | | |
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| <u>. </u> | | | |
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| <u>. </u> | | | |
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| | | | |
| | | | |
| . Z0500. Signature of RN Assessment Coordir A. Signature: | nator Verifying Assessmen | t Completion B. Date RN Assessment Cod | ordinator signed |
| | | assessment as complete | _ |
| | | - - | |

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Month

Day

Year

| Resident | Identifier | Data |
|----------|------------|--------|
| RESIDEDI | Identitier | Date . |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed Tracking (NT/ST) Item Set

| Section | on A - Identification Information |
|------------|--|
| | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): |
| | B. CMS Certification Number (CCN): |
| | |
| | C. State Provider Number: |
| | |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |
| | |

A0310 continued on next page

| Resident | Identifier | | Date | |
|--|--|---|--------------------------------|--|
| Section | on A - Identification Information | | | |
| A0310. | Type of Assessment - Continued | | | |
| Enter Code | Type of discharge - Complete only if A0310F = 10 or 11 Planned Unplanned | | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes Unit Certification or Licensure Designation | | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS data is Unit is neither Medicare nor Medicaid certified but MDS data is Unit is Medicare and/or Medicaid certified | not required by the State required by the State | | |
| A0500. | Legal Name of Resident | | | |
| | A. First name: C. Last name: | | B. Middle initial: 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 | Male Female | | | |
| A0900. | Birth Date | | | |
| | Month Day Year | | | |
| | Ethnicity Full imposite Lating/a or Charlish arisin? | | | |
| | f Hispanic, Latino/a, or Spanish origin? | | | |
| | Check all that apply | | | |
| | A. No, not of Hispanic, Latino/a, or Spanish origin | | | |
| | B. Yes, Mexican, Mexican American, Chicano/a | | | |
| | C. Yes, Puerto Rican | | | |
| | D. Yes, Cuban | | | |
| | E. Yes, another Hispanic, Latino/a, or Spanish origin Y Recident unable to respond | | | |
| | X. Resident unable to respondY. Resident declines to respond | | | |
| \sqcup | Y. Resident declines to respond | | | |

| Resident | | Identifier Date |
|----------------------|-----|--|
| Section | n . | A - Identification Information |
| A1010. What is yo | | |
| | | |
| | | eck all that apply |
| | | White |
| | | Black or African American |
| | | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | H. | Korean |
| | I. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1200. | Ma | rital Status |
| Enter Code | | Never married Married Widowed Separated Divorced |
| A1300. | Op | tional Resident Items |
| | A. | Medical record number: |
| | | |
| | B. | Room number: |
| | | |
| | C. | Name by which resident prefers to be addressed: |
| | | |
| | D. | Lifetime occupation(s) - put "/" between two occupations: |
| | | |
| | | |

| Resident | Identifier | Date |
|---|---------------------------|--|
| Section A - Identification Information | | |
| Most Recent Admission/Entry or Reentry into this Fac A1600. Entry Date | ility | |
| Month Day Year | | |
| A1700. Type of Entry | | |
| 1. Admission 2. Reentry | | |
| A1805. Entered From | | |
| O1. Home/Community (e.g., private home/apt., board/car residential care arrangements) O2. Nursing Home (long-term care facility) O3. Skilled Nursing Facility (SNF, swing beds) O4. Short-Term General Hospital (acute hospital, IPPS) O5. Long-Term Care Hospital (LTCH) O6. Inpatient Rehabilitation Facility (IRF, free standing for Inpatient Psychiatric Facility (psychiatric hospital or O8. Intermediate Care Facility (ID/DD facility) O9. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service of O9. Not listed | acility or unit) unit) | itional living, other |
| A1900. Admission Date (Date this episode of care in | this facility began) | |
| Month Day Year | | |
| A2000. Discharge Date Complete only if A0310F = 10, 11, or 12 | | |
| Month Day Year | | |
| A2105. Discharge Status Complete only if A0310F = 10, 11, or 12 | | |
| 01. Home/Community (e.g., private home/apt., board/car arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing f 07. Inpatient Psychiatric Facility (psychiatric hospital or 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service 13. Deceased 99. Not listed | acility or unit) unit) | itional living, other residential care |

| Resident | | Identifier Date | | |
|---|---|--|--|--|
| Section | n A | A - Identification Information | | |
| A2400. | Ме | dicare Stay | | |
| Enter Code | A. | Has the resident had a Medicare-covered stay since the most recent entry? 0. No → Skip to Section X, Correction Request 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 | | |

| Resident | | Identifier | Date |
|--------------------------|---|---|--|
| Section | on X - Correction Request | | |
| Identific section, re | te Section X only if A0050 = 2 or 3 cation of Record to be Modified/Inactivated - The foll eproduce the information EXACTLY as it appeared on the existing nation is necessary to locate the existing record in the National M | erroneous record, even if the information | essment record that is in error. In this ation is incorrect. |
| X0150. | Type of Provider (A0200 on existing record to be modified/ | nactivated) | |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | Name of Resident (A0500 on existing record to be modified | d/inactivated) | |
| | A. First name: | | |
| | | | |
| | C. Last name: | | |
| | | | |
| X0300. | Gender (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | Male Female | | |
| X0400. | Birth Date (A0900 on existing record to be modified/inactivated | ed) | |
| | | | |
| | Month Day Year | | |
| X0500. | Social Security Number (A0600A on existing record to be | e modified/inactivated) | |
| | | | |
| X0600. | Type of Assessment (A0310 on existing record to be mod | ified/inactivated) | |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive ass 06. Significant correction to prior quarterly assessment 99. None of the above | | |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A S 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | | |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |

| Resident | | Identifier Date |
|--------------|------------|--|
| Section | n i | X - Correction Request |
| X0700. | Dat | e on existing record to be modified/inactivated - Complete one only |
| | A. | Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 |
| | | Month Day Year |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 |
| | | Month Day Year |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 |
| | | Month Day Year |
| | | Attestation Section - Complete this section to explain and attest to the modification/inactivation request |
| | Co | rrection Number |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one |
| X0900. | Rea | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) |
| <u></u> | Che | ck 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. | Rea | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) |
| \downarrow | Che | ck 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: |
| | | |
| | В. | Attesting individual's last name: |
| | ٥. | |
| | C . | Attesting individual's title: |
| | | |
| | D. | Signature |
| | E. | Attestation date |
| | | Month Day Year |

| I certify that the accompanying information accurately reflect of this information on the dates specified. To the best of my I requirements. I understand that this information is used as a from federal funds. I further understand that payment of sucl conditioned on the accuracy and truthfulness of this informativil, and/or administrative penalties for submitting false information. | knowledge, this information was colle basis for ensuring that residents rec n federal funds and continued partici tion, and that I may be personally su | ected in accordance with applicable Neive appropriate and quality care, are pation in the government-funded heabject to or may subject my organizati | Medicare and Medicaid as a basis for payment lth care programs is on to substantial criminal, |
|---|--|--|---|
| Signature | Title | Sections | Date Section Completed |
| <u>A</u> . | | | |
| В. | | | |
| <u>C.</u> | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Identifier

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Section Z - Assessment Administration

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

| Resident | Identifier | Data |
|----------|------------|--------|
| RESIDEDI | Identitier | Date . |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Part A PPS Discharge (NPE) Item Set

| Section | n. | A - Identification Information |
|------------|----------------|---|
| A0050. | Тур | pe of Record |
| Enter Code | | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Fac | cility Provider Numbers |
| | А. В. С. | National Provider Identifier (NPI): CMS Certification Number (CCN): State Provider Number: |
| | | |
| A0200. | Тур | pe of Provider |
| Enter Code | Тур | e of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Тур | pe of Assessment |
| Enter Code | A. | Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. | PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | E. | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes |
| Enter Code | F. | Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

A0310 continued on next page

| Resident | ldentifier | | Date |
|------------|--|------|-----------------|
| Section | on A - Identification Information | | |
| A0310. | Type of Assessment - Continued | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |
| A0410. | Unit Certification or Licensure Designation | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS data is not required by the S Unit is neither Medicare nor Medicaid certified but MDS data is required by the State Unit is Medicare and/or Medicaid certified | tate | |
| A0500. | Legal Name of Resident | | |
| | A. First name: | В. | 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. Male2. Female | | |
| A0900. | Birth Date | | |
| | Month Day Year | | |
| | | | |

| Resident | | | Identifier | Date |
|--------------|--------|--|------------|------|
| A1005. | Eth | | | |
| Are you o | f His | panic, Latino/a, or Spanish origin? | | |
| \downarrow | Che | eck all that apply | | |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin | | |
| | В. | Yes, Mexican, Mexican American, Chicano/a | | |
| | C. | Yes, Puerto Rican | | |
| | D. | Yes, Cuban | | |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin | | |
| | X. | Resident unable to respond | | |
| | Y. | Resident declines to respond | | |
| A1010. | | | | |
| What is yo | our ra | ice? | | |
| | Che | eck all that apply | | |
| | A. | White | | |
| | B. | Black or African American | | |
| | C. | American Indian or Alaska Native | | |
| | D. | Asian Indian | | |
| | E. | Chinese | | |
| | F. | Filipino | | |
| | G. | Japanese | | |
| | Н. | Korean | | |
| | l. | Vietnamese | | |
| | J. | Other Asian | | |
| | K. | Native Hawaiian | | |
| | L. | Guamanian or Chamorro | | |
| | M. | Samoan | | |
| | N. | Other Pacific Islander | | |
| | Χ. | Resident unable to respond | | |
| | Y. | Resident declines to respond | | |
| | Z. | None of the above | | |
| A1200. | Ма | rital Status | | |
| Enter Code | | Never married Married Widowed Separated Divorced | | |

| Resident | | Identifier Date |
|-------------------|------------|---|
| Section | n . | A - Identification Information |
| | | Insportation (from NACHC©) Insportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? |
| ↓ | | eck all that apply |
| | Α. | Yes, it has kept me from medical appointments or from getting my medications |
| | B. | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| | C. | No |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| and its resour | ces a | ssociation of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE re proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute part or whole without written consent from NACHC. |
| A1300. | Op | tional Resident Items |
| | A. | Medical record number: |
| | | |
| | B. | Room number: |
| | | |
| | C. | Name by which resident prefers to be addressed: |
| | | |
| | D. | Lifetime occupation(s) - put "/" between two occupations: |
| | | |
| Most Re A1600. | | nt Admission/Entry or Reentry into this Facility try Date |
| | | |
| | | Month Day Year |
| A1700. | Тур | pe of Entry |
| Enter Code | | 1. Admission |
| | | 2. Reentry |
| A1805. | Ent | tered From |
| Enter Code | 01. | Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other |
| | 02. | residential care arrangements) Nursing Home (long-term care facility) |
| | 03. 04. | Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) |
| | 05. | Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or unit) |
| | 07. | Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) |
| | 09. | Hospice (home/non-institutional) |
| | 11. | Hospice (institutional facility) Critical Access Hospital (CAH) |
| | 12. 99. | Home under care of organized home health service organization Not listed |



| Resident | | Identifier | | Date |
|--------------|-------|---|--|----------------------------------|
| Section | n. | A - Identification Information | | |
| A1900. | Ad | dmission Date (Date this episode of care in this facility | began) | |
| | | Month Day Year | | |
| | | scharge Date v if A0310F = 10, 11, or 12 | | |
| | | Month Day Year | | |
| | | ovision of Current Reconciled Medication List to Subs y if A0310H = 1 | equent Provider at Discharge | |
| Enter Code | At t | the time of discharge to another provider, did your facility provide the re | sident's current reconciled medication | list to the subsequent provider? |
| | | No - Current reconciled medication list not provided to the subset Yes - Current reconciled medication list provided to the subsequence | | essment Reference Date |
| Indicate th | e rou | Poute of Current Reconciled Medication List Transmission bute(s) of transmission of the current reconciled medication list to the surplif A2121 = 1 | | |
| \downarrow | Che | eck all that apply | | |
| | | Route of Transmission | | |
| | A. | Electronic Health Record | | |
| | B. | Health Information Exchange | | |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) | | |
| | D. | Paper-based (e.g., fax, copies, printouts) | | |
| | E. | Other methods (e.g., texting, email, CDs) | | |
| A2300. | As | ssessment Reference Date | | |
| | Ob | bservation end date: Month Day Year | | |
| A2400. | Me | edicare Stay | | |
| Enter Code | Α. | Has the resident had a Medicare-covered stay since the most re 0. No → Skip to B1300, Health Literacy 1. Yes → Continue to A2400B, Start date of most recent Medicare | • | |
| | В. | Start date of most recent Medicare stay: | | |
| | C. | End date of most recent Medicare stay - Enter dashes if stay is on Month Day Year | going: | |

| Look | back period for all items is 7 days unless another time frame is indicated |
|------------|---|
| | |
| Section | on B - Hearing, Speech, and Vision |
| B1300. | Health Literacy |
| Enter Code | How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond |

Identifier _

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Resident _

| Resident | | Identifier | Date |
|-------------|--|-------------------------------|---|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C020 conduct interview with all residents | 0-C0500) be Conducted | 1? |
| Enter Code | No (resident is rarely/never understood) → Skip to Yes → Continue to C0200, Repetition of Three Wo | | and Symptoms of Delirium (from CAM©) |
| Brief I | Interview for Mental Status (BIM | IS) | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to remer The words are: sock, blue, and bed. Now tell me the three 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 | e words." | |
| | the words up to two more times. | (Sock, Something to Wear, D. | ide, a color, bed, a piece of farmare j. Tou may repeat |
| 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 wer cue (something to wear; a color; a piece of furniture) for that A. Able to recall "sock" 0. No - could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required | | ed you to repeat?" If unable to remember a word, give |
| 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 Enter 99 if the resident was unable to complete the inter- | , | |



| Resident | Id | entifier | Date |
|--|--|---|---|
| Section C - | Cognitive Patterns | | |
| Delirium | | | |
| | nd Symptoms of Delirium (from CAM©) | | |
| A. Acute Onset I | Mental Status Change | | |
| Enter Code Is there e | | resident's baseline? | |
| Coding: | | | |
| Behavior not Behavior con Behavior pre | t present ntinuously present, does not fluctuate esent, fluctuates (comes and goes, changes in severity) | | |
| Enter Codes in Boxes | | | |
| what C. Diso flow D. Alter | tention - Did the resident have difficulty focusing attentions twas being said? organized Thinking - Was the resident's thinking disorgan of ideas, or unpredictable switching from subject to subject red Level of Consciousness - Did the resident have alter vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being asked questions, be stuporous - very difficult to arouse and keep aroused for the integration comatose - could not be aroused et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment | ized or incoherent (rambling or irrelevant contt)? red level of consciousness, as indicated by an ut responded to voice or touch erview | versation, unclear or illogical ny of the following criteria? |
| Section D - | | | |
| | Resident Mood Interview be Conducted? | | |
| F.1 O. I. | nterview with all residents | | |
| | No (resident is rarely/never understood) \rightarrow Skip to D0700 Yes \rightarrow Continue to D0150, Resident Mood Interview (PH | • | |

| Resider | nt | Identifier | | Date | |
|---|---------------------------|---|---|------------------------|--------------|
| Se | ction D | - Mood | | | |
| D01 | I50. Reside | nt Mood Interview (PHQ-2 to 9©) | | | |
| Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?" If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the resident: "About how often have you been bothered by this?" Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency. 1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank) | | | | | |
| 2. | Symptom Fre | · | | 1. | 2. |
| | 0. Never o | | | Symptom | Symptom |
| | | s (several days) | | Presence | Frequency |
| | | rs (half or more of the days) ays (nearly every day) | | ↓ Enter Scores | |
| | | 7 - ()))) | | • | • |
| A. | Little intere | st or pleasure in doing things | | | |
| В. | Feeling do | vn, depressed, or hopeless | | | |
| If bo | oth D0150A1 ai | nd D0150B1 are coded 9, OR both D0150A2 and D0150B2 are code | d 0 or 1, END the PHQ | interview; otherwise | e, continue. |
| | | | | | |
| C. | Trouble fall | ing or staying asleep, or sleeping too much | | | |
| D. | Feeling tire | d or having little energy | | | |
| E. | Poor appet | ite or overeating | | | |
| F. | Feeling bac family dow | l about yourself - or that you are a failure or have let you | ourself or your | | |
| G. | Trouble contelevision | ncentrating on things, such as reading the newspaper | or watching | | |
| H. | | speaking so slowly that other people could have notice being so fidgety or restless that you have been moving usual | | | |
| I. | Thoughts t | hat you would be better off dead, or of hurting yoursel | f in some way | | |
| D01 | 160. Total S | everity Score | | | |
| Enter S | Add sco | res for all frequency responses in Column 2, Symptom Frequency. if unable to complete interview (i.e., Symptom Frequency is blank for 3 | Total score must be bet or more required items | ween 00 and 27. s). | |
| D07 | 700. Social | Isolation | | | |
| Enter (| | Never Rarely Sometimes Often Always Resident declines to respond Resident unable to respond | | | |

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| Resident | | Identifier | Date | | | |
|--|---|--|--|--|--|--|
| Section | GG - Functional Abi | lities and Goals - Discharge |) | | | |
| GG0130. S | GG0130. Self-Care (Assessment period is the last 3 days of the Stay) | | | | | |
| Complete whe | en A0310G is not = 2 and A0310H = 1 a | nd A2400C minus A2400B is greater than 2. | | | | |
| | ident's usual performance at the end ode the reason. | of the stay for each activity using the 6-point sca | ale. If an activity was not attempted at the end | | | |
| amount of ass Activities may 06. Indepe 05. Setup 04. Super comple 03. Partial the eff 02. Subst effort. 01. Depen require If activity was 07. Reside 09. Not ap 10. Not at | istance provided. be completed with or without assistive of completed with or without assistive of clean-up assistance - Helper sets of vision or touching assistance - Helper does activity. Assistance may be provided if moderate assistance - Helper does Lort. antial/maximal assistance - Helper does defort - Helper does ALL of the effort. Read for the resident to complete the activities not attempted, code reason: ent refused oplicable - Not attempted and the resident resident resident resident resident. | y by themself with no assistance from a helper. up or cleans up; resident completes activity. Helper activity or intermittently. ESS THAN HALF the effort. Helper lifts, holds, or suppletes MORE THAN HALF the effort. Helper lifts or holds esident does none of the effort to complete the activity. ent did not perform this activity prior to the current illn ions (e.g., lack of equipment, weather constraints) | ssists only prior to or following the activity. d/or contact guard assistance as resident pports trunk or limbs, but provides less than half s trunk or limbs and provides more than half the ty. Or, the assistance of 2 or more helpers is | | | |
| 3. Discharge Performance Enter Codes in Bo ↓ | xes | | | | | |
| A. | Eating: The ability to use suitable ute before the resident. | ensils to bring food and/or liquid to the mouth and swa | allow food and/or liquid once the meal is placed | | | |
| В. | Oral hygiene: The ability to use suita from the mouth, and manage denture | ble items to clean teeth. Dentures (if applicable): The soaking and rinsing with use of equipment. | e ability to insert and remove dentures into and | | | |
| C. | Toileting hygiene: The ability to main managing an ostomy, include wiping t | ntain perineal hygiene, adjust clothes before and afte the opening but not managing equipment. | er voiding or having a bowel movement. If | | | |
| E. | Shower/bathe self: The ability to bat include transferring in/out of tub/show | he self, including washing, rinsing, and drying self (e. ver. | excludes washing of back and hair). Does not | | | |
| F. | Upper body dressing: The ability to | dress and undress above the waist; including fastene | ers, if applicable. | | | |
| G. | Lower body dressing: The ability to | dress and undress below the waist, including fastened | ers; does not include footwear. | | | |
| Н. | Putting on/taking off footwear: The including fasteners, if applicable. | ability to put on and take off socks and shoes or other | er footwear that is appropriate for safe mobility; | | | |
| | | | | | | |

| esident | | Identifier | | Date |
|--|--|--|---|--|
| Sect | tion | n GG - Functional Abilities and Goals | - Discharge | |
| | | Mobility (Assessment period is the last 3 days of the Stay) | | |
| • | | then A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is great the state of the stat | | |
| of the | stay, co | esident's usual performance at the end of the stay for each activity us code the reason. | ing the 6-point scale. If an activity | was not attempted at the end |
| amoun Activitie 06. 05. 04. 03. 02. 01. If activ 07. 09. 10. | and Quit of assi es may Indepe Setup Superv comple Partial, the effort. Dependerequire vity was Reside Not ap | stantial/maximal assistance - Helper does MORE THAN HALF the effort | from a helper. tes activity. Helper assists only prior to uching/steadying and/or contact guard nittently. per lifts, holds, or supports trunk or lin . Helper lifts or holds trunk or limbs an complete the activity. Or, the assistan | o or following the activity. d assistance as resident nbs, but provides less than half nd provides more than half the nce of 2 or more helpers is |
| 3. Discha Performa Enter Cod | ance des in Box | | nt side, and return to lying on back on | the bed. |
| | В. | B. Sit to lying: The ability to move from sitting on side of bed to lying flat | on the bed. | |
| |] C. | C. Lying to sitting on side of bed: The ability to move from lying on the support. | back to sitting on the side of the bed | and with no back |
| | D. | D. Sit to stand: The ability to come to a standing position from sitting in | a chair, wheelchair, or on the side of t | he bed. |
| | E. | E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed | to a chair (or wheelchair). | |
| |] F. | F. Toilet transfer: The ability to get on and off a toilet or commode. | | |
| | G. | G. Car transfer: The ability to transfer in and out of a car or van on the p door or fasten seat belt. | assenger side. Does not include the a | ability to open/close |
| \perp |] I. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a rois coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) | om, corridor, or similar space. If disch | narge performance |
| | J. | J. Walk 50 feet with two turns: Once standing, the ability to walk at lea | st 50 feet and make two turns. | |
| I | K. | K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a | corridor or similar space. | |
| | | | | |

| esident | Identifier Date |
|--|--|
| Section | GG - Functional Abilities and Goals - Discharge |
| | obility (Assessment period is the last 3 days of the Stay) n A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2. |
| Code the resid | dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end de the reason. |
| amount of assis Activities may be a completed of the efformation of th | ntial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the dent - 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 d for the resident to complete the activity. not attempted, code reason: |
| 3. Discharge Performance Enter Codes in Box | Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| M. | 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or $88 \rightarrow \text{Skip}$ to GG0170P, Picking up object |
| N. | 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or $88 \rightarrow \text{Skip}$ to GG0170P, Picking up object |
| 0. | 12 steps: The ability to go up and down 12 steps with or without a rail. |
| P. | Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| | Q3. Does the resident use a wheelchair and/or scooter? |
| | No → Skip to J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent Yes → Continue to GG0170R, Wheel 50 feet with two turns |
| R. | Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | RR3. Indicate the type of wheelchair or scooter used. |
| | 1. Manual 2. Motorized |
| S. | Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | SS3. Indicate the type of wheelchair or scooter used. |
| | 1. Manual 2. Motorized |
| | |

| Resident | | Identifier | Date |
|------------------------|---|---|--|
| Section | on J - Health (| conditions | |
| J0200. | Should Pain Asses | sment Interview be Conducted? | |
| Attempt to Assessme | o conduct interview with all ent (OBRA or Scheduled P | residents. If resident is comatose or if A0310G = 2, skip to J180 PS). Otherwise, attempt to conduct interview with all residents. | 00. Any Falls Since Admission/Entry or Reentry or Prior |
| Enter Code | or Scheduled F | rarely/never understood) → Skip to J1800. Any Falls Since Ad PS), whichever is more recent ue to J0300, Pain Presence | mission/Entry or Reentry or Prior Assessment (OBRA |
| Pain <i>A</i> | Assessment li | nterview | |
| J0300. | Pain Presence | | |
| Enter Code | No → Skip to more recent Yes → Continuo | The bound of the last 5 days? Display the last 5 days. Display the last 6 days the last 6 days. Display the last 6 days 6 days 6 days. Display the last 6 days 6 day | ressment (OBRA or Scheduled PPS), whichever is |
| J0510. | Pain Effect on Slee |) | |
| Enter Code | Ask resident: "Over the p 1. Rarely or not a 2. Occasionally 3. Frequently 4. Almost consta | nntly | hard for you to sleep at night?" |
| J0520. | Pain Interference w | ith Therapy Activities | |
| Enter Code | due to pain?" | intly | , |
| J0530. | Pain Interference w | ith Day-to-Day Activities | |
| Enter Code | Ask resident: "Over the post of pain?" 1. Rarely or not a constant of the post of pain?" 2. Occasionally 3. Frequently 4. Almost constant | | vities (<u>excluding</u> rehabilitation therapy sessions) |



8. Unable to answer

| Resider | nt | | Identifier Date _ | |
|--------------|-------------------------------|-----------------|--|----------------------------|
| Se | ctic | n J | - Health Conditions | |
| J18 | 300. | _ | Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS ever is more recent |), |
| Enter | Code | Has t | ne resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS t? | s), whichever is more |
| | _ | | No → Skip to K0520, Nutritional Approaches Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or | Scheduled PPS) |
| J19 | 900. | | ber of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Schedule recent | ed PPS), whichever is |
| 0. I 1. (| ling: None One Two o | r more | | |
| Enter | Code | s in B | oxes | |
| | | | No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no copy the resident; no change in the resident's behavior is noted after the fall | mplaints of pain or injury |
| | | | njury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-he resident to complain of pain | related injury that causes |
| | | C. | Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hemato | ma |
| | | | | |
| | | | | |
| Se | ctic | n k | ⟨ - Swallowing/Nutritional Status | |
| | | | itional Approaches | |
| | | | following nutritional approaches that apply | |
| 4. | At Dis Assess | charg sment | e period is the last 3 days of the SNF PPS Stay ending on A2400C | |
| | | | | 4. |
| | | | | At Discharge |
| | | | | Check all that apply |
| A. | Parer | nteral/ | IV feeding | $\stackrel{\star}{\Box}$ |
| В. | Feed | ing tu | De (e.g., nasogastric or abdominal (PEG)) | |
| C. | Mech food, | anica thicke | Ily altered diet - require change in texture of food or liquids (e.g., pureed ned liquids) | |
| D. | Thera | apeuti | c diet (e.g., low salt, diabetic, low cholesterol) | |
| Z. | None | of the | above | |

| Resident | | | Identifier Date | | | | |
|--------------|-----------------------------|-------------|---|--|--|--|--|
| | Section M - Skin Conditions | | | | | | |
| | | Re | port based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage | | | | |
| M0210. | Un | heal | led Pressure Ulcers/Injuries | | | | |
| Enter Code | Doe | 0. 1. | is resident have one or more unhealed pressure ulcers/injuries? No → Skip to N0415, High-Risk Drug Classes: Use and Indication Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | | | |
| M0300. | Cu | rren | t Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | | | |
| Enter Number | B. | Sta as a | ge 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present an intact or open/ruptured blister | | | | |
| | | 1. | Number of Stage 2 pressure ulcers - If $0 \rightarrow \text{Skip}$ to M0300C, Stage 3 | | | | |
| Enter Number | | 2. | Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | |
| Enter Number | C. | Sta doe | ge 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but s not obscure the depth of tissue loss. May include undermining and tunneling | | | | |
| | | 1. | Number of Stage 3 pressure ulcers - If $0 \rightarrow \text{Skip}$ to M0300D, Stage 4 | | | | |
| Enter Number | | 2. | Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | |
| Enter Number | D. | | ge 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound . Often includes undermining and tunneling | | | | |
| | | 1. | Number of Stage 4 pressure ulcers - If 0 \rightarrow Skip to M0300E, Unstageable - Non-removable dressing/device | | | | |
| Enter Number | | 2. | Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | |
| | E. | Uns | stageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device | | | | |
| Enter Number | | 1. | Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If $0 \rightarrow$ Skip to M0300F, Unstageable - Slough and/or eschar | | | | |
| Enter Number | | 2. | Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | |
| Enter Number | F. | Uns | stageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar | | | | |
| Enter Number | | 1. | Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If $0 \rightarrow$ Skip to M0300G, Unstageable - Deep tissue injury | | | | |
| Line Number | | 2. | Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | | | |
| | G. | Uns | stageable - Deep tissue injury: | | | | |

1. Number of unstageable pressure injuries presenting as deep tissue injury - If $0 \rightarrow Skip$ to N2005, Medication Intervention

Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were noted

at the time of admission/entry or reentry

Enter Number

Enter Number

2.

| Resident | | Identifier | Date | |
|----------|---|--|------------------------|--------------------|
| Sec | tion N - Medications | | | |
| N041 | 5. High-Risk Drug Classes: Use and Indication | | | |
| 1. 2. | Is taking Check if the resident is taking any medications by pharmacological cor reentry if less than 7 days Indication noted If Column 1 is checked, check if there is an indication noted for all medication. | | he last 7 days or sind | ce admission/entry |
| | | | 1. | 2. |
| | | | Is taking | Indication noted |
| | | | ↓ Check all | that apply↓ |
| A. | Antipsychotic | | | |
| В. | Antianxiety | | | |
| C. | Antidepressant | | | |
| D. | Hypnotic | | | |
| E. | Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin | ırin) | | |
| F. | Antibiotic | | | |
| G. | Diuretic | | | |
| H. | Opioid | | | |
| I. | Antiplatelet | | | |
| J. | Hypoglycemic (including insulin) | | | |
| Z. | None of the above | | | |
| N200 | 5. Medication Intervention - Complete only if A0310H = 1 | | | |
| Enter Co | Did the facility contact and complete physician (or physician calendar day each time potential clinically significant medica 0. No 1. Yes 9. NA - There were no potential clinically significant medical | ation issues were identified since the | admission? | |
| | | | | |

| Resident | | Identifier | Date | |
|----------|--|--------------------|------|-----------------------------------|
| | tion O - Special Treatments, Procedures, and Programs | ures, and Programs | | |
| Check | all of the following treatments, procedures, and programs that were pe | erformed | | |
| | t Discharge ssessment period is the last 3 days of the SNF PPS Stay ending on A | 2400C | | c. At Discharge |
| | | | | Check all that apply \downarrow |
| Cance | r Treatments | | | |
| A1. C | hemotherapy | | | |
| Α | 2. IV | | | |
| A | 3. Oral | | | |
| A | 10. Other | | | |
| B1. R | adiation | | | |
| Respi | atory Treatments | | | |
| C1. (| xygen therapy | | | |
| C | 2. Continuous | | | |
| C | 3. Intermittent | | | |
| C | 4. High-concentration | | | |
| D1. S | uctioning | | | |
| | 2. Scheduled | | | |
| | 3. As needed | | | |
| E1. T | racheostomy care | | | |
| F1. lı | vasive Mechanical Ventilator (ventilator or respirator) | | | |
| G1. N | on-invasive Mechanical Ventilator | | | |
| | 2. BiPAP | | | |
| G | 3. CPAP | | | |
| Othe | T . | | | |
| H1. I | / Medications | | | |
| Н | 2. Vasoactive medications | | | |
| Н | 3. Antibiotics | | | |
| H | 4. Anticoagulant | | | |
| H | 10. Other | | | |
| 11. T | ransfusions | | | |
| O0110 | continued on next page | | | |

| Resi | lent lo | entifier | Date | |
|------|--|----------|------|----------------------|
| | ection O - Special Treatments, Procedu 0110. Special Treatments, Procedures, and Programs - Co | , | | |
| C | neck all of the following treatments, procedures, and programs that were per | ormed | | |
| C. | At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A240 | 0C | | c. At Discharge |
| | | | | Check all that apply |
| J1. | Dialysis | | | |
| | J2. Hemodialysis | | | |
| | J3. Peritoneal dialysis | | | |
| K1. | Hospice Care | | | |
| M1 | Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | | |
| 01 | IV Access | | | |
| | O2. Peripheral | | | |
| | O3. Midline | | | |
| | O4. Central (e.g., PICC, tunneled, port) | | | |
| No | ne of the Above | | | |
| Z1. | None of the above | | | |

| Section O - 00425. Part A TI | Special Treatments, Procedures, and Programs |
|---------------------------------|---|
| Complete only if A031 | |
| | A. Speech-Language Pathology and Audiology Services |
| Enter Number of Minutes | 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 | 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 | 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) |
| Enter Number of Minutes | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0425B, Occupational Therapy |
| Enter Number of Days | 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) |
| | Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | B. Occupational Therapy |
| Enter Number of Minutes | D. Occupational iniciapy |
| 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) |
| Entor Number of Williago | 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 | 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, \rightarrow skip to O0425C, Physical Therapy |
| Enter Number of Minutes | |
| Enter Number of Days | 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) |
| | 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 | C. Physical Therapy |
| | 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 | 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 | Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Days | 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) |
| | |

| Resident | Identifier | • | Date |
|-----------------------|---|--|---|
| Section O - | Special Treatments, Procedures | , and Programs | |
| O0430. Distinct | Calendar Days of Part A Therapy | | |
| Complete only if A031 | H = 1 | | |
| Enter Number of Days | Record the number of calendar days that the resident receir Therapy, or Physical Therapy for at least 15 minutes since the (A2400B) | /ed Speech-Language Pathology and A le start date of the resident's most rece | Audiology Services, Occupational nt Medicare Part A stay |

| Resident | | Identifier | Date |
|--------------------------|---|--|--------------------------------------|
| Section | on X - Correction Request | | |
| Identific section, re | te Section X only if A0050 = 2 or 3 cation of Record to be Modified/Inactivated - The follow produce the information EXACTLY as it appeared on the existing enation is necessary to locate the existing record in the National MDS | rroneous record, even if the information is inco | ord that is in error. In this prect. |
| X0150. | Type of Provider (A0200 on existing record to be modified/ina | ictivated) | |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | Name of Resident (A0500 on existing record to be modified/in | nactivated) | |
| | A. First name: | | |
| | | | |
| | C. Last name: | | |
| | | | |
| X0300. | Gender (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | Male Female | | |
| X0400. | Birth Date (A0900 on existing record to be modified/inactivated |) | |
| | Month Day Year | | |
| X0500. | Social Security Number (A0600A on existing record to be n | nodified/inactivated) | |
| | | | |
| X0600. | Type of Assessment (A0310 on existing record to be modified | ed/inactivated) | |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive asses 06. Significant correction to prior quarterly assessment 99. None of the above | sment | |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | Ā | |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |

| Resident | | Identifier Date | | | |
|--------------|----------------|--|--|--|--|
| Section | n Ì | X - Correction Request | | | |
| X0700. | Dat | ate on existing record to be modified/inactivated - Complete one only | | | |
| | A. | Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 | | | |
| | Month Day Year | | | | |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 | | | |
| | | Month Day Year | | | |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 | | | |
| | | Month Day Year | | | |
| Correct | ion <i>i</i> | Attestation Section - Complete this section to explain and attest to the modification/inactivation request | | | |
| X0800. | Co | rrection Number | | | |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one | | | |
| X0900. I | Reas | sons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | |
| ţ | Che | ck 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. | Rea | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | |
| \downarrow | | ck 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: | | | |
| | | | | | |
| | В. | Attesting individual's last name: | | | |
| | | | | | |
| | C. | Attesting individual's title: | | | |
| | D. | Signature | | | |
| | E. | Attestation date | | | |
| | | Month Day Year | | | |

| Z0400. Signature of Persons Completing | ng the Assessment or Entry/Dea | th Reporting | |
|--|--|---|---|
| I certify that the accompanying information accurately roof this information on the dates specified. To the best of requirements. I understand that this information is used from federal funds. I further understand that payment of conditioned on the accuracy and truthfulness of this infocivil, and/or administrative penalties for submitting false | f my knowledge, this information was colled as a basis for ensuring that residents red from the formation, and that I may be personally su | ected in accordance with applicable ceive appropriate and quality care, a pation in the government-funded he bject to or may subject my organiza | Medicare and Medicaid and as a basis for payment alth care programs is tion to substantial criminal, |
| Signature | Title | Sections | Date Section Completed |
| <u>A.</u> | | | |
| B. | | | |
| <u>C</u> . | | | |
| <u>D</u> . | | | |
| E | | | |
| F | | | |
| G. | | | |
| Н. | | | |
| <u>I.</u> | | | |
| J. | | | |
| <u>K</u> . | | | |
| L. | | | |
| Z0500. Signature of RN Assessment Co | pordinator Verifying Assessmen | • | |
| A. Signature: | | B. Date RN Assessment C | • |
| | | assessment as comple | ete: |
| | | Month Day | Year |
| | | | |
| | | | |
| | | | |

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Resident

Section Z - Assessment Administration

| Resident | Identifier | Date |
|------------|------------|------|
| 1/63/461/1 | IUCIIIIICI | Dale |

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

| Saction | Δ_ | Identification | Information |
|---------|----|----------------|-------------|

| | m// Idontinodion mornation |
|------------|---|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): B. CMS Certification Number (CCN): C. State Provider Number: |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99 None of the above |

A0310 continued on next page

| Resident | Identifier _ | | Date |
|------------|---|-----------|--------------------------|
| Section | on A - Identification Information | | |
| A0310. | Type of Assessment - Continued | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 111. Planned2. Unplanned | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment?0. No1. Yes | | |
| A0410. | Unit Certification or Licensure Designation | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS data Unit is neither Medicare nor Medicaid certified but MDS data is Unit is Medicare and/or Medicaid certified | | |
| A0500. | Legal Name of Resident | | |
| | A. First name: C. Last name: | В. D. | Middle initial: 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 | | |

| Resident | | Identifier Date |
|--------------|-----|--|
| Section | on. | A - Identification Information |
| A1005. | Eth | nnicity |
| | | panic, Latino/a, or Spanish origin? |
| \downarrow | Che | eck all that apply |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin |
| | В. | Yes, Mexican, Mexican American, Chicano/a |
| | C. | Yes, Puerto Rican |
| | D. | Yes, Cuban |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| A1010. | | |
| What is ye | | |
| ↓ | Che | eck all that apply |
| | A. | White |
| | B. | Black or African American |
| | C. | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | Н. | Korean |
| | I. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1110. | Laı | nguage |
| | A. | What is your preferred language? |
| | | |
| Enter Code | В. | |
| Ш | | 0. No 1. Yes |
| | | 9. Unable to determine |



| Resident | | Identifier Date |
|----------------|--------|---|
| Section | on | A - Identification Information |
| A1200. | Ма | arital Status |
| Enter Code | | Never married Married Widowed Separated Divorced |
| A1250. | Tra | ansportation (from NACHC©) |
| Has lack | of tra | ansportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? |
| \downarrow | Che | eck all that apply |
| | A. | Yes, it has kept me from medical appointments or from getting my medications |
| | В. | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| | C. | No |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| and its resour | ces a | Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute part or whole without written consent from NACHC. |
| A1300. | Op | otional Resident Items |
| | A. | Medical record number: |
| | | |
| | B. | Room number: |
| | | |
| | C. | Name by which resident prefers to be addressed: |
| | ٥. | Thaine by which resident prefers to be addressed. |
| | D. | Lifetime occupation(s) - put "/" between two occupations: |
| | υ. | Lifetime occupation(s) - put // between two occupations. |
| | | |
| | | |

| Resident | | Identifier | Date | | | |
|---|--|--|--------------------|--|--|--|
| Section A - Identification Information | | | | | | |
| Most Recent Admission/Entry or Reentry into this Facility A1600. Entry Date | | | | | | |
| | Month Day Year | | | | | |
| A1700. | Type of Entry | | | | | |
| Enter Code | Admission Reentry | | | | | |
| A1805. | Entered From | | | | | |
| Enter Code | Home/Community (e.g., private home/apt., board/care, ass residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health service organized | or unit) | }F | | | |
| A1900. | Admission Date (Date this episode of care in this | facility began) | | | | |
| | Month Day Year | | | | | |
| | Discharge Date only if A0310F = 10, 11, or 12 | | | | | |
| | Month Day Year | | | | | |
| | Discharge Status | | | | | |
| Complete | only if A0310F = 10, 11, or 12 | | | | | |
| Enter Code | 01. Home/Community (e.g., private home/apt., board/care, ass arrangements) → Skip to A2123, Provision of Current Record 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organized 13. Deceased 14. Not listed → Skip to A2123, Provision of Current Reconcile | nciled Medication List to Resident at Discharge or unit) | r residential care | | | |

| | | Identifies Date | | | | |
|--|--|--|--|--|--|--|
| esident | | Identifier Date | | | | |
| Section A - Identification Information | | | | | | |
| A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge Complete only if A0310H = 1 and A2105 = 02-12 | | | | | | |
| Enter Code | At tl | the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider? | | | | |
| | | No - Current reconciled medication list not provided to the subsequent provider → Skip to A2300, Assessment Reference Date Yes - Current reconciled medication list provided to the subsequent provider | | | | |
| A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider. Complete only if A2121 = 1 | | | | | | |
| ↓ C | heck | all that apply | | | | |
| | | Route of Transmission | | | | |
| | A. | Electronic Health Record | | | | |
| | В. | Health Information Exchange | | | | |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) | | | | |
| | D. | Paper-based (e.g., fax, copies, printouts) | | | | |
| | E. | Other methods (e.g., texting, email, CDs) | | | | |
| | A2123. Provision of Current Reconciled Medication List to Resident at Discharge Complete only if A0310H = 1 and A2105 = 01, 99 | | | | | |
| Enter Code | At t | the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? O. No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver | | | | |
| A2124. Route of Current Reconciled Medication List Transmission to Resident Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver. Complete only if A2123 = 1 | | | | | | |
| ↓ Check all that apply | | | | | | |
| | | Route of Transmission | | | | |
| | A. | Electronic Health Record (e.g., electronic access to patient portal) | | | | |
| | В. | Health Information Exchange | | | | |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) | | | | |
| | D. | Paper-based (e.g., fax, copies, printouts) | | | | |
| | E. | Other methods (e.g., texting, email, CDs) | | | | |

| Resident | | Identifier | Date | | | | |
|--|---|---|------------------|--|--|--|--|
| Section A - Identification Information | | | | | | | |
| A2300. | 00. 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 0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent | • | | | | | |
| | B. Start date of most recent Medicare stay: | | | | | | |
| | 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 day | s unless another time fra | ame is indicated | | | | |
| Section | Continu D. Honging Chooph and Vision | | | | | | |
| OUULI | on b = deadho, soeech, and visioi | 1 | | | | | |
| D0400 | on B - Hearing, Speech, and Vision | 1 | | | | | |
| | Comatose | 1 | | | | | |
| B0100. | • | | | | | | |
| | Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday A | Activities | | | | | |
| Enter Code | Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday | Activities y used) interaction, listening to TV g., when person speaks softly or setting is noisy | | | | | |
| Enter Code B0200. | Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday A Hearing Ability to hear (with hearing aid or hearing appliances if normall 0. Adequate - no difficulty in normal conversation, social 1. Minimal difficulty - difficulty in some environments (e. 2. Moderate difficulty - speaker has to increase volume 3. Highly impaired - absence of useful hearing Hearing Aid | Activities y used) interaction, listening to TV g., when person speaks softly or setting is noisy and speak distinctly | | | | | |
| B0200. | Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday A Hearing Ability to hear (with hearing aid or hearing appliances if normall 0. Adequate - no difficulty in normal conversation, social 1. Minimal difficulty - difficulty in some environments (e. 2. Moderate difficulty - speaker has to increase volume 3. Highly impaired - absence of useful hearing | Activities y used) interaction, listening to TV g., when person speaks softly or setting is noisy and speak distinctly | | | | | |
| B0200. Enter Code B0300. | Comatose Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday A Hearing Ability to hear (with hearing aid or hearing appliances if normall 0. Adequate - no difficulty in normal conversation, social 1. Minimal difficulty - difficulty in some environments (e. 2. Moderate difficulty - speaker has to increase volume 3. Highly impaired - absence of useful hearing Hearing Aid Hearing aid or other hearing appliance used in completing B000000000000000000000000000000000000 | Activities y used) interaction, listening to TV g., when person speaks softly or setting is noisy and speak distinctly | | | | | |

| Resident _ | | ldentifier | Date |
|---------------|--|--|---------------------------------------|
| Secti | ion B - Hearing, Speech, a | and Vision | |
| B0700. | . Makes Self Understood | | |
| Enter Code | Ability to express ideas and wants, consider 0. Understood 1. Usually understood - difficulty community 2. Sometimes understood - ability is li 3. Rarely/never understood | municating some words or finishing thoughts | but is able if prompted or given time |
| B0800. | . Ability To Understand Others | | |
| Enter Code | | e (with hearing aid or device if used) e part/intent of message but comprehends n s adequately to simple, direct communication | |
| B1000. | . Vision | | |
| Enter Code | 3. Highly impaired - object identification4. Severely impaired - no vision or see | regular print in newspapers/books | ects |
| B1200. | . Corrective Lenses | | |
| Enter Code | Corrective lenses (contacts, glasses, or ma 0. No 1. Yes | gnifying glass) used in completing B1000, | Vision |
| | . Health Literacy te only if A0310B = 01 or A0310G = 1 and A0310H | 1 = 1 | |
| Enter Code | How often do you need to have someone help pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | | , |
| rrie Singie I | Item Literacy Screener is licensed under a Creative Cor | ninons Auribulion-NonCommercial 4.0 internation | iai Licerise. |

| Resident | | Identifier | Date |
|-------------|--|--|-----------------------------------|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C0200-conduct interview with all residents | C0500) be Conducted? | |
| Enter Code | No (resident is rarely/never understood) → Skip to at Yes → Continue to C0200, Repetition of Three Word | · | Mental Status |
| Brief I | Interview for Mental Status (BIMS |) | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to rememb The words are: sock, blue, and bed. Now tell me the three w Number of words repeated after first attempt 0. None | · | rree. |
| Ш | One Two Three After the resident's first attempt, repeat the words using cues ("at the words up to two more times. | sock, something to wear; blue, a color; bed, a pie | ce of furniture"). You may repeat |
| C0300. | Temporal Orientation (orientation to year, month, and day | v) | |
| 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. | | | |
| Enter Code | Ask resident: "Let's go back to an earlier question. What were the lf unable to remember a word, give cue (something to wear; a content of the letter of the | | |
| 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 (0 Enter 99 if the resident was unable to complete the intervie | · | |



| Resident | | Identifier | Date |
|---------------------|--|--|--|
| Section | on C - Cognitive Patterns | | |
| C0600. | Should the Staff Assessment for Mental | Status (C0700 - C1000) be Cor | nducted? |
| Enter Code | No (resident was able to complete Brief IrYes (resident was unable to complete Brief | | |
| Staff As | sessment for Mental Status | | |
| Do not co | nduct if Brief Interview for Mental Status (C0200-C05 | 00) 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 | | |
| \downarrow | 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 they are in a nursing home/hospital sw | ving bed | |
| | Z. None of the above were recalled | | |
| C1000. | Cognitive Skills for Daily Decision Making | ng | |
| Enter Code | Made decisions regarding tasks of daily life 0. Independent - decisions consistent/reasc 1. Modified independence - some difficulty 2. Moderately impaired - decisions poor; cu 3. Severely impaired - never/rarely made | in new situations only ues/supervision required | |
| Deliriun C1310. | n Signs and Symptoms of Delirium (from | CAM©) | |
| Code afte | er completing Brief Interview for Mental Status or Sta | off Assessment, and reviewing medical re | ecord |
| A. Acute | e Onset Mental Status Change | | |
| Enter Code | Is there evidence of an acute change in mental s 0. No 1. Yes | status from the resident's baseline? | |
| 1. Be | ehavior not present ehavior continuously present, does not fluctuate ehavior present, fluctuates (comes and goes, chang | ges in severity) | |
| Enter Code in Boxes | es | | |
| | what was being said? C. Disorganized Thinking - Was the resident's the flow of ideas, or unpredictable switching from s | ninking disorganized or incoherent (ramb subject to subject)? | ily distractible or having difficulty keeping track of bling or irrelevant conversation, unclear or illogical ss, as indicated by any of the following criteria? |
| Ц | vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being as stuporous - very difficult to arouse and keep a comatose - could not be aroused | sked questions, but responded to voice or to | |

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

| esideı | nt | Identifier | Date | |
|-----------------------|---|--|------------------------|---------------|
| Se | ction D | - Mood | | |
| D0′ | 100. Shoul | d Resident Mood Interview be Conducted? - Attempt to conduct interview with all | residents | |
| Enter | Code 0. 1. | No (resident is rarely/never understood) \rightarrow Skip to and complete D0500-D0600, Staff Asses Yes \rightarrow Continue to D0150, Resident Mood Interview (PHQ-2 to 9©) | ssment of Resident Mod | od (PHQ-9-OV) |
| D0′ | 150. Resid | ent Mood Interview (PHQ-2 to 9©) | | |
| If sy If ye Rea | mptom is prese s in column 1, d and show the Symptom Pre 0. No (ent 1. Yes (en | Over the last 2 weeks, have you been bothered by any of the following part, enter 1 (yes) in column 1, Symptom Presence. hen ask the resident: "About how often have you been bothered by this?" resident a card with the symptom frequency choices. Indicate response in column 2, Symptom sence er 0 in column 2) ter 0-3 in column 2) ter 0-3 in column 2 blank) | | |
| 2. | Symptom Fre | quency | 1. | 2. |
| | 0. Never of 1. 2-6 day | r 1 day s (several days) | Symptom | Symptom |
| | 2. 7-11 da | ys (half or more of the days) | Presence | Frequency |
| | 3. 12-14 d | ays (nearly every day) | ↓ Enter Scores | in Boxes↓ |
| Α. | Little intere | est or pleasure in doing things | | |
| В. | Feeling do | wn, depressed, or hopeless | | |
| If bo | oth D0150A1 a | nd D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHC | Q interview; otherwise | , continue. |
| | | | | |
| C. | Trouble fai | ling or staying asleep, or sleeping too much | | |
| D. | Feeling tire | ed or having little energy | | |
| E. | Poor appe | ite or overeating | | |
| F. | Feeling ba family dow | d about yourself - or that you are a failure or have let yourself or your n | | |
| G. | Trouble co television | ncentrating on things, such as reading the newspaper or watching | | |
| H. | _ | speaking so slowly that other people could have noticed. Or the being so fidgety or restless that you have been moving around a lot usual | | |
| l. | Thoughts | hat you would be better off dead, or of hurting yourself in some way | | |
| D0 | 160. Total \$ | Severity Score | | |
| Enter | - Add Sc | ores for all frequency responses in Column 2, Symptom Frequency. Total score must be be if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required item | etween 00 and 27. | |



| Resident | | Identifier | Date | |
|------------------------------------|--|--------------------------------------|-----------------|-----------|
| Sectio | n D - Mood | | | |
| | Staff Assessment of Resident Mood (PHQ-9-OV*) duct if Resident Mood Interview (D0150-D0160) was completed | | | |
| If symptom Then move 1. Symp 0. 1. | ast 2 weeks, did the resident have any of the following proble is present, enter 1 (yes) in column 1, Symptom Presence. to column 2, Symptom Frequency, and indicate symptom frequentom Presence No (enter 0 in column 2) Yes (enter 0-3 in column 2) | | | |
| 2. Symp | tom Frequency | | 1. | 2. |
| | Never or 1 day 2-6 days (several days) | | Symptom | Symptom |
| | 7-11 days (half or more of the days) | | Presence | Frequency |
| 3. | 12-14 days (nearly every day) | | ↓ Enter Scores | n Boxes↓ |
| A. Little | interest or pleasure in doing things | | | |
| B. Feelin | g or appearing down, depressed, or hopeless | | | |
| C. Troub | le falling or staying asleep, or sleeping too much | | | |
| D. Feelin | g tired or having little energy | | | |
| E. Poor a | appetite or overeating | | | |
| F. Indica | ating that they feel bad about self, are a failure, or have let sel | f or family down | | |
| G. Troub | le concentrating on things, such as reading the newspaper o | r watching television | | |
| H. Movin being | g or speaking so slowly that other people have noticed. Or the so fidgety or restless that they have been moving around a l | ne opposite - ot more than usual | | |
| I. States | s that life isn't worth living, wishes for death, or attempts to h | arm self | | |
| J. Being | short-tempered, easily annoyed | | | |
| D0600. | Total Severity Score | | | |
| Enter Score | Add scores for all frequency responses in Column 2, Sympton | m Frequency. Total score must be bet | ween 00 and 30. | |
| D0700. | Social Isolation | | | |
| Enter Code | How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond | | | |
| | | | | |



| Resident | | | dentifier | Date |
|--------------|----------------|---|---|--|
| Section | on | E - Behavior | | |
| E0100. | Po | tential Indicators of Psychosis | | |
| ↓ Cł | neck | all that apply | | |
| | A. | Hallucinations (perceptual experiences in the absence of rea | al external sensory stimuli) | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, cor | ntrary to reality) | |
| | Z. | None of the above | | |
| Behavio | oral | Symptoms | | |
| E0200. | Be | havioral Symptom - Presence & Frequency | | |
| Note pres | sence | e of symptoms and their frequency | | |
| 1. Be | ehavi ehavi | or not exhibited or of this type occurred 1 to 3 days or of this type occurred 4 to 6 days, but less than daily or of this type occurred daily | | |
| Enter Code | A. | Physical behavioral symptoms directed toward others (e. | g., hitting, kicking, pushing, scratching, grabbi | ng, abusing others sexually) |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g., | threatening others, screaming at others, cursi | ng at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e rummaging, public sexual acts, disrobing in public, throwing o disruptive sounds) | e.g., physical symptoms such as hitting or scra r smearing food or bodily wastes, or verbal/vo | tching self, pacing, cal symptoms like screaming, |
| E0800. | Re | jection of Care - Presence & Frequency | | |
| Enter Code | goa | the resident reject evaluation or care (e.g., bloodwork, takin talls for health and well-being? Do not include behaviors that h dent or family), and determined to be consistent with resident v 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 th 3. Behavior of this type occurred daily | ave already been addressed (e.g., by discussi alues, preferences, or goals. | |
| E0900. | Wa | ndering - Presence & Frequency | | |
| Enter Code | Has | the resident wandered? 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less th 3. Behavior of this type occurred daily | an daily | |

| Resident | | | Identifie | r | Date |
|------------------------------------|----------------------------------|---|-------------------|---|--------------------------------------|
| | | GG - Functional Abilities and | | | |
| exacerbat | tion, d | rior Functioning: Everyday Activities. Indica or injury if A0310B = 01 | te the residen | t's usual ability with everyday activities | prior to the current illness, |
| withou 2. Need person | ende ut an ed So n to c | ent - Resident completed all the activities by themself, wassistive device, with no assistance from a helper. ome Help - Resident needed partial assistance from an omplete any activities. t - A helper completed all the activities for the resident. | 9. | Unknown. Not Applicable. | |
| Enter Code | s in | Boxes | | | |
| | A. | Self-Care: Code the resident's need for assistance wi or injury. | th bathing, dre | essing, using the toilet, or eating prior t | o the current illness, exacerbation |
| | В. | Indoor Mobility (Ambulation): Code the resident's no cane, crutch, or walker) prior to the current illness, exa | | | vith or without a device such as |
| | C. | Stairs: Code the resident's need for assistance with into the current illness, exacerbation, or injury. | nternal or exte | rnal stairs (with or without a device suc | ch as cane, crutch, or walker) prior |
| | D. | Functional Cognition: Code the resident's need for a medication prior to the current illness, exacerbation, o | | n planning regular tasks, such as shop | oing or remembering to take |
| | | rior Device Use. Indicate devices and aids used by if A0310B = 01 | the resident p | rior to the current illness, exacerbation | ı, or injury |
| Check all t | hat a | pply | | | |
| | A. | Manual wheelchair | | | |
| | В. | Motorized wheelchair and/or scooter | | | |
| | C. | Mechanical lift | | | |
| | D. | Walker | | | |
| | E. | Orthotics/Prosthetics | | | |
| | Z. | None of the above | | | |
| GG0115 | 5. F | unctional Limitation in Range of Motion | | | |
| Code for | limit | ation that interfered with daily functions or placed resident | ent at risk of ir | ijury in the last 7 days | |
| | pair rmer | nent It on one side It on both sides | | | |
| Enter Code | es in | Boxes | | | |
| | A. | Upper extremity: (shoulder, elbow, wrist, hand) | | | |
| | В. | Lower extremity: (hip, knee, ankle, foot) | | | |
| | | | | | |

| Resident | | | Identifier | Date |
|--|---|--|--|---|
| Section G | G - I | Functional Abilitie | s and Goals - Admiss | ion |
| Complete column | 1 whe | (Assessment period is the first 3 da in A0310A = 01. Complete column tay begins on A2400B. When A031 | ays of the stay) ns 1 and 2 when A0310B = 01. 0B = 99, the stay begins on A1600. | |
| at the start of the | stay (a | al performance at the start of the admission), code the reason. Cod s permissible to code end of SNF | de the resident's end of SNF PPS stay | ng the 6-point scale. If activity was not attempted (discharge) goal(s) using the 6-point scale. Use of |
| amount of assistan Activities may be of the completes of the effort. O2. Substantia effort. O3. Partial/month effort. O4. Substantia effort. O5. Substantia effort. O6. Dependent required for the completes of the complete of the comp | nt - Re lean-up n or to activity. derate I/maxi t - Help the re attem efused able - Noted du | vided. ed with or without assistive devices sident completes the activity by the assistance - Helper sets up or clouching assistance - Helper provided througassistance - Helper does LESS Themal assistance - Helper does MOF er does ALL of the effort. Resident sident to complete the activity. pted, code reason: Not attempted and the resident did in the sident did in the | emself with no assistance from a helper. eans up; resident completes activity. Help des verbal cues and/or touching/steadyin ghout the activity or intermittently. HAN HALF the effort. Helper lifts, holds, or RE THAN HALF the effort. Helper lifts or does none of the effort to complete the a | per assists only prior to or following the activity. It illness, exacerbation, or injury. |
| 1. 2. Admission Dischar Performance Goal | | | | |
| Enter Codes in Boxes | | A. Eating: The ability to use suita meal is placed before the resid | | the mouth and swallow food and/or liquid once the |
| |] | | se suitable items to clean teeth. Dentures uth, and manage denture soaking and rin | (if applicable): The ability to insert and remove sing with use of equipment. |
| | <u> </u> | Toileting hygiene: The ability movement. If managing an oste | to maintain perineal hygiene, adjust cloth omy, include wiping the opening but not r | nes before and after voiding or having a bowel managing equipment. |
| | | E. Shower/bathe self: The ability Does not include transferring in | | , and drying self (excludes washing of back and hair). |
| | f | . Upper body dressing: The ab | oility to dress and undress above the wais | st; including fasteners, if applicable. |
| | | G. Lower body dressing: The ab | oility to dress and undress below the wais | st, including fasteners; does not include footwear. |
| | | Putting on/taking off footwea safe mobility; including fastene | ar: The ability to put on and take off socks | s and shoes or other footwear that is appropriate for |

| Resident | | | Ident | fier | Date |
|--|--|---|---|--|--|
| Sectio | n GG | · Fu | ınctional Abilities and Goal | s - Admission | |
| Complete | column 1 w | hen A | essment period is the first 3 days of the stay) .0310A = 01. Complete columns 1 and 2 when A03 begins on A2400B. When A0310B = 99, the stay beg | 110B = 01. ins on A1600. | |
| at the star | t of the stay | (adm | erformance at the start of the stay (admission) fo ission), code the reason. Code the resident's end ermissible to code end of SNF PPS stay (discharg | l of SNF PPS stay (discharge) goal(s) ι | If activity was not attempted using the 6-point scale. Use of |
| amount of a Activities m 06. Inde 05. Set 04. Sup com 03. Par the 02. Sub effo 01. Dep requ If activity v 07. Res 09. Not | assistance p nay be comp ependent - up or clean pervision or npletes activ tial/modera effort. ostantial/ma ort. pendent - He uired for the was not atte sident refus t applicable | rovide leted v Reside -up as toucl ity. Ass te ass eximal elper c reside empte ed - Not | with or without assistive devices. ent completes the activity by themself with no assista sistance - Helper sets up or cleans up; resident con ning assistance - Helper provides verbal cues and/o sistance may be provided throughout the activity or in sistance - Helper does LESS THAN HALF the effort. assistance - Helper does MORE THAN HALF the effort does ALL of the effort. Resident does none of the effort to complete the activity. d, code reason: attempted and the resident did not perform this activity | nce from a helper. npletes activity. Helper assists only prior to touching/steadying and/or contact guarantermittently. Helper lifts, holds, or supports trunk or linfort. Helper lifts or holds trunk or limbs a rt to complete the activity. Or, the assistaty prior to the current illness, exacerbatio | to or following the activity. d assistance as resident mbs, but provides less than half nd provides more than half the nce of 2 or more helpers is |
| 10. Not 88. Not | attempted attempted | due to | o environmental limitations (e.g., lack of equipmen o medical condition or safety concerns | t, weather constraints) | ., c. nja j. |
| 1. Admission Performance Enter Codes | 2. Discharge Goal in Boxes | | | | |
| | | A. | Roll left and right: The ability to roll from lying on b | ack to left and right side, and return to lyi | ng on back on the bed. |
| | | В. | Sit to lying: The ability to move from sitting on side | of bed to lying flat on the bed. | |
| | | C. | Lying to sitting on side of bed: The ability to move support. | from lying on the back to sitting on the s | ide of the bed and with no back |
| | | D. | Sit to stand: The ability to come to a standing posit | on from sitting in a chair, wheelchair, or c | on the side of the bed. |
| | | E. | Chair/bed-to-chair transfer: The ability to transfer | to and from a bed to a chair (or wheelcha | ir). |
| | | F. | Toilet transfer: The ability to get on and off a toilet | or commode. | |
| | | G. | Car transfer: The ability to transfer in and out of a codoor or fasten seat belt. | ar or van on the passenger side. Does no | ot include the ability to open/close |
| | | l. | Walk 10 feet: Once standing, the ability to walk at less coded 07, 09, 10, or $88 \rightarrow \text{Skip to GG0170M}$, 1 s | east 10 feet in a room, corridor, or similar tep (curb) | space. If admission performance |
| | | J. | Walk 50 feet with two turns: Once standing, the ab | ility to walk at least 50 feet and make two | o turns. |
| | | K. | Walk 150 feet: Once standing the ability to walk at | least 150 feet in a corridor or similar space | :e |

| Resident | Identifier | Date |
|---|---|---|
| Section GG - F | Functional Abilities and Goals - Admission | |
| Complete column 1 when | ssessment period is the first 3 days of the stay) 1 A0310A = 01. Complete columns 1 and 2 when A0310B = 01. ay begins on A2400B. When A0310B = 99, the stay begins on A1600. | |
| at the start of the stay (ad | Il performance at the start of the stay (admission) for each activity using the dmission), code the reason. Code the resident's end of SNF PPS stay (dischapermissible to code end of SNF PPS stay (discharge) goal(s). | |
| amount of assistance provid Activities may be completed 06. Independent - Resi 05. Setup or clean-up 04. Supervision or tou completes activity. A 03. Partial/moderate at the effort. 02. Substantial/maxim effort. 01. Dependent - Helper required for the residual for the residual form. Resident refused 09. Not applicable - Not attempted due 88. Not attempted due | and with or without assistive devices. Sident completes the activity by themself with no assistance from a helper. Assistance - Helper sets up or cleans up; resident completes activity. Helper assuching assistance - Helper provides verbal cues and/or touching/steadying and/or Assistance may be provided throughout the activity or intermittently. Assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or support assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds to the defort. Resident does none of the effort to complete the activity. Ident to complete the activity. | ists only prior to or following the activity. or contact guard assistance as resident orts trunk or limbs, but provides less than half runk or limbs and provides more than half the Or, the assistance of 2 or more helpers is |
| 1. 2. Admission Discharge Performance Goal Enter Codes in Boxes | Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven o turf or gravel. | r sloping surfaces (indoor or outdoor), such as |
| M. | I. 1 step (curb): The ability to go up and down a curb and/or up and down one s If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Pick | tep. ing up object |
| N. | . 4 steps: The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Pick | ing up object |
| O. | . 12 steps: The ability to go up and down 12 steps with or without a rail. | |
| P. | Picking up object: The ability to bend/stoop from a standing position to pick u the floor. | p a small object, such as a spoon, from |
| | Q1. Does the resident use a wheelchair and/or scooter? | |
| | No → Skip to GG0130, Self Care (Discharge) Yes → Continue to GG0170R, Wheel 50 feet with two turns | |
| R. | . Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability t | o wheel at least 50 feet and make two turns. |
| | RR1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized | |
| s. | | st 150 feet in a corridor or similar space. |
| | SS1. Indicate the type of wheelchair or scooter used. | |
| | 1. Manual 2. Motorized | |

| Resident | | Identifier Date | |
|--|--|--|-------------|
| Section | on (| GG - Functional Abilities and Goals - Discharge | |
| Complete When A03 For all oth Code the | colu 310G er Dis resid | telf-Care (Assessment period is the last 3 days of the stay) tumn 3 when A0310F = 10 or 11 or when A0310H = 1. To is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. This ischarge assessments, the stay ends on A2000. The dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the code the reason. | end |
| Coding | | oue the reason. | |
| Safety an amount of Activities (a) 06. Ind 05. See 04. Su co 03. Pa the 02. Su eff 01. De reco | d Quad assist and be dependently to the continuous cont | antial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half dent - 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 d for the resident to complete the activity. a not attempted, code reason: ent refused eplicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. | half the |
| 10. No 88. No | ot atte | tempted due to environmental limitations (e.g., lack of equipment, weather constraints) tempted due to medical condition or safety concerns | |
| 3. Discharge Performanc Enter Codes i | e in Box | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is pla | ced |
| | | before the resident. | |
| | B. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into a from the mouth, and manage denture soaking and rinsing with use of equipment. | and |
| | C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. | |
| | E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does no include transferring in/out of tub/shower. | ıt |
| | F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. | |
| | G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. | |
| | Н. | Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobi including fasteners, if applicable. | lity; |
| | | | |

| Section GG - Functional Abilities and Goals - Discharge | |
|---|---|
| CC0470 Mehility (Accomment period in the least 2 days of the atom) | |
| GG0170. Mobility (Assessment period is the last 3 days of the stay) Complete column 3 when A0310F = 10 or 11 or when A0310H = 1. When A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the For all other Discharge assessments, the stay ends on A2000. | ne stay ends on A2400C. |
| Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If a of the stay, code the reason. | n activity was not attempted at the en |
| Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe amount of assistance provided. Activities may be completed with or without assistive devices. 06. Independent - Resident completes the activity by themself with no assistance from a helper. 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists of the 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 the effort. 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk effort. 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, to 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, etc. 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) 88. Not attempted due to medical condition or safety concerns | only prior to or following the activity. Intact guard assistance as resident trunk or limbs, but provides less than hal or limbs and provides more than half the the assistance of 2 or more helpers is |
| 3. Discharge Performance | |
| Enter Codes in Boxes A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back to left and right side. | on back on the bed. |
| B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. | |
| C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side support. | of the bed and with no back |
| D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the | he side of the bed. |
| E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). | |
| F. Toilet transfer: The ability to get on and off a toilet or commode. | |
| G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not in door or fasten seat belt. | nclude the ability to open/close |
| Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar spains coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) | ace. If discharge performance |
| J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two tu | rns. |
| K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. | |

| esident | | _ Identifier | Date |
|--|---|---|---|
| Section | GG - Functional Abilities and G | Goals - Dischar | ge |
| When A0310G | Mobility (Assessment period is the last 3 days of the stay) lumn 3 when A0310F = 10 or 11 or when A0310H = 1. G is not = 2 and A0310H = 1 and A2400C minus A2400B is goischarge assessments, the stay ends on A2000. | greater than 2 and A2105 is | not = 04, the stay ends on A2400C. |
| | ident's usual performance at the end of the stay for each code the reason. | activity using the 6-point | scale. If an activity was not attempted at the end |
| amount of ass Activities may 06. Indepe 05. Setup 04. Supern comple 03. Partial the effo 02. Substa effort. 01. Depen require If activity was 07. Reside 09. Not ap 10. Not att | tantial/maximal assistance - Helper does MORE THAN HA | assistance from a helper. dent completes activity. Helpes and/or touching/steadying vity or intermittently. e effort. Helper lifts, holds, o LF the effort. Helper lifts or h the effort to complete the ac | er assists only prior to or following the activity. I and/or contact guard assistance as resident or supports trunk or limbs, but provides less than half the colds trunk or limbs and provides more than half the ctivity. Or, the assistance of 2 or more helpers is tillness, exacerbation, or injury. |
| 3. Discharge Performance Enter Codes in Box | | 10 feet on uneven or slopin | g surfaces (indoor or outdoor), such as turf or gravel. |
| M. | . 1 step (curb): The ability to go up and down a curb and/o If discharge performance is coded 07, 09, 10, or 88 → Sk | r up and down one step. ip to GG0170P, Picking up o | bject |
| N. | 4 steps: The ability to go up and down four steps with or v If discharge performance is coded 07, 09, 10, or $88 \rightarrow 8k$ | without a rail. ip to GG0170P, Picking up o | bject |
| 0. | . 12 steps: The ability to go up and down 12 steps with or w | without a rail. | |
| P. | Picking up object: The ability to bend/stoop from a stand | ling position to pick up a sma | all object, such as a spoon, from the floor. |
| | O2 Does the westdown was a subsalabely and/ay asset | | |
| | Q3. Does the resident use a wheelchair and/or scool 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet | | |
| R. | 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet | t with two turns | I at least 50 feet and make two turns. |
| R. | 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet | t with two turns | I at least 50 feet and make two turns. |
| R. | 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet Wheel 50 feet with two turns: Once seated in wheelchair RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized | t with two turns | |
| | 0. No → Skip to H0100, Appliances 1. Yes → Continue to GG0170R, Wheel 50 feet Wheel 50 feet with two turns: Once seated in wheelchair RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized | t with two turns r/scooter, the ability to whee ability to wheel at least 150 for | |

| Resident | Identifier Date |
|--------------|---|
| Section | on H - Bladder and Bowel |
| H0100. | Appliances |
| \downarrow | 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 | A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. No → Skip to H0300, Urinary Continence 1. Yes → Continue to H0200C, Current toileting program or trial 9. Unable to determine → Continue to H0200C, Current toileting program or trial |
| Enter Code | 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? No 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 |

| esident | | Identifier | Date |
|---------|--|--|---------|
| Sectio | n I - Active Diagnoses | | |
| | Indicate the resident's primary medical condition only if A0310B = 01 or 08 | category | |
| | Indicate the resident's primary medical condition category t | hat best describes the primary reason for ad | mission |
| | 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions 10020B. ICD Code | | |

| Active Diagnoses in the last 7 days - Chock all that apply Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists Cancer | Resident | | Identifier | Date |
|--|------------|--|--|------------------------------------|
| Deagnoses lisied in parentheses are provided as examples and should not be considered as all-inclusive lists Cancer 10100. Cancer (with or without metastasis) Heart/Circulation 10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell) 10400. Coronary Artery Disease (CAD) (e.g., angins, myocardial infarction, and atherosclerotic heart disease (ASHD)) 10600. Heart Failure (e.g., congesive heart failure (CHF) and pulmorary edema) 10700. Hyperfension 10800. Preipheral Vascular Diseases (PVD) or Peripheral Arterial Disease (PAD) 10800. Peripheral Vascular Diseases (PVD) or Peripheral Arterial Disease (PAD) 10800. Peripheral Vascular Disease, or Inflammatory Bowel Disease 10800. Preipheral Vascular Disease, or Inflammatory Bowel Disease 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 10800. Preumonia 10800. | Section | on I - Active Diagnoses | | |
| | | • | e considered as all-inclusive lists | |
| Heart/Circulation 10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell 10400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD)) 10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema) 10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema) 10800. Orthostatic Hypotension 10800. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) 10800. Orthostatic Hypotension 10800. Peripheral Vascular Disease, or Inflammatory Bowel Disease 11900. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 11500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 11500. Neurogenic Bladder 11600. Obstructive Uropathy 11600. Obstructive Uropathy 11600. Neurogenic Bladder 11600. Obstructive Uropathy 11600. Neurogenic Bladder 11600. Obstructive Uropathy 11700. Multidrug-Resistant Organism (MDRO) 12000. Pneumonia 12100. Septeemia 12200. Tuberculosis 12300. Urinary Tract Infection (UTI) (LAST 30 DAYS) 12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) 12300. Univary Tract Infection (Iter than foot) 12300. Univary Tract Infection (Iter than foot) 12300. Hyperkalemia | Cancer | | | |
| | | | | |
| | Heart/Circ | culation | | |
| | | 10400. Coronary Artery Disease (CAD) (e.g., angina, myocard 10600. Heart Failure (e.g., congestive heart failure (CHF) and p 10700. Hypertension 10800. Orthostatic Hypotension | ial infarction, and atherosclerotic heart disease (ulmonary edema) | (ASHD)) |
| I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) I1550. Neurogenic Bladder I1650. Obstructive Uropathy Infections I1650. Obstructive Uropathy Infections I1650. Obstructive Uropathy Infections I1700. Multidrug-Resistant Organism (MDRO) I2000. Pneumonia I2100. Septicemia I2200. Tuberculosis I2200. Tuberculosis I2200. Tuberculosis I2200. Tuberculosis I2200. Urinary Tract Infection (UTI) (LAST 30 DAYS) I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) I2500. Wound Infection (other than foot) I2500. Hyperkalemia I3300. Hyperhipidemia (e.g., hypercholesterolemia) I3100. Hyponatremia I3300. Hyperhipidemia (e.g., hypercholesterolemia) I3300. Hyperlipidemia (e.g., hypercholesterolemia) I3000. Hyperlipidemia (e.g., hypercholesterolemia) I4000. Other Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures of the trochanter and femoral neck) I4000. Other Fracture I4000. Other Ia000 I40000 I400000 I40000 I40000 I400000 I400000 I400000 I400000 I400000 I400000 I400000 | Gastroint | estinal | | |
| Cenitourinary 11500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) 11550. Neurogenic Bladder 11650. Obstructive Uropathy 11700. Multidrug-Resistant Organism (MDRO) 12000. Pneumonia 12100. Septicemia 12200. Tuberculosis 12200. Tuberculosis 12200. Tuberculosis 12200. Urinary Tract Infection (UTI) (LAST 30 DAYS) 12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) 12500. Wound Infection (other than foot) 12 | | I1300. Ulcerative Colitis. Crohn's Disease, or Inflammatory E | Bowel Disease | |
| I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) I1550. Neurogenic Bladder I1650. Neurogenic Bladder I1650. Neurogenic Bladder I1650. Neutrotive Uropathy I1650. Neurogenic Bladder I165 | | • | | |
| 1700. Multidrug-Resistant Organism (MDRO) 12000. Pneumonia 12100. Septicemia 12100. Septicemia 12100. Tuberculosis 12300. Urinary Tract Infection (UTI) (LAST 30 DAYS) 12400. Virial Hepatitis (e.g., Hepatitis A, B, C, D, and E) 12500. Wound Infection (other than foot) 13100. Hyponatremia 13200. Hyperlipidemia (e.g., hypercholesterolemia) 13300. Hyperlipidemia (e.g., hypercholesterolemia) 13300. Hyperlipidemia (e.g., hypercholesterolemia) 13300. Hyperlipidemia (e.g., hypercholesterolemia) 14000. Other 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) 14000. Other Fracture 14000. Other Fracture 14000. Alphasia 14000. Cerebral Palsy 14000. Alphasia 14000. Cerebral Palsy 14000. Non-Alzheimer's Disease 14000. Non-Alzheimer's Dementia (e.g., Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia suct as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) 14900. Hemiplegia or Hemiparesis 15000. Paralpegia 15000. Multiple Sclerosis (MS) 15200. Huntington's Disease 15300. Parkinson's Disease 15300. Pa | | I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal I1550. Neurogenic Bladder | I Disease (ESRD) | |
| 12000. Pneumonia 12100. Septicemia 12100. Septicemia 12200. Tuberculosis 12200. Urinary Tract Infection (UTI) (LAST 30 DAYS) 12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) 12500. Wound Infection (other than foot) 12500. Wound Infection (other than foot) 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) 13100. Hyponatremia 13200. Hyperkalemia 13200. Hyperkalemia 13200. Hyperkalemia 13200. Hyperlipidemia (e.g., hypercholesterolemia) 13900. 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) 14000. Other Fracture 14200. Alzheimer's Disease 14300. Aphasia 14400. Cerebral Palsy 14500. Mon-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia suct as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) 14900. Hemiplegia or Hemiparesis 15000. Paralinson's Disease 15100. Quadriplegia 15100. Quadriplegia 15100. Quadriplegia 15200. Multiple Sclerosis (MS) 15250. Huntington's Disease 15300. Parkinson's Disease 15300. Tourette's Syndrome | Infections | 3 | | |
| I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) I3100. Hyponatremia I3200. Hyperkalemia I3300. Hyperlipidemia (e.g., hypercholesterolemia) Musculoskeletal 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) I4000. Other Fracture I4200. Alzheimer's Disease I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, 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) I4900. Hemiplegia or Hemiparesis I5000. Paraplegia I5100. Quadriplegia I5100. Quadriplegia I5200. Multiple Sclerosis (MS) I5250. Huntington's Disease I5300. Parkinson's Disease I5350. Tourette's Syndrome | | I2000. Pneumonia I2100. Septicemia I2200. Tuberculosis I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E) | | |
| I3100. Hyponatremia I3200. Hyperkalemia I3200. Hyperlipidemia (e.g., hypercholesterolemia) Musculoskeletal I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures of the trochanter and femoral neck) I4000. Other Fracture I4000. Other Fracture I4200. Alzheimer's Disease I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebral Palsy I4500. Cerebravascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, 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) I4900. Hemiplegia or Hemiparesis I5000. Paraplegia I5100. Quadriplegia I5100. Multiple Sclerosis (MS) I5250. Huntington's Disease I5300. Parkinson's Disease I5300. Parkinson's Disease I5300. Parkinson's Disease I5300. Parkinson's Disease I5350. Tourette's Syndrome | Metabolio | ` | | |
| I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures of the trochanter and femoral neck) I4000. Other Fracture | | I3100. Hyponatremia I3200. Hyperkalemia | opathy, and neuropathy) | |
| the trochanter and femoral neck) I4000. Other Fracture | Musculos | skeletal | | |
| □ I4200. Alzheimer's Disease □ I4300. Aphasia □ I4400. Cerebral Palsy □ I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke □ I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, 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) □ I4900. Hemiplegia or Hemiparesis □ I5000. Paraplegia □ I5100. Quadriplegia □ I5200. Multiple Sclerosis (MS) □ I5250. Huntington's Disease □ I5300. Parkinson's Disease □ I5350. Tourette's Syndrome | | the trochanter and femoral neck) | current status, treatments, monitoring (e.g., sub- | capital fractures, and fractures o |
| I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, 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) I4900. Hemiplegia or Hemiparesis I5000. Paraplegia I5100. Quadriplegia I5200. Multiple Sclerosis (MS) I5250. Huntington's Disease I5300. Parkinson's Disease I5350. Tourette's Syndrome | Neurolog | ical | | |
| ☐ I5300. Parkinson's Disease ☐ I5350. Tourette's Syndrome | | 14200. Alzheimer's Disease 14300. Aphasia 14400. Cerebral Palsy 14500. Cerebrovascular Accident (CVA), Transient Ischemic Italian (e.g. Lewy body dementia, was Pick's disease; and dementia related to stroke, Parkinson's of 14900. Hemiplegia or Hemiparesis 15000. Paraplegia 15100. Quadriplegia 15200. Multiple Sclerosis (MS) | rascular or multi-infarct dementia; mixed dement | ia; frontotemporal dementia such |
| ☐ I5350. Tourette's Syndrome | | | | |
| | | | | |
| | Neurolog | • | | |

| esident | | Identifier | Date | | | | | |
|------------|---|---|----------------------|----------|--------|-------|------|--|
| Section | on I - Active Diagnoses | | | | | | | |
| | Diagnoses in the last 7 days - Check all that apply slisted in parentheses are provided as examples and should not b | e considered as all-inclusive lists | | | | | | |
| Neurolog | cal - Continued | | | | | | | |
| | I5400. Seizure Disorder or Epilepsy I5500. Traumatic Brain Injury (TBI) | | | | | | | |
| Nutritiona | I | | | | | | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | | | | | | |
| Psychiatr | ic/Mood Disorder | | | | | | | |
| | I5700. Anxiety Disorder I5800. Depression (other than bipolar) I5900. Bipolar Disorder I5950. Psychotic Disorder (other than schizophrenia) I6000. Schizophrenia (e.g., schizoaffective and schizophreniforr I6100. Post Traumatic Stress Disorder (PTSD) | n disorders) | | | | | | |
| Pulmonai | у | | | | | | | |
| | I6200. Asthma, Chronic Obstructive Pulmonary Disease (COI diseases such as asbestosis) I6300. Respiratory Failure | PD), or Chronic Lung Disease (e.g., chronic | bronchi | tis and | restri | ctive | lung | |
| Other | • • | | | | | | | |
| | 18000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the decin | nal for the code in the appropriate box. | | | | | | |
| | A | | \coprod | <u> </u> | | | | |
| | B | | Щ | | | | | |
| | C | | \coprod | | | | | |
| | D | <u>_</u> | Щ | <u> </u> | | | | |
| | E | | $\perp \!\!\! \perp$ | | | | | |
| | F | <u>_</u> | $\perp \!\!\! \perp$ | | | | | |
| | G | <u>_</u> | $\perp \!\!\! \perp$ | | | | | |
| | Н. | | $\perp \!\!\! \perp$ | | | | | |
| | I | | \coprod | | | | | |
| | J. | | \coprod | | | | | |

| Resident | Identifier Date | |
|------------|---|-----|
| Section | on J - Health Conditions | |
| | Pain Management - Complete for all residents, regardless of current pain level me in the last 5 days, has the resident: | |
| Enter Code | A. Received scheduled pain medication regimen? 0. No 1. Yes | |
| Enter Code | B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes | |
| Enter Code | C. Received non-medication intervention for pain? 0. No 1. Yes | |
| | Should Pain Assessment Interview be Conducted? to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea) | |
| Enter Code | No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain Yes → Continue to J0300, Pain Presence | |
| Pain A | 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 J0410, Pain Frequency 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain | |
| J0410. | Pain Frequency | |
| Enter Code | Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 9. Unable to answer | |
| J0510. | Pain Effect on Sleep | |
| Enter Code | Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | |
| J0520. | Pain Interference with Therapy Activities | |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pair 0. Does not apply - I have not received rehabilitation therapy in the past 5 days 1. Rarely or not at all 2. Occasionally 3. Frequently 4 Almost constantly | n?" |



8. Unable to answer

| esident | | Identifier | Date | |
|--------------------|--|--|---|---------|
| Section | on J - Health Conditions | | | |
| Pain <i>A</i> | Assessment Interview - Cor | ntinued | | |
| J0530. | Pain Interference with Day-to-Day Activ | rities | | |
| Enter Code | Ask resident: "Over the past 5 days, how often had because of pain?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | ve you limited your day-to-day activities | (<u>excluding</u> rehabilitation therapy session | ons) |
| J0600. | Pain Intensity - Administer ONLY ONE of | the following pain intensity question | ns (A or B) | |
| Enter Code | A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain ove can imagine." (Show resident 00 -10 pain scale Enter two-digit response. Enter 99 if unable B. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your contents of your contents." | e) e to answer. | | in you |
| | Mild Moderate Severe Very severe, horrible Unable to answer | | , | |
| J0700. | Should the Staff Assessment for Pain b | e Conducted? | | |
| Enter Code | No (J0410 = 1 thru 4) → Skip to J1100, S Yes (J0410 = 9) → Continue to J0800, Ir | | | |
| Staff As J0800. | ssessment for Pain Indicators of Pain or Possible Pain in the last 5 d | lays | | |
| \downarrow | Check all that apply | | | |
| | A. Non-verbal sounds (e.g., crying, whining, gas | sping, moaning, or groaning) | | |
| | B. Vocal complaints of pain (e.g., that hurts, ou | ich, stop) | | |
| | C. Facial expressions (e.g., grimaces, winces, v | wrinkled forehead, furrowed brow, clenched | teeth or jaw) | |
| | D. Protective body movements or postures (e during movement) | .g., bracing, guarding, rubbing or massaging | g a body part/area, clutching or holding a boo | dy part |
| | Z. None of these signs observed or document | ted → If checked, skip to J1100, Shortness | of Breath (dyspnea) | |
| J0850. | Frequency of Indicator of Pain or Possi | ible Pain in the last 5 days | | |
| Enter Code | Frequency with which resident complains or shows 1. Indicators of pain or possible pain observable. 2. Indicators of pain or possible pain observable. 3. Indicators of pain or possible pain observable. | rved 1 to 2 days rved 3 to 4 days | | |



| Resident | Identifier Date | |
|---------------------------|--|--|
| Section | on J - Health Conditions | |
| Other J1100. | Health Conditions Shortness of Breath (dyspnea) | |
| \downarrow | 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. No1. Yes | |
| J1550. | Problem Conditions | |
| \downarrow | Check all that apply | |
| | A. Fever | |
| | B. Vomiting | |
| | C. Dehydrated | |
| | D. Internal bleeding | |
| | Z. None of the above | |
| J1700. | Fall History on Admission/Entry or Reentry | |
| Complete on Enter Code | nly if A0310A = 01 or A0310E = 1 | |
| Litter Code | A. Did the resident have a fall any time in the last month prior to admission/entry or reentry? | |
| | 0. No 1. Yes | |
| Enter Code | 9. Unable to determine | |
| | B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? | |
| | 0. No 1. Yes | |
| Enter Code | 9. Unable to determine | |
| | C. Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry?0. No | |
| | 1. Yes | |
| | 9. Unable to determine | |
| 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? | |
| | No → Skip to J2000, Prior Surgery Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) | |

| esident | | | Identifier | | Date |
|---------------------------------|--------|---|----------------------------------|------------------------------|-----------------------------------|
| Section | n . | J - Health Conditions | | | |
| J1900. | Nun | ber of Falls Since Admission/Entry or Reentry or | Prior Assessment (OBRA or | Scheduled PPS), which | ever is more recent |
| Coding: 0. None 1. One 2. Two o | | re | | | |
| inter Code ↓ | s in I | Boxes | | | |
| | A. | No injury - no evidence of any injury is noted on phy by the resident; no change in the resident's behavior | | e or primary care clinician; | no complaints of pain or injury |
| | В. | Injury (except major) - skin tears, abrasions, lacera the resident to complain of pain | itions, superficial bruises, hem | atomas and sprains; or an | y fall-related injury that causes |
| | C. | Major injury - bone fractures, joint dislocations, clos | ed head injuries with altered c | onsciousness, subdural h | ematoma |
| J2000. | Prio | r Surgery - Complete only if A0310B = 01 | | | |
| Enter Code | Did | he resident have major surgery during the 100 days 0. No 1. Yes 8. Unknown | prior to admission? | | |
| J2100. | Rec | ent Surgery Requiring Active SNF Care - Complete | e only if A0310B = 01 or 08 | | |
| Enter Code | Did | he resident have a major surgical procedure during to the control of the control | he prior inpatient hospital stay | that requires active care of | during the SNF stay? |

Unknown

| esident | | Identifier | Date |
|--------------|--|---|--------------|
| Sectio | on J - Health Conditions | | |
| Surgical | I Procedures - Complete only if J2100 = 1 | | |
| \downarrow | Check all that apply | | |
| Major Join | nt Replacement | | |
| | J2300. Knee Replacement - partial or total J2310. Hip Replacement - partial or total J2320. Ankle Replacement - partial or total J2330. Shoulder Replacement - partial or total | | |
| Spinal Su | rgery | | |
| | J2400. Involving the spinal cord or major spinal nerves J2410. Involving fusion of spinal bones J2420. Involving lamina, discs, or facets J2499. Other major spinal surgery | | |
| Other Ortl | hopedic Surgery | | |
| | J2500. Repair fractures of the shoulder (including clavicle and J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle J2520. Repair but not replace joints J2530. Repair other bones (such as hand, foot, jaw) J2599. Other major orthopedic surgery | | |
| Neurologi | cal Surgery | | |
| | J2600. Involving the brain, surrounding tissue or blood vess J2610. Involving the peripheral or autonomic nervous system J2620. Insertion or removal of spinal or brain neurostimulate J2699. Other major neurological surgery | n - open or percutaneous | , |
| Cardiopul | monary Surgery | | |
| | J2700. Involving the heart or major blood vessels - open or polygon. Involving the respiratory system, including lungs, broducing. Other major cardiopulmonary surgery | • | r endoscopic |
| Genitouri | nary Surgery | | |
| | J2800. Involving genital systems (such as prostate, testes, ova J2810. Involving the kidneys, ureters, adrenal glands, or blace nephrostomies or urostomies) J2899. Other major genitourinary surgery | | removal of |
| Other Maj | or Surgery | | |
| | J2900. Involving tendons, ligaments, or muscles J2910. Involving the gastrointestinal tract or abdominal cont pancreas, or spleen - open or laparoscopic (including or J2920. Involving the endocrine organs (such as thyroid, parath | eation or removal of ostomies or percutaneous f | |
| | J2930. Involving the breast J2940. Repair of deep ulcers, internal brachytherapy, bone m J5000. Other major surgery not listed above | | |

| Resident _ | | | | Identifier | | D | ate | |
|------------------------------------|--|---|---|---|-------------------|--------------------|-----------------|----------------|
| Secti | on | K. | Swallowing/Nutritional St | tatus | | | | |
| | | | wing Disorder s of possible swallowing disorder | | | | | |
| ↓ ↓ | • | • | I that apply | | | | | |
| | A. | Los | s of liquids/solids from mouth when eating or c | | | | | |
| | B. | Hol | ding food in mouth/cheeks or residual food in n | nouth after meals | | | | |
| | C. | Co | ighing or choking during meals or when swallo | wing medications | | | | |
| | D. | Co | nplaints of difficulty or pain with swallowing | | | | | |
| □ K0200 | Z. | | ne of the above and Weight - While measuring, if the number is | X 1 - X 4 round down:) | ₹5 or greater ro | und un | | |
| Inches | | ·y··· | and Proight Willio Modouring, it the number is | 7X.1 X.4 Tourid down, 7 | tio or grouter re | ина ир | | |
| |] | A. | Height (in inches). Record most recent height me | asure since the most rec | cent admission/e | entry or reentry | | |
| Pounds | | B. | Weight (in pounds). Base weight on most recent practice (e.g., in a.m. after voiding, before meal, w | | measure weigh | it consistently, a | ccording to sta | ndard facility |
| K0300 | . We | eigh | Loss | | | | | |
| Enter Code | Los | s of | 5% or more in the last month or loss of 10% or | more in last 6 months | | | | |
| | | 0. 1. 2. | No or unknown Yes, on physician-prescribed weight-loss regimer Yes, not on physician-prescribed weight-loss reg | | | | | |
| K0310 | . We | eigh | | | | | | |
| Enter Code | Gai | n of | 5% or more in the last month or gain of 10% or | more in last 6 months | | | | |
| | | 0. | No or unknown | | | | | |
| | | 1. 2. | Yes , on physician-prescribed weight-gain regiment Yes , not on physician-prescribed weight-gain regiment | | | | | |
| K0520 | . Nu | triti | onal Approaches | | | | | |
| | | | wing nutritional approaches that apply | | | | | |
| 2. While Performance Only 3. While | essme le Not ormed check le a Re | nt pe a Re whi c colu eside | e NOT a resident of this facility and within the Ia mn 2 if resident entered (admission or reentry) IN 1 | e st 7 days THE LAST 7 DAYS. If res | sident last enter | ed 7 or more da | ys ago, leave c | olumn 2 blank. |
| 4. At D | ischa | rge | · | - | | | | |
| ASSE | essme | ii pe | iod is the last 3 days of the SNF PPS Stay ending | 011 A2400C | 1. | 2. | 3. | 4. |
| | | | | | On | While Not a | While a | At |
| | | | | | Admission | Resident | Resident | Discharge |
| | | | | | | ↓ Check all | that apply↓ | |
| A. Par | entera | al/IV | eeding | | | | | |
| B. Fee | ding | ube | e.g., nasogastric or abdominal (PEG)) | | | | | |
| C. Med | chanic d, thick | cally kened | altered diet - require change in texture of food or li liquids) | quids (e.g., pureed | | | | |
| D. The | erapeu | ıtic d | et (e.g., low salt, diabetic, low cholesterol) | | | | | |
| Z. Noi | ne of t | he a | oove | | | | | |

| Resident | Identifier | Date | |
|--------------------------|---|---------------------------------------|-------------------------|
| Section | on K - Swallowing/Nutritional Status | | |
| K0710. | Percent Intake by Artificial Route - Complete K0710 only if Column 2 a | nd/or Column 3 are checked for K0520A | and/or K0520B |
| 3. D | Thile a Resident erformed while a resident of this facility and within the last 7 days uring Entire 7 Days erformed during the entire last 7 days | 2. While a Resident | 3. During Entire 7 Days |
| A. Pro 1. 2. 3. | oportion of total calories the resident received through parenteral or tube fee 25% or less 26-50% 51% or more | ↓ Enter (| Codes |
| B. Av 1. 2. | erage fluid intake per day by IV or tube feeding 500 cc/day or less 501 cc/day or more | | |
| Section L0200. | on L - Oral/Dental Status | | |
| ↓ | Check all that apply | | |
| | | nable or lease) | |
| | Broken or loosely fitting full or partial denture (chipped, cracked, unclea) Mouth or facial pain, discomfort or difficulty with chewing | nable, of loose) | |
| Section | on M - Skin Conditions | | |
| | Report based on highest stage of existing ul | • | rst; |
| | do not "reverse" sta | ge | |
| M0100. | Determination of Pressure Ulcer/Injury Risk | | |
| \downarrow | Check all that apply | | |
| | A. Resident has a pressure ulcer/injury, 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/Injuries | | |
| Enter Code | Is this resident at risk of developing pressure ulcers/injuries? 0. No 1. Yes | | |
| M0210. | Unhealed Pressure Ulcers/Injuries | | |
| Enter Code | Does this resident have one or more unhealed pressure ulcers/injuries? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers | | |

Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

| Resident | | Identifier | Date |
|---------------|----|---|--|
| Section | on | n M - Skin Conditions | |
| M0300. | Cu | Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage | |
| Enter Number | A. | A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony previsible blanching; in dark skin tones only it may appear with persistent blue or purple hues | rominence. Darkly pigmented skin may not have a |
| | | 1. Number of Stage 1 pressure injuries | |
| Enter Number | В. | Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or p as an intact or open/ruptured blister | oink wound bed, without slough. May also present |
| Enter Number | | 1. Number of Stage 2 pressure ulcers - If $0 \rightarrow \text{Skip}$ to M0300C, Stage 3 | |
| Enter Number | | Number of these Stage 2 pressure ulcers that were present upon admission/entry time of admission/entry or reentry | ry or reentry - enter how many were noted at the |
| Enter Number | C. | Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or m does not obscure the depth of tissue loss. May include undermining and tunneling | nuscle is not exposed. Slough may be present but |
| | | 1. Number of Stage 3 pressure ulcers - If $0 \rightarrow$ Skip to M0300D, Stage 4 | |
| Enter Number | | Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry time of admission/entry or reentry | ry or reentry - enter how many were noted at the |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar bed. Often includes undermining and tunneling | may be present on some parts of the wound |
| | | 1. Number of Stage 4 pressure ulcers - If $0 \rightarrow Skip$ to M0300E, Unstageable - Non-remarks | movable dressing/device |
| Enter Number | | 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry time of admission/entry or reentry | ry or reentry - enter how many were noted at the |
| Enter Number | E. | E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-rem | movable dressing/device |
| Enter Number | | Number of unstageable pressure ulcers/injuries due to non-removable dressing. Slough and/or eschar | /device - If $0 \rightarrow \text{Skip}$ to M0300F, Unstageable - |
| | | Number of these unstageable pressure ulcers/injuries that were present upon active noted at the time of admission/entry or reentry | dmission/entry or reentry - enter how many |
| Fates Normber | F. | Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound | d bed by slough and/or eschar |
| Enter Number | | Number of unstageable pressure ulcers due to coverage of wound bed by sloug Unstageable - Deep tissue injury | In and/or eschar - If $0 \rightarrow \text{Skip}$ to M0300G, |
| Enter Number | | 2. Number of these unstageable pressure ulcers that were present upon admission at the time of admission/entry or reentry | n/entry or reentry - enter how many were noted |
| | G. | G. Unstageable - Deep tissue injury: | |
| Enter Number | | 1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 - Ulcers | → Skip to M1030, Number of Venous and Arterial |
| Enter Number | | 2. Number of these unstageable pressure injuries that were present upon admission at the time of admission/entry or reentry | on/entry or reentry - enter how many were noted |
| | | | |

| Resident | | Identifier Date | | | | |
|--------------|------|---|--|--|--|--|
| Section | n I | M - Skin Conditions | | | | |
| M1030. | Nui | Number of Venous and Arterial Ulcers | | | | |
| Enter Number | Ente | er the total number of venous and arterial ulcers present | | | | |
| M1040. | Oth | ner Ulcers, Wounds and Skin Problems | | | | |
| \downarrow | Che | ck all that apply | | | | |
| | F | oot Problems | | | | |
| | A. | Infection of the foot (e.g., cellulitis, purulent drainage) | | | | |
| | B. | Diabetic foot ulcer(s) | | | | |
| | C. | Other open lesion(s) on the foot | | | | |
| | 0 | ther Problems | | | | |
| | D. | Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) | | | | |
| | E. | Surgical wound(s) | | | | |
| | F. | Burn(s) (second or third degree) | | | | |
| | G. | Skin tear(s) | | | | |
| | Н. | Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) | | | | |
| | N | one of the Above | | | | |
| | Z. | None of the above were present | | | | |
| M1200. | Ski | n and Ulcer/Injury Treatments | | | | |
| \downarrow | Che | ck all that apply | | | | |
| | A. | Pressure reducing device for chair | | | | |
| | B. | Pressure reducing device for bed | | | | |
| | C. | Turning/repositioning program | | | | |
| | D. | Nutrition or hydration intervention to manage skin problems | | | | |
| | E. | Pressure ulcer/injury care | | | | |
| | F. | Surgical wound care | | | | |
| | G. | Application of nonsurgical dressings (with or without topical medications) other than to feet | | | | |
| | H. | Applications of ointments/medications other than to feet | | | | |
| | l. | Application of dressings to feet (with or without topical medications) | | | | |
| | Z. | None of the above were provided | | | | |

| esident _ | | ldentifier | Date | | | |
|----------------|--|---|------------------------|------------------------------|--|--|
| | | N - Medications | | | | |
| Enter Day | 1/6 | cord the number of days that injections of any type were received during the last 7 days or since as $10 \rightarrow 8$ skip to N0415, High-Risk Drug Classes: Use and Indication | admission/entry or re | entry if less than 7 | | |
| N035 | 0. Ins | ulin | | | | |
| Enter Day: | A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days | | | | | |
| N041 | 5. Hig | h-Risk Drug Classes: Use and Indication | | | | |
| 1. | or reen | f the resident is taking any medications by pharmacological classification, not how it is used, during the try if less than 7 days ion noted nn 1 is checked, check if there is an indication noted for all medications in the drug class | ne last 7 days or sind | e admission/entry | | |
| | | | Is taking | Indication noted that apply↓ | | |
| Α. | Antips | ychotic | | | | |
| | Antian | | | | | |
| C. | Antide | pressant | | | | |
| D. | Hypno | tic | | | | |
| | Antico | agulant (e.g., warfarin, heparin, or low-molecular weight heparin) | | | | |
| F. | | | Ш | | | |
| ••• | Antibio | | | | | |
| G. | Antibio Diureti | tic | _ | | | |
| G. | Antibio Diureti Opioid | otic c | | | | |
| G. H. I. | Antibio Diureti Opioid Antipla | otic C | | | | |
| G. H. I. | Antibio Diureti Opioid Antipla Hypog | etic c Itelet lycemic (including insulin) | | | | |
| G. H. I. | Antibio Diureti Opioid Antipla Hypog | otic C | | | | |

| esident | | Identifier | Date | | |
|------------|---|---|-------|--|--|
| Section | on N - Medications | | | | |
| N2001. | Drug Regimen Review - Complete only if AC |)310B = 01 | | | |
| Enter Code | Did a complete drug regimen review identify po | otential clinically significant medication is | sues? | | |
| | No - No issues found during review Yes - Issues found during review NA - Resident is not taking any medicati | ions | | | |
| N2003. | Medication Follow-up - Complete only if N2001 = 1 | | | | |
| Enter Code | Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues? | | | | |
| | 0. No 1. Yes | | | | |
| N2005. | Medication Intervention - Complete only if | A0310H = 1 | | | |
| Enter Code | Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission? | | | | |
| | 0. No 1. Yes | | | | |

NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

| Resident Identifie | er | Date | |
|--|-------------------------------|------------------------|--------------------|
| Section O - Special Treatments, Procedures | s, and Program | าร | |
| O0110. Special Treatments, Procedures, and Programs | | | |
| Check all of the following treatments, procedures, and programs that were performe | d | | |
| a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A24 b. While a Resident Performed while a resident of this facility and within the last 14 days | a. OOB On Admission | b. While a Resident | c. At Discharge |
| c. At Discharge | | Check all that apply | |
| Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | \downarrow | | \downarrow |
| Cancer Treatments | | | |
| A1. Chemotherapy | | | |
| A2. IV | | | |
| A3. Oral | | | |
| A10. Other | | | |
| B1. Radiation | | | |
| Respiratory Treatments | | | |
| C1. Oxygen therapy | | | |
| C2. Continuous | | | |
| C3. Intermittent | | | |
| C4. High-concentration | | | |
| D1. Suctioning | | | |
| D2. Scheduled | | | |
| D3. As needed | | | |
| E1. Tracheostomy care | | | |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | | | |
| G1. Non-invasive Mechanical Ventilator | | | |
| G2. BiPAP | | | |
| G3. CPAP | | | |
| Other | | | |
| H1. IV Medications | | | |
| H2. Vasoactive medications | | | |
| H3. Antibiotics | | | |
| H4. Anticoagulant | | | |
| H10. Other | | | |
| I1. Transfusions | | | |
| O0110 continued on next page | | | |
| | | | |

| Resident | | Identifier | | Date | |
|----------------------|---|--|------------------------|--------------------------|--------------------|
| Sect | ion | O - Special Treatments, Procedures, ar | nd Program | S | |
| O011 | 0. Sp | pecial Treatments, Procedures, and Programs - Continued | | | |
| Check | all of th | ne following treatments, procedures, and programs that were performed | | | |
| Ass b. W h | ile a R | esion ont period is days 1 through 3 of the SNF PPS Stay starting with A2400B esident I while a resident of this facility and within the last 14 days | a. On Admission | b. While a Resident | c. At Discharge |
| c. At | Discha | • | I | Check all that apply | ı |
| J1. Dia | lvsis | , , , | \ | ` | \ |
| | - | odialysis | | | |
| J3. | Perit | oneal dialysis | | | |
| K1. Ho | spice (| Care | | | |
| | | or quarantine for active infectious disease include standard body/fluid precautions) | | | |
| 01. IV | Access | • | | | |
| 02 | . Perip | heral | | | |
| O3 | . Midli | ne | | | |
| 04 | . Cent | ral (e.g., PICC, tunneled, port) | | | |
| None of | the Al | pove | | | |
| Z1. No | ne of t | he above | | | |
| O025 | 0. In | fluenza Vaccine - Refer to current version of RAI manual for current influ | enza vaccination seas | son and reporting period | |
| Enter Cod | A. Did the resident receive the influenza vaccine <i>in this facility</i> for this year's influenza vaccination season? 0. No → Skip to O0250C, If influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date influenza vaccine received | | | | |
| | B. | Date influenza vaccine received → Complete date and skip to O0300A, Month Day Month | Is the resident's Pneu | imococcal vaccination u | p to date? |
| | C. | If influenza vaccine not received, state reason: | | | |
| Enter Cod | е | Resident not in this facility during this year's influenza vaccination Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | season | | |
| O0300 | . Pr | neumococcal Vaccine | | | |
| Enter Cod | e A. | Is the resident's Pneumococcal vaccination up to date? | | | |
| | | 0. No \rightarrow Continue to O0300B, If Pneumococcal vaccine not received, s 1. Yes \rightarrow Skip to O0400, Therapies | tate reason | | |
| Enter Cod | В. | If Pneumococcal vaccine not received, state reason: | | | |
| ENTER COO | 5 | Not eligible - medical contraindication Offered and declined Not offered | | | |
| | | | | | |

| Resident | ldentifier | Date |
|---|---|---|
| Section O - | Special Treatments, Procedures, and Progran | ns |
| O0400. Therap Complete only when | | |
| | A. Speech-Language Pathology and Audiology Services | |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was aclast 7 days | Iministered to the resident individually in the |
| Enter Number of Minutes | 2. Concurrent minutes - record the total number of minutes this therapy was a with one other resident in the last 7 days | administered to the resident concurrently |
| Enter Number of Minutes | Group minutes - record the total number of minutes this therapy was admin residents in the last 7 days | istered to the resident as part of a group of |
| | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to 004 | 00A5, Therapy start date |
| Enter Number of Minutes | 3A. Co-treatment minutes - record the total number of minutes this therapy was sessions in the last 7 days | s administered to the resident in co-treatment |
| Enter Number of Days | 4. Days - record the number of days this therapy was administered for at leas | et 15 minutes a day in the last 7 days |
| | 5. Therapy start date - record the date the most recent therapy regimen (since | e the most recent entry) started |
| | Month Day Year | |
| | 6. Therapy end date - record the date the most recent therapy regimen (since therapy is ongoing | the most recent entry) ended - enter dashes it |
| | Month Day Year | |
| 5 · N · · · · · · · · · | B. Occupational Therapy | |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was aclast 7 days | Iministered to the resident individually in the |
| Enter Number of Minutes | Concurrent minutes - record the total number of minutes this therapy was a with one other resident in the last 7 days | administered to the resident concurrently |
| Enter Number of Minutes | Group minutes - record the total number of minutes this therapy was admin residents in the last 7 days | istered to the resident as part of a group of |
| | If the sum of individual, concurrent, and group minutes is zero, \rightarrow $skip$ to $O04$ | 00B5, Therapy start date |
| Enter Number of Minutes Enter Number of Days | 3A. Co-treatment minutes - record the total number of minutes this therapy was sessions in the last 7 days | s administered to the resident in co-treatment |
| Enter Number of Bays | 4. Days - record the number of days this therapy was administered for at leas | st 15 minutes a day in the last 7 days |
| | 5. Therapy start date - record the date the most recent therapy regimen (since | e the most recent entry) started |
| | Month Day Year | |
| | Therapy end date - record the date the most recent therapy regimen (since therapy is ongoing | the most recent entry) ended - enter dashes it |
| | Month Day Year | |
| O0400 continued | • | |

| Resident | Identifier Date |
|---------------------------------------|---|
| Section O - | Special Treatments, Procedures, and Programs |
| O0400. Therapide Complete only when A | |
| | C. Physical Therapy |
| Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days |
| Enter Number of Minutes | 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days |
| Enter Number of Minutes | 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, \rightarrow skip to O0400C5, Therapy start date |
| Enter Number of Minutes | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days |
| Enter Number of Days | 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 |
| | Month Day Year |
| | 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes in therapy is ongoing |
| | Month Day Year |
| | D. Respiratory Therapy |
| Enter Number of Days | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| | E. Psychological Therapy (by any licensed mental health professional) |
| Enter Number of Days | 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days |
| O0420. Distinct | alendar Days of Therapy |
| Complete only when A | 310B = 01 |
| 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 in the past 7 days. |
| | |

| Section O - | Spe | ecial Treatments, Procedures, and Programs |
|--|-----|---|
| O0425. Part A 1 Complete only if A03 | • | |
| E . N | Α. | Speech-Language Pathology and Audiology Services |
| Enter Number of Minutes 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) |
| Effet Number of Militales | | 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | If | the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy |
| Enter Number of Minutes | | 4. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Days | | 5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | В. | Occupational Therapy |
| Enter Number of Minutes | | 1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Minutes | | 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Minutes | | 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | If | the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy |
| Enter Number of Minutes | | 4. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Days | | 5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | C. | Physical Therapy |
| Enter Number of Minutes | | Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Minutes | | 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Minutes | | 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | If | the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy |
| Enter Number of Minutes | | Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Days | | 5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| | | |

| esident | | | dentifier | Date |
|------------------------|---------------------|--|---|---|
| Section | n | O - Special Treatments, Procedu | ires, and Programs | |
| O0430. | Dis | tinct Calendar Days of Part A Therapy | | |
| Complete | only | if A0310H = 1 | | |
| Enter Number | of Day | Record the number of calendar days that the resider Therapy, or Physical Therapy for at least 15 minutes (A2400B) | nt received Speech-Language Pathology and A since the start date of the resident's most rece | Audiology Services, Occupational nt Medicare Part A stay |
| O0500. | Res | storative Nursing Programs | | |
| Record the none or les | num s tha | ber of days each of the following restorative programs was pen 15 minutes daily) | erformed (for at least 15 minutes a day) in the l | ast 7 calendar days (enter 0 if |
| Number of Days | Tec | chnique | | |
| | Α. | Range of motion (passive) | | |
| | В. | Range of motion (active) | | |
| | C. | Splint or brace assistance | | |
| Number of Days | Tra | ining and Skill Practice In: | | |
| | D. | Bed mobility | | |
| | E. | Transfer | | |
| | F. | Walking | | |
| | G. | Dressing and/or grooming | | |
| | Н. | Eating and/or swallowing | | |
| | l. | Amputation/prostheses care | | |
| <u> </u> | J. | Communication | | |

| Resident | | lo | dentifier | Date |
|-------------------|----------------|--|---|---|
| Sec | tic | on P - Restraints and Alarms | | |
| P010 | 0. | Physical Restraints | | |
| Physic individ | cal re dual | estraints are any manual method or physical or mechanical device, r cannot remove easily which restricts freedom of movement or norma | material or equipme al access to one's b | nt attached or adjacent to the resident's body that the ody |
| 1. | No Us | ot used sed less than daily sed daily | | |
| Enter C | Code | es in Boxes | | |
| \downarrow | Use | d in Bed | | |
| | Α. | Bed rail | | |
| $\overline{}$ | | Trunk restraint | | - |
| | _ | Limb restraint | | |
| | D. | Other | | - |
| | Use | d in Chair or Out of Bed | | |
| | E. | Trunk restraint | | - |
| | F. | Limb restraint | | - |
| | G. | Chair prevents rising | | - |
| | Н. | Other | | |
| | | | | |
| | | | | |
| | | | | |
| Sec | tic | on Q - Participation in Assessment | and Goal S | Setting |
| Q011 | 0. | Participation in Assessment and Goal Setting | | |
| Identif | y all | active participants in the assessment process | | |
| \downarrow | | Check all that apply | | |



Other legally authorized representative

A.

B.

C.

D.

E.

Resident

Significant other

None of the above

Legal guardian

Family

| esident | | | Identifier | Date | | |
|------------|---------------------------|----------------------------|--|---|--|--|
| Section | n | Q - | Participation in Assessment and Goal Setting | | | |
| Q0310. | . Resident's Overall Goal | | | | | |
| Complete | only | if A03 | 10E = 1 | | | |
| Enter Code | Α. | 1. 2. 3. | dent's overall goal for discharge established during the assessment process Discharge to the community Remain in this facility Discharge to another facility/institution Unknown or uncertain | | | |
| Enter Code | B. | 1. 2. 3. 4. 5. | cate information source for Q0310A Resident Family Significant other Legal guardian Other legally authorized representative None of the above | | | |
| Q0400. | Dis | char | ge Plan | | | |
| Enter Code | Α. | 0. | tive discharge planning already occurring for the resident to return to the community? No Yes \to Skip to Q0610, Referral | | | |
| | | | nt's Documented Preference to Avoid Being Asked Question Q0500B 10A = 02, 06, or 99 | | | |
| Enter Code | Doe | 0. | ident's clinical record document a request that this question (Q0500B) be asked only on a compr No Yes \rightarrow Skip to Q0610, Referral | ehensive assessment? | | |
| Q0500. | Ret | | to Community | | | |
| Enter Code | B. | respo | the resident (or family or significant other or guardian or legally authorized representative only if reside and): "Do you want to talk to someone about the possibility of leaving this facility and returning to community?" No | ent is unable to understand or o live and receive services in | | |
| | | 1. | Yes Unknown or uncertain | | | |
| Enter Code | C. | 1. 2. 3. 4. | rate information source for Q0500B Resident Family Significant other Legal guardian Other legally authorized representative None of the above | | | |
| Q0550. | Res | sider | nt's Preference to Avoid Being Asked Question Q0500B | | | |
| Enter Code | A. | respo | s resident (or family or significant other or guardian or legally authorized representative only if resident ond) want to be asked about returning to the community on all assessments? (Rather than on comp. No - then document in resident's clinical record and ask again only on the next comprehensive assessing the comprehensive as a comprehensive assessing the comprehensive assessing the compr | orehensive assessments alone) | | |
| | | 1. 8. | Yes Information not available | | | |
| Enter Code | C. | 1. 2. 3. 4. 5. 9. | cate information source for Q0550A Resident Family Significant other Legal guardian Other legally authorized representative None of the above | | | |



| esident | Identifier _ | | Date |
|------------|--|--------------|------|
| Section | on Q - Participation in Assessment and | Goal Setting | |
| Q0610. | Referral | | |
| Enter Code | A. Has a referral been made to the Local Contact Agency (LCA)? 0. No 1. Yes | | |
| | Reason Referral to Local Contact Agency (LCA) Not Made only if Q0610 = 0 | , | |
| Enter Code | Indicate reason why referral to LCA was not made 1. LCA unknown 2. Referral previously made 3. Referral not wanted 4. Discharge date 3 or fewer months away 5. Discharge date more than 3 months away | | |

| Resident | | Identifier _ | | Date | |
|--------------------------|---|---|---|---------------------------------------|--|
| Section | n 2 | X - Correction Request | | | |
| Identific section, re | atio produ | Section X only if A0050 = 2 or 3 on of Record to be Modified/Inactivated - The following items duce the information EXACTLY as it appeared on the existing erroneous on is necessary to locate the existing record in the National MDS Database | record, even if the information is inco | ord that is in error. In this orrect. | |
| X0150. | Тур | rpe of Provider (A0200 on existing record to be modified/inactivated) | | | |
| Enter Code | Тур | rpe of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | | |
| X0200. | Nar | ame of Resident (A0500 on existing record to be modified/inactivated | i) | | |
| | | | | | |
| X0300. | Ger | ender (A0800 on existing record to be modified/inactivated) | | | |
| Enter Code | | 1. Male 2. Female | | | |
| X0400. | Birt | rth Date (A0900 on existing record to be modified/inactivated) | | | |
| X0500. | Month Day Year Social Security Number (A0600A on existing record to be modified/inactivated) | | | | |
| | | | | | |
| | | | | | |
| X0600. | Тур | rpe of Assessment (A0310 on existing record to be modified/inactive | ated) | | |
| Enter Code | A. | Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above | | | |
| Enter Code | B. | PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment | | | |
| | | PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | | | |
| | | | | | |
| Enter Code | F. | Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | | |
| Enter Code | Н. | Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | | |

| Resident | | Identifier Date | | | |
|--------------|--|--|--|--|--|
| Section | n | X - Correction Request | | | |
| X0700. | Date on existing record to be modified/inactivated - Complete one only | | | | |
| | A. | Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 | | | |
| | | | | | |
| | | Month Day Year | | | |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 | | | |
| | | Month Day Year | | | |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 | | | |
| | | Month Day Year | | | |
| Correcti | ion <i>i</i> | Attestation Section - Complete this section to explain and attest to the modification/inactivation request | | | |
| X0800. | Со | rrection Number | | | |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one | | | |
| X0900. | Rea | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | |
| \downarrow | Che | eck all that apply | | | |
| | A. | Transcription error | | | |
| | B. | Data entry error | | | |
| | C. | Software product error | | | |
| | D. | Item coding error | | | |
| | Z . | - | | | |
| | ۷. | If "Other" checked, please specify: | | | |
| X1050. | Rea | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | |
| \ | Che | eck 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: | | | |
| | | | | | |
| | В. | Attesting individual's last name: | | | |
| | ъ. | Attesting individual's last fiame. | | | |
| | | | | | |
| | C. | Attesting individual's title: | | | |
| | D. | Signature | | | |
| | | Attestation date | | | |
| | | | | | |
| | | Month Day Year | | | |

| Resident | Identifier | Date | | | |
|--|---------------------------------------|------|--|--|--|
| Section Z - Assessment Administration | Section Z - Assessment Administration | | | | |
| Z0100. Medicare Part A Billing | | | | | |
| A. Medicare Part A HIPPS code: | | | | | |
| | | | | | |
| B. Version code: | | | | | |
| | | | | | |
| Z0200. State Medicaid Billing (if required by the state) | | | | | |
| A. Case Mix group: | | | | | |
| | | | | | |
| B. Version code: | | | | | |
| | | | | | |
| | | | | | |
| Z0250. Alternate State Medicaid Billing (if required by th | e state) | | | | |
| A. Case Mix group: | | | | | |
| | | | | | |
| B. Version code: | | | | | |
| | | | | | |
| 70200 Incurence Billing | | | | | |
| Z0300. Insurance Billing | | | | | |
| A. Billing code: | | | | | |
| | | | | | |
| B. Billing version: | | | | | |
| | | | | | |
| | | | | | |

| civil, and/or administrative penalties for submitting f | alse information. I also certify that I am auth | • | this facility on its behalf. |
|---|---|-----------------------|------------------------------|
| Signature | Title | Sections | Date Section Completed |
| A. | | _ | |
| В. | | _ | |
| C. | | _ | |
| D. | | _ | |
| <u>E.</u> | | | |
| F. | | | _ |
| G. | | | _ |
| Н. | | | |
| l. | | | _ |
| J. | | | _ |
| К. | | | _ |
| L. 70500 0: | O wife in A | ort Consolistics | |
| Z0500. Signature of RN Assessment A. Signature: | Coordinator verifying Assessme | B. Date RN Assessment | Coordinator signed |
| | | assessment as comp | _ |
| | | Month Day | Year |

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Section Z - Assessment Administration

| Resident | 1.1 | D-1- |
|----------|------------|------|
| Resident | Identitier | Date |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

Interim Payment Assessment (IPA) Item Set

| Section | on A - Identification Information |
|------------|---|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): |
| | B. CMS Certification Number (CCN): |
| | |
| | C. State Provider Number: |
| | |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment |
| | PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment |
| | Not PPS Assessment 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

A0310 continued on next page

| Resident | Identifier | Date |
|--------------|--|--------------------|
| Section | on A - Identification Information | |
| A0310. | Type of Assessment - Continued | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | |
| A0410. | Unit Certification or Licensure Designation | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 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 | |
| A0000. | 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 | |
| A100E | Ethnicity | |
| | Hispanic, Latino/a, or Spanish origin? | |
| 7 | Check all that apply | |
| | A. No, not of Hispanic, Latino/a, or Spanish origin | |
| | B. Yes, Mexican, Mexican American, Chicano/a | |
| | C. Yes, Puerto Rican | |
| | D. Yes, Cuban | |
| | E. Yes, another Hispanic, Latino/a, or Spanish origin | |
| | X. Resident unable to respond | |
| | Y. Resident declines to respond | |
| | | |



| Resident | | Identifier Date | e |
|--------------------------|-----|--|---|
| Section | on | A - Identification Information | |
| A1010. What is yo | | | |
| \downarrow | Che | neck all that apply | |
| | A. | White | |
| | В. | Black or African American | |
| | C. | American Indian or Alaska Native | |
| | D. | Asian Indian | |
| | E. | Chinese | |
| | F. | Filipino | |
| | G. | Japanese | |
| | H. | Korean | |
| | I. | Vietnamese | |
| | J. | Other Asian | |
| | K. | Native Hawaiian | |
| | L. | Guamanian or Chamorro | |
| | M. | Samoan | |
| | N. | Other Pacific Islander | |
| | X. | Resident unable to respond | |
| | Y. | Resident declines to respond | |
| | Z. | None of the above | |
| A1110. | | anguage | |
| 5. 0. | | What is your preferred language? | |
| Enter Code | B. | Do you need or want an interpreter to communicate with a doctor or health care staff? 0. No 1. Yes 9. Unable to determine | |
| A1200. | Ма | arital Status | |
| Enter Code | | Never married Married Widowed Separated Divorced | |

| Resident | Identifier Date | | | | | |
|------------|--|--|--|--|--|--|
| Section | on A - Identification Information | | | | | |
| A1300. | Optional Resident Items | | | | | |
| | A. Medical record number: | | | | | |
| | | | | | | |
| | B. Room number: | | | | | |
| | | | | | | |
| | C. Name by which resident prefers to be addressed: | | | | | |
| | | | | | | |
| | D. Lifetime occupation(s) - put "/" between two occupations: | | | | | |
| | | | | | | |
| A2300. | Assessment Reference Date | | | | | |
| | Observation end date: | | | | | |
| | | | | | | |
| | Month Day Year | | | | | |
| A2400. | • | | | | | |
| 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 | y back poriod for all itoms is 7 days uploss another time frame is indicated | | | | | |
| LOOP | back period for all items is 7 days unless another time frame is indicated | | | | | |
| Section | on B - Hearing, Speech, and Vision | | | | | |
| B0100. | Comatose | | | | | |
| Enter Code | Persistent vegetative state/no discernible consciousness 0. No → Continue to B0700, Makes Self Understood | | | | | |
| B0700. | Yes → Skip to GG0130, Self-Care Makes Self Understood | | | | | |
| Enter Code | Ability to express ideas and wants, consider both verbal and non-verbal expression | | | | | |
| | O. Understood 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time Sometimes understood - ability is limited to making concrete requests Rarely/never understood | | | | | |

| Resident | | Identifier | Date |
|-------------|---|------------------------|--|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C020 conduct interview with all residents |)-C0500) be Conducted? | |
| Enter Code | No (resident is rarely/never understood) → Skip t Yes → Continue to C0200, Repetition of Three W | · | sment for Mental Status |
| Brief I | Interview for Mental Status (BIM | S) | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to remer The words are: sock, blue, and bed. Now tell me the three Number of words repeated after first attempt 0. None 1. One 2. Two | • | said all three. |
| | 3. Three After the resident's first attempt, repeat the words using cues the words up to two more times. | · | ed, a piece of furniture"). You may repeat |
| C0300. | Temporal Orientation (orientation to year, month, and o | lay) | |
| 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 cue (something to wear; a color; a piece of furniture) for that A. Able to recall "sock" O. No - could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required | | eat?" If unable to remember a word, give |
| 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 Enter 99 if the resident was unable to complete the interv | • | |



| Resident | | | Identifier | Date |
|------------|---|--|---|--|
| Section | on C - Cogı | nitive Patterns | | |
| C0600. | Should the Sta | ff Assessment for Mental | Status (C0700 - C1000) be C | onducted? |
| Enter Code | 0. No (resid | | nterview for Mental Status) → Skip to | D D0100, Should Resident Mood Interview be |
| | 1. Yes (res | ident was unable to complete Bri | ef Interview for Mental Status) $ ightarrow$ Co | entinue to C0700, Short-term Memory OK |
| Staff As | sessment for M | ental Status | | |
| Do not co | nduct if Brief Intervie | w for Mental Status (C0200-C050 | 00) was completed | |
| C0700. | Short-term Mer | nory OK | | |
| Enter Code | Seems or appears 0. Memory 1. Memory | | | |
| C1000. | Cognitive Skills | s for Daily Decision Makin | ng | |
| Enter Code | 0. Independ 1. Modified 2. Moderate | garding tasks of daily life dent - decisions consistent/reason independence - some difficulty ely impaired - decisions poor; cu- impaired - never/rarely made de | in new situations only es/supervision required | |

| esider | nt | Identifier | Date | |
|-----------------------|--|---|-------------------------|-------------------|
| Se | ction D - Mood | | | |
| D01 | 100. Should Resident Mood Interview be Conducted? | | | |
| Enter (| No (resident is rarely/never understood) → Skip to and Yes → Continue to D0150, Resident Mood Interview (| | ssment of Resident Moc | od (PHQ-9-OV) |
| D01 | 150. Resident Mood Interview (PHQ-2 to 9©) | | | |
| If sy If ye Rea | y to resident: "Over the last 2 weeks, have you been bo imptom is present, enter 1 (yes) in column 1, Symptom Presence. It is in column 1, then ask the resident: "About how often have you been at ad and show the resident a card with the symptom frequency choices. In Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank) | bothered by this?" | | |
| 2. | Symptom Frequency | | 1. | 2. |
| | 0. Never or 1 day1. 2-6 days (several days) | | Symptom Presence | Symptom Frequency |
| | 7-11 days (half or more of the days) 12-14 days (nearly every day) | | ↓ Enter Scores i | |
| | or in the state of | | — | |
| A. | Little interest or pleasure in doing things | | | |
| В. | Feeling down, depressed, or hopeless | | | |
| If bo | oth D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D015 | 0B2 are coded 0 or 1, END the PHO | Q interview; otherwise | , continue. |
| C. | Trouble falling or staying asleep, or sleeping too much | 'n | | |
| D. | Feeling tired or having little energy | | | |
| E. | Poor appetite or overeating | | | |
| F. | Feeling bad about yourself - or that you are a failure o family down | r have let yourself or your | | |
| G. | Trouble concentrating on things, such as reading the television | newspaper or watching | | |
| H. | Moving or speaking so slowly that other people could opposite - being so fidgety or restless that you have be more than usual | | | |
| l. | Thoughts that you would be better off dead, or of hurt | ing yourself in some way | | |
| | 160. Total Severity Score | | | |
| Enter | Add scores for all frequency responses in Column 2, Symptom Enter 99 if unable to complete interview (i.e., Symptom Frequence) | om Frequency. Total score must be be by is blank for 3 or more required item | tween 00 and 27. s). | |



| Section D - Mood | | |
|---|------------------|-----------|
| D0500. Staff Assessment of Resident Mood (PHQ-9-OV*) Do not conduct if Resident Mood Interview (D0150-D0160) was completed | | |
| Over the last 2 weeks, did the resident have any of the following problems or behavior of 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) | s? | |
| 2. Symptom Frequency | 1. | 2. |
| 0. Never or 1 day1. 2-6 days (several days) | Symptom | Symptom |
| 2. 7-11 days (several days) | Presence | Frequency |
| 3. 12-14 days (nearly every day) | ↓ Enter Scores | in Boxes↓ |
| A. Little interest or pleasure in doing things | | |
| B. Feeling or appearing down, depressed, or hopeless | | |
| C. Trouble falling or staying asleep, or sleeping too much | | |
| D. Feeling tired or having little energy | | |
| E. Poor appetite or overeating | | |
| F. Indicating that they feel bad about self, are a failure, or have let self or family down | | |
| G. Trouble concentrating on things, such as reading the newspaper or watching television | | |
| H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual | | |
| I. States that life isn't worth living, wishes for death, or attempts to harm self | | |
| J. Being short-tempered, easily annoyed | | |
| D0600. Total Severity Score | | |
| Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be be | tween 00 and 30. | |
| | | |

Identifier

Resident _

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| Resident | | Identifier | Date |
|---------------------------|--------------|--|---|
| Section | on | E - Behavior | |
| E0100. | Po | tential Indicators of Psychosis | |
| ↓ Cł | neck | all that apply | |
| | A. | Hallucinations (perceptual experiences in the absence of real external sensory stimuli) | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, contrary to reality) | |
| | Z. | None of the above | |
| Behavio | oral | Symptoms | |
| E0200. | Ве | havioral Symptom - Presence & Frequency | |
| Note pres | sence | e of symptoms and their frequency | |
| 1. Be 2. Be | havi havi | or not exhibited or of this type occurred 1 to 3 days or of this type occurred 4 to 6 days, but less than daily or of this type occurred daily | |
| Enter Code | Α. | Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabb | ing, abusing others sexually) |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, curs | sing at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scrarummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/ved disruptive sounds) | atching self, pacing, ocal symptoms like screaming, |
| E0800. | Re | jection of Care - Presence & Frequency | |
| Enter Code | goa | I the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discuss ident 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 | ssary to achieve the resident's ion or care planning with the |
| E0900. | Wa | andering - Presence & Frequency | |
| Enter Code | Has | the resident wandered? Behavior not exhibited Behavior of this type occurred 1 to 3 days Behavior of this type occurred 4 to 6 days, but less than daily Behavior of this type occurred daily | |

| esident | | Identifier | Date |
|--|--|--|---|
| Section | GG - Functional Abilitie | s and Goals - OBRA/Ir | nterim |
| Complete col | elf-Care (Assessment period is the ARD plus umn 5 when A0310A = 02 - 06 and A0310B = dent's usual performance for each activity of | 99 or when A0310B = 08. | s not attempted, code the reason. |
| Coding: Safety and Quamount of ass Activities may 06. Indepe 05. Setup 04. Super comple 03. Partial the effo 02. Substa effort. 01. Depen require If activity was 07. Reside 09. Not ap 10. Not att 88. Not att | pality of Performance - If helper assistance is istance provided. be completed with or without assistive devices. Indent - Resident completes the activity by the or clean-up assistance - Helper sets up or clearision or touching assistance - Helper provides activity. Assistance may be provided through moderate assistance - Helper does LESS Thort. Intential/maximal assistance - Helper does MOF dent - Helper does ALL of the effort. Resident of for the resident to complete the activity. | required because resident's performance maself with no assistance from a helper eans up; resident completes activity. Helpe les verbal cues and/or touching/steadying ghout the activity or intermittently. HAN HALF the effort. Helper lifts, holds, or RE THAN HALF the effort. Helper lifts or hold does none of the effort to complete the activity prior to the current end perform this activity prior to the current e.g., lack of equipment, weather constraints | is unsafe or of poor quality, score according to er assists only prior to or following the activity. and/or contact guard assistance as resident supports trunk or limbs, but provides less than half olds trunk or limbs and provides more than half the tivity. Or, the assistance of 2 or more helpers is illness, exacerbation, or injury |
| 5. OBRA/Interim Performance | | | |
| nter Codes in Box | | bring food and/or liquid to the mouth and | swallow food and/or liquid once the meal is placed |
| В. | Oral hygiene: The ability to use suitable item from the mouth, and manage denture soaking | ns to clean teeth. Dentures (if applicable): g and rinsing with use of equipment. | The ability to insert and remove dentures into and |
| C. | Toileting hygiene: The ability to maintain pe managing an ostomy, include wiping the open | | after voiding or having a bowel movement. If |

| esident | | Identifier Date |
|--|--|--|
| Section | on | GG - Functional Abilities and Goals - OBRA/Interim |
| | | bility (Assessment period is the ARD plus 2 previous calendar days) |
| Complet | e colu | mn 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08. |
| Code the | resid | lent's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason. |
| Coding | : | |
| Safety ar amount of Activities 06. In 05. So 04. So 05. So | nd Quarier and Quarier and Quarier and Quarier and artial/ | Initial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the lent - 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 for the resident to complete the activity. Inot attempted, code reason: Interfused Initializing the initialization of the effort to complete the activity. Or, the assistance of 2 or more helpers is a for the resident to complete the activity. Inot attempted, code reason: Interfused Initialization of the effort to complete the activity. Or, the assistance of 2 or more helpers is a for the resident to complete the activity. Or, the assistance of 2 or more helpers is a for the resident to complete the activity. Or, the assistance of 2 or more helpers is a for the resident to complete the activity. |
| 5. | | empted due to medical condition or safety concerns |
| OBRA/Inte | | |
| nter Codes | in Boxe | es s |
| | В. | Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| | C. | Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. |
| | D. | Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| | E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| | F. | Toilet transfer: The ability to get on and off a toilet or commode. |
| | l. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100, Appliances |
| | J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| | K. | Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
| | | |

| Resident | | lden | tifier | Date |
|--------------|--|---|--|---------------------------------|
| Section | n | H - Bladder and Bowel | | |
| H0100. | Ap | pliances | | |
| \downarrow | Che | eck all that apply | | |
| | C. | Ostomy (including urostomy, ileostomy, and colostomy) | | |
| | D. | Intermittent catheterization | | |
| | Z. | None of the above | | |
| H0200. | Uri | inary Toileting Program | | |
| Enter Code | C. | Current toileting program or trial - Is a toileting program (e.g., sused to manage the resident's urinary continence? 0. No 1. Yes | scheduled toileting, prompted voiding, or bl | adder training) currently being |
| H0500. | Bo | wel Toileting Program | | |
| Enter Code | ls a | a toileting program currently being used to manage the resider 0. No 1. Yes | it's bowel continence? | |
| | | | | |
| Section | n | I - Active Diagnoses | | |
| 10020. | Ind | dicate the resident's primary medical condition cate | gory | |
| Enter Code | 01. 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. | dicate the resident's primary medical condition cate mission Stroke Non-Traumatic Brain Dysfunction Traumatic Brain Dysfunction Non-Traumatic Spinal Cord Dysfunction Traumatic Spinal Cord Dysfunction Progressive Neurological Conditions Other Neurological Conditions Amputation Hip and Knee Replacement Fractures and Other Multiple Trauma Other Orthopedic Conditions Debility, Cardiorespiratory Conditions Medically Complex Conditions 20B. ICD Code | gory that best describes the prir | nary reason for |
| | \Box | | | |

| Resident | Identifier | | | L |)ate | | | |
|-----------|---|---------------------|----------|-------|-----------|--------|----------|--------|
| Secti | on I - Active Diagnoses | | | | | | | |
| | Diagnoses in the last 7 days - Check all that apply es listed in parentheses are provided as examples and should not be considered as all-included. | usive lists | | | | | | |
| Gastroir | itestinal | | | | | | | |
| | I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease | | | | | | | |
| Infection | ns en | | | | | | | |
| | I1700. Multidrug-Resistant Organism (MDRO) I2000. Pneumonia I2100. Septicemia I2500. Wound Infection (other than foot) | | | | | | | |
| Metaboli | ic | | | | | | | |
| | 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) |) | | | | | | |
| Neurolo | gical | | | | | | | |
| | I4300. Aphasia I4400. Cerebral Palsy I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke I4900. Hemiplegia or Hemiparesis I5100. Quadriplegia I5200. Multiple Sclerosis (MS) I5300. Parkinson's Disease I5500. Traumatic Brain Injury (TBI) | | | | | | | |
| Nutrition | nal | | | | | | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | | | | | | |
| Pulmona | ary | | | | | | | |
| | I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung I diseases such as asbestosis) I6300. Respiratory Failure | Disease (e.g | ., chron | c bro | nchitis a | nd res | strictiv | e lung |
| None of | | | | | | | | |
| | I7900. None of the above active diagnoses within the last 7 days | | | | | | | |
| Other | | | | | | | | |
| | I8000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the approximately approximately active diagnoses. | ppropriate bo | X. | _ | | | | |
| A | | | | | | | | |
| В | | | | | | | | |
| C | | | | | | | | |
| D | | | | | | | | |
| E | | | | | | | | |
| F | | | | | | | | |
| G | | | | | | | | |
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| l | | | | | | | | |
| | | | | | | 1 | П | |

| Resident | | ldentifier | Date |
|--------------|--|--|----------------------|
| Section | on J - Health Conditions | | |
| 045 11 | Landida O and Alexandra | | |
| | lealth Conditions Shortness of Breath (dyspnea) | | |
| 1 | Check all that apply | | |
| | C. Shortness of breath or trouble breathing when lying fla | at | |
| | Z. None of the above | | |
| J1550. | Problem Conditions | | |
| | Check all that apply | | |
| | A. Fever | | |
| | B. Vomiting | | |
| | Z. None of the above | | |
| J2100. | Recent Surgery Requiring Active SNF Care | | |
| Enter Code | Did the resident have a major surgical procedure during the p 0. No 1. Yes 8. Unknown | rior inpatient hospital stay that requires active care | during the SNF stay? |
| Surgica | I Procedures - Complete only if J2100 = 1 | | |
| \downarrow | Check all that apply | | |
| Major Joi | int Replacement | | |
| | J2300. Knee Replacement - partial or total J2310. Hip Replacement - partial or total J2320. Ankle Replacement - partial or total J2330. Shoulder Replacement - partial or total | | |
| Spinal Su | ırgery | | |
| | J2400. Involving the spinal cord or major spinal nerves J2410. Involving fusion of spinal bones J2420. Involving lamina, discs, or facets J2499. Other major spinal surgery | | |
| Other Ort | thopedic Surgery | | |
| | J2500. Repair fractures of the shoulder (including clavicle and J2510. Repair fractures of the pelvis, hip, leg, knee, or and J2520. Repair but not replace joints J2530. Repair other bones (such as hand, foot, jaw) J2599. Other major orthopedic surgery | · · · · · · · · · · · · · · · · · · · | |
| Neurolog | ical Surgery | | |
| | J2600. Involving the brain, surrounding tissue or blood v J2610. Involving the peripheral or autonomic nervous sys J2620. Insertion or removal of spinal or brain neurostimu J2699. Other major neurological surgery | stem - open or percutaneous | , |

| esident | | Identifier | | Date |
|--------------|--------------------------|---|---|------------|
| Section | n | n J - Health Conditions | | |
| Surgica | l Pr | Procedures - Continued | | |
| \downarrow | Che | Check all that apply | | |
| Cardiopu | lmor | nonary Surgery | | |
| | J27 | J2700. Involving the heart or major blood vessels - open or percutaneous produced J2710. Involving the respiratory system, including lungs, bronchi, trachea, I J2799. Other major cardiopulmonary surgery | | endoscopic |
| Genitour | nary | ary Surgery | | |
| | J28 | J2800. Involving genital systems (such as prostate, testes, ovaries, uterus, vag J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or la nephrostomies or urostomies) J2899. Other major genitourinary surgery | · , | removal of |
| Other Ma | jor S | or Surgery | | |
| | J29 J29 J29 J29 | J2900. Involving tendons, ligaments, or muscles J2910. Involving the gastrointestinal tract or abdominal contents from the e pancreas, or spleen - open or laparoscopic (including creation or remova J2920. Involving the endocrine organs (such as thyroid, parathyroid), neck, lyi J2930. Involving the breast J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem J5000. Other major surgery not listed above | l of ostomies or percutaneous fe nph nodes, or thymus - open | |
| | | n K - Swallowing/Nutritional Status Swallowing Disorder | | |
| | | symptoms of possible swallowing disorder | | |
| \downarrow | Che | Check all that apply | | |
| | A. | A. Loss of liquids/solids from mouth when eating or drinking | | |
| | В. | B. Holding food in mouth/cheeks or residual food in mouth after meals | | |
| | C. | C. Coughing or choking during meals or when swallowing medications | | |
| | D. | D. Complaints of difficulty or pain with swallowing | | |
| | Z. | Z. None of the above | | |
| K0300. | We | Weight Loss | | |
| Enter Code | Los | Loss of 5% or more in the last month or loss of 10% or more in last 6 month 0. No or unknown 1. Yes, on physician-prescribed weight-loss regimen 2. Yes, not on physician-prescribed weight-loss regimen | 3 | |

| Resident | : | Identifier | | Date | |
|-----------------------|---|--|----------------------|-------------------------|-------------------------------|
| Sec | tion K - Swallowing/Nutritional State | us | | | |
| K05 | 20. Nutritional Approaches k all of the following nutritional approaches that apply | | | | |
| 9 0 3. W | In the Not a Resident erformed while NOT a resident of this facility and within the last 7 inly check column 2 if resident entered (admission or reentry) IN THE In this a Resident erformed while a resident of this facility and within the last 7 days | AST 7 DAYS. If resident last entered 7 | or more o | days ago, leave | e column 2 blank |
| | | | | 2. | 3. |
| | | | ١ | While Not a Resident | While a Resident |
| | | | | ↓ Check | all that apply↓ |
| A . I | Parenteral/IV feeding | | | | |
| В. І | Feeding tube (e.g., nasogastric or abdominal (PEG)) | | | | |
| | Mechanically altered diet - require change in texture of food or liquids ood, thickened liquids) | s (e.g., pureed | | | |
| Z. I | None of the above | | | | |
| K07 | 10. Percent Intake by Artificial Route - Complete K0710 or | nly if Column 2 and/or Column 3 are ch | ecked for | K0520A and/or | K0520B |
| 2. 3. | While a Resident Performed while a resident of this facility and within the last 7 days During Entire 7 Days Performed during the entire last 7 days | S | 2. While Resid | - | 3. During Entire 7 Days |
| | | | \downarrow | Enter Code | es ↓ |
| A. | Proportion of total calories the resident received through paren 1. 25% or less 2. 26-50% 3. 51% or more | teral or tube feeding | |] | |
| В. | Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more | | |] | |
| | | | | | |

| Resident | Identifier | Date | | |
|--|------------|------|--|--|
| Section M - Skin Conditions | | | | |
| Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage | | | | |

| M0210. | Un | healed Pressure Ulcers/Injuries |
|--------------|-----|---|
| Enter Code | Do | es this resident have one or more unhealed pressure ulcers/injuries? |
| | | No → Skip to M1030, Number of Venous and Arterial Ulcers Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| M0300. | Cu | rrent Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| Enter Number | В. | Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister |
| | | 1. Number of Stage 2 pressure ulcers |
| Enter Number | C. | Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling |
| | | 1. Number of Stage 3 pressure ulcers |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling |
| | | 1. Number of Stage 4 pressure ulcers |
| Enter Number | 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 |
| M1030. | Nu | mber of Venous and Arterial Ulcers |
| Enter Number | En | ter the total number of venous and arterial ulcers present |
| M1040. | Ot | her Ulcers, Wounds and Skin Problems |
| \downarrow | Ch | eck all that apply |
| | Fo | ot Problems |
| | A. | Infection of the foot (e.g., cellulitis, purulent drainage) |
| | В. | Diabetic foot ulcer(s) |
| | C. | Other open lesion(s) on the foot |
| | Otl | ner Problems |
| | D. | Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) |
| | E. | Surgical wound(s) |
| | F. | Burn(s) (second or third degree) |
| | No | ne of the Above |
| | Z. | None of the above were present |

| Resident | | Identifier Date |
|----------|-----|---|
| Section | on | M - Skin Conditions |
| M1200. | Sk | in and Ulcer/Injury Treatments |
| | Che | eck all that apply |
| | A. | Pressure reducing device for chair |
| | В. | Pressure reducing device for bed |
| | C. | Turning/repositioning program |
| | D. | Nutrition or hydration intervention to manage skin problems |
| | E. | Pressure ulcer/injury care |
| | F. | Surgical wound care |
| | G. | Application of nonsurgical dressings (with or without topical medications) other than to feet |
| | Н. | Applications of ointments/medications other than to feet |
| | I. | Application of dressings to feet (with or without topical medications) |
| | Z. | None of the above were provided |
| | | |

N0350. Insulin Enter Days A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or

B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days

Section N - Medications

reentry if less than 7 days

| Resident | Identifier | Date |
|---|--|-----------------------------------|
| Section O - Special Treatments, Proced | ures, and Programs | |
| O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were p | erformed | |
| While a Resident Performed while a resident of this facility and within the last 14 days | | b. While a Resident |
| | | Check all that apply \downarrow |
| Cancer Treatments | | |
| A1. Chemotherapy | | |
| B1. Radiation | | |
| Respiratory Treatments | | |
| C1. Oxygen therapy | | |
| D1. Suctioning | | |
| E1. Tracheostomy care | | |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | | |
| Other | | |
| H1. IV Medications | | |
| I1. Transfusions | | |
| J1. Dialysis | | |
| M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | |
| None of the Above | | |
| Z1. None of the above | | |
| O0400. Therapies | | |
| D. Respiratory Therapy | | |
| 2. Days - record the number of days this the | erapy was administered for at least 15 minutes | a day in the last 7 days |
| | | |

| Resident | Identifier Date | |
|----------------|--|----------------------|
| Section | tion O - Special Treatments, Procedures, and Programs | |
| O0500. | 00. Restorative Nursing Programs | |
| Record the | the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 caler r less than 15 minutes daily) | dar days (enter 0 if |
| Number of Days | Technique | |
| | A. Range of motion (passive) | |
| | B. Range of motion (active) | |
| | C. Splint or brace assistance | |
| Number of Days | Training and Skill Practice In: | |
| | D. Bed mobility | |
| | E. Transfer | |
| | F. Walking | |
| | G. Dressing and/or grooming | |
| | H. Eating and/or swallowing | |
| | I. Amputation/prostheses care | |
| | J. Communication | |
| | | |

| Resident | | Ide | entifier | Date |
|--------------------------|------------------------|---|---|------|
| Section | on) | X - Correction Request | | |
| Identific section, re | catio eprodu | rection X only if A0050 = 2 or 3 on of Record to be Modified/Inactivated - The followin uce the information EXACTLY as it appeared on the existing erro n is necessary to locate the existing record in the National MDS I | neous record, even if the information is inco | |
| X0150. | Тур | De of Provider (A0200 on existing record to be modified/inaction | ivated) | |
| Enter Code | Тур | pe of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | | me of Resident (A0500 on existing record to be modified/inac | ctivated) | |
| | | | | |
| | C. | Last name: | | |
| X0300. | Gen | nder (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | | 1. Male 2. Female | | |
| X0400. | Birt | th Date (A0900 on existing record to be modified/inactivated) | | |
| | | Month Day Year | | |
| X0500. | Soc | cial Security Number (A0600A on existing record to be more | dified/inactivated) | |
| | | | | |
| X0600. | Тур | pe of Assessment (A0310 on existing record to be modified/ | inactivated) | |
| Enter Code | | Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above | nent | |
| Enter Code | B. | PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | | |
| Enter Code | | Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record | | |

| Resident | | | Identifier | Date |
|--------------|-------|---|---|----------|
| Section | n) | X - Correction Request | | |
| X0700. | Date | e on existing record to be modified/inactivated | | |
| | A. | Assessment Reference Date (A2300 on existing record to Month Day Year | be modified/inactivated) - Complete only if X06 | 00B = 08 |
| Correct | ion A | Attestation Section - Complete this section to explain ar | nd attest to the modification/inactivation reques | t |
| X0800. | Cor | rection Number | | |
| Enter Number | Ente | er the number of correction requests to modify/inactivate | the existing record, including the present of | ne |
| X0900. | Rea | sons for Modification - Complete only if Type of Reco | rd is to modify a record in error (A0050 = 2) | |
| \downarrow | Chec | ck all that apply | | |
| | A. | Transcription error | | |
| | В. | Data entry error | | |
| | C. | Software product error | | |
| | D. | Item coding error | | |
| | | Other error requiring modification If "Other" checked, please specify: | | |

| Resident | | Identifier | Date |
|--------------|------------|---|------|
| Section | n | X - Correction Request | |
| X1050. | Re | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | |
| \downarrow | Che | eck 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: | |
| | В. | Attesting individual's last name: | |
| | C. | Attesting individual's title: | |
| | D. | Signature | |
| | E. | Attestation date Month Day Year | |
| | | | |
| Section | n | Z - Assessment Administration | |
| Z0100. I | Vled | icare Part A Billing | |
| | A . | | |
| | B. | Version code: | |

| I certify that the accompanying information accurately refle of this information on the dates specified. To the best of my requirements. I understand that this information is used as from federal funds. I further understand that payment of su conditioned on the accuracy and truthfulness of this inform civil, and/or administrative penalties for submitting false inf | y knowledge, this information was colle a basis for ensuring that residents rece ich federal funds and continued particip lation, and that I may be personally sub | cted in accordance with applicable Neive appropriate and quality care, are ation in the government-funded heaplect to or may subject my organization. | Medicare and Medicaid as a basis for payment lth care programs is on to substantial criminal, |
|--|---|---|---|
| Signature | Title | Sections | Date Section Completed |
| A. | | | |
| В. | | | |
| C. | | | |
| D. | | | |
| E | | | |
| F | | | |
| G. | | | |
| н. | | | |
| I. | | | |
| J. | | | |
| К. | | | |
| L. | | | |
| Z0500. Signature of RN Assessment Coor | dinator Verifying Assessment | Completion | |
| A. Signature: | | B. Date RN Assessment Co | |
| | | assessment as complet | e: |
| | | | |
| | | Month Day | Year |
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Section Z - Assessment Administration

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

| Resident | 1.1 | D-1- |
|----------|------------|------|
| Resident | Identitier | Date |
| | | |

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Swing Bed PPS (SP) Item Set

| Section | on A - Identification Information |
|------------|---|
| A0050. | Type of Record |
| Enter Code | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Facility Provider Numbers |
| | A. National Provider Identifier (NPI): B. CMS Certification Number (CCN): C. State Provider Number: |
| A0200. | Type of Provider |
| Enter Code | Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Type of Assessment |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? No Yes |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above |

A0310 continued on next page

| Resident | Identifi | er | Date |
|------------|---|--|--------------------------|
| Section | on A - Identification Information | | |
| A0310. | Type of Assessment - Continued | | |
| Enter Code | Type of discharge - Complete only if A0310F = 10 or 11 Planned Unplanned | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment?0. No1. Yes | | |
| A0410. | Unit Certification or Licensure Designation | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS d Unit is neither Medicare nor Medicaid certified but MDS da Unit is Medicare and/or Medicaid certified | ata is not required by the State ata is required by the State | |
| A0500. | Legal Name of Resident | | |
| | A. First name: C. Last name: | В. D. | Middle initial: Suffix: |
| A0600. | Social Security and Medicare Numbers | | |
| | A. Social Security Number: | | |
| | | | |
| | B. Medicare number: | | |
| | | | |
| A0700. | Medicaid Number - Enter "+" if pending, "N" if not a Medica | aid recipient | |
| | | | |
| A0800. | Gender | | |
| Enter Code | 1. Male 2. Female | | |
| A0900. | Birth Date | | |
| | Month Day Year | | |

| Resident | | Identifier Date |
|------------|--------|---|
| Section | on. | A - Identification Information |
| A1005. | Eth | nnicity |
| Are you o | f Hisp | panic, Latino/a, or Spanish origin? |
| \ | Che | eck all that apply |
| | A. | No, not of Hispanic, Latino/a, or Spanish origin |
| | В. | Yes, Mexican, Mexican American, Chicano/a |
| | C. | Yes, Puerto Rican |
| | D. | Yes, Cuban |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| A1010. | | |
| What is ye | our ra | ice? |
| | Che | eck all that apply |
| | A. | White |
| | В. | Black or African American |
| | C. | American Indian or Alaska Native |
| | D. | Asian Indian |
| | E. | Chinese |
| | F. | Filipino |
| | G. | Japanese |
| | H. | Korean |
| | l. | Vietnamese |
| | J. | Other Asian |
| | K. | Native Hawaiian |
| | L. | Guamanian or Chamorro |
| | M. | Samoan |
| | N. | Other Pacific Islander |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| | Z. | None of the above |
| A1110. | Lar | nguage |
| | A. | What is your preferred language? |
| | | |
| Enter Code | В. | Do you need or want an interpreter to communicate with a doctor or health care staff? |
| Ш | | 0. No 1. Yes |
| | | 9. Unable to determine |



| Resident | | Identifier Date |
|-------------------|----------|--|
| Section | n A | A - Identification Information |
| A1200. | Mar | ital Status |
| Enter Code | | Never married Married Widowed Separated Divorced |
| A1250. | Trar | nsportation (from NACHC©) |
| Has lack o | of trans | sportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? |
| \downarrow | Chec | ck all that apply |
| | A. | Yes, it has kept me from medical appointments or from getting my medications |
| | B. | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| | C. | No |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| and its resour | ces are | sociation of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute art or whole without written consent from NACHC. |
| A1300. | Opt | ional Resident Items |
| | A. | Medical record number: |
| | В. | Room number: |
| | C. | Name by which resident prefers to be addressed: |
| | | |
| | D. | Lifetime occupation(s) - put "/" between two occupations: |
| | | |
| Most Re A1600. | | Admission/Entry or Reentry into this Facility ry Date |
| | | Month Day Year |
| A1700. | Тур | e of Entry |
| Enter Code | | 1. Admission |



| Resident | | Identifier | Date | |
|---|--|---|----------------------------------|--|
| Section A - Identification Information | | | | |
| A1805. | Entered From | | | |
| Enter Code | O1. Home/Community (e.g., private home/apt., board/care residential care arrangements) O2. Nursing Home (long-term care facility) O3. Skilled Nursing Facility (SNF, swing beds) O4. Short-Term General Hospital (acute hospital, IPPS) O5. Long-Term Care Hospital (LTCH) O6. Inpatient Rehabilitation Facility (IRF, free standing Inpatient Psychiatric Facility (psychiatric hospital of Intermediate Care Facility (ID/DD facility) O9. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health see 99. Not listed | facility or unit) r unit) ervice organization | other | |
| A1900. | Admission Date (Date this episode of care in this | facility began) | | |
| | Month Day Year | | | |
| | Discharge Date | | | |
| Complete | only if A0310F = 10, 11, or 12 | | | |
| | Month Day Year | | | |
| | Discharge Status | | | |
| Complete | only if A0310F = 10, 11, or 12 | | | |
| Enter Code | 01. Home/Community (e.g., private home/apt., board/care arrangements) → Skip to A2123, Provision of Current Reco 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing Inpatient Psychiatric Facility (psychiatric hospital or Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health set 13. Deceased 99. Not listed → Skip to A2123, Provision of Current Recond | nciled Medication List to Resident at Discharge facility or unit) unit) ervice organization | other residential care | |
| A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge Complete only if A0310H = 1 and A2105 = 02-12 | | | | |
| Enter Code | At the time of discharge to another provider, did your facility provider | de the resident's current reconciled medication | list to the subsequent provider? | |
| | No - Current reconciled medication list not provided to Yes - Current reconciled medication list provided to the | | essment Reference Date | |
| | | | | |

| Resident | | Identifier Date |
|--------------------|-------|---|
| Section | n A | A - Identification Information |
| Indicate th | e rou | ute of Current Reconciled Medication List Transmission to Subsequent Provider tte(s) of transmission of the current reconciled medication list to the subsequent provider. |
| ↓ | Che | ck all that apply Route of Transmission |
| | A. | Electronic Health Record |
| | В. | Health Information Exchange |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | E. | Other methods (e.g., texting, email, CDs) |
| A2123. Complete | | ovision of Current Reconciled Medication List to Resident at Discharge if A0310H = 1 and A2105 = 01, 99 |
| Enter Code | At th | ne time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver? 1. No - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2300, Assessment Reference Date 1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver |
| Indicate th | e rou | ute of Current Reconciled Medication List Transmission to Resident te(s) of transmission of the current reconciled medication list to the resident/family/caregiver. if A2123 = 1 |
| ↓ Ch | eck a | all that apply |
| | | Route of Transmission |
| | A. | Electronic Health Record (e.g., electronic access to patient portal) |
| | B. | Health Information Exchange |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) |
| | D. | Paper-based (e.g., fax, copies, printouts) |
| | E. | Other methods (e.g., texting, email, CDs) |
| A2300. | Ass | sessment Reference Date |
| | Ob | servation end date: Month Day Year |
| A2400. | Ме | dicare Stay |
| Enter Code | Α. | Has the resident had a Medicare-covered stay since the most recent entry? No → Skip to B0100, Comatose Yes → Continue to A2400B, Start date of most recent Medicare stay |
| | B. | Start date of most recent Medicare stay: |
| | C. | End date of most recent Medicare stay - Enter dashes if stay is ongoing: Month |

| esident | Identifier Date | | | | |
|---|---|--|--|--|--|
| Look | back period for all items is 7 days unless another time frame is indicated | | | | |
| Section B - Hearing, Speech, and Vision | | | | | |
| B0100. | Comatose | | | | |
| Enter Code | Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to GG0100, Prior Functioning: Everyday Activities | | | | |
| B0200. | Hearing | | | | |
| Enter Code | Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly 3. Highly impaired - absence of useful hearing | | | | |
| B0300. | Hearing Aid | | | | |
| Enter Code | Hearing aid or other hearing appliance used in completing B0200, Hearing 0. No 1. Yes | | | | |
| B0600. | Speech Clarity | | | | |
| Enter Code | Select best description of speech pattern 0. Clear speech - distinct intelligible words 1. Unclear speech - slurred or mumbled words 2. No speech - absence of spoken words | | | | |
| B0700. | Makes Self Understood | | | | |
| Enter Code | Ability to express ideas and wants, consider both verbal and non-verbal expression 0. Understood 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/never understood | | | | |
| B0800. | Ability To Understand Others | | | | |
| Enter Code | Understanding verbal content, however able (with hearing aid or device if used) 0. Understands - clear comprehension 1. Usually understands - misses some part/intent of message but comprehends most conversation 2. Sometimes understands - responds adequately to simple, direct communication only 3. Rarely/never understands | | | | |
| B1000. | | | | | |
| Enter Code | Ability to see in adequate light (with glasses or other visual appliances) 0. Adequate - sees fine detail, such as regular print in newspapers/books 1. Impaired - sees large print, but not regular print in newspapers/books 2. Moderately impaired - limited vision; not able to see newspaper headlines but can identify objects 3. Highly impaired - object identification in question, but eyes appear to follow objects 4. Severely impaired - no vision or sees only light, colors or shapes; eyes do not appear to follow objects | | | | |

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision 0. No 1. Yes

B1200. Corrective Lenses

Enter Code

| Resident | | ldentifier | Date |
|------------|---|--|--|
| Section | on B - Hearing, Speech | , and Vision | |
| | Health Literacy e only if A0310B = 01 or A0310G = 1 and A0 | 310H = 1 | |
| Enter Code | How often do you need to have someone pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to resident unable to response | nelp you when you read instructions, pamphlets, or pond pond | other written material from your doctor or |

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| Resident | | | | Identifier | | Date |
|-----------|--------------|---|---|-----------------------------|--------------------------------|----------------------------------|
| Sec | tion (| C - Cognitive | Patterns | | | |
| | | uld Brief Interview uct interview with all resi | for Mental Status (C0: | 200-C0500) be Condu | cted? | |
| Enter Co | 1 | | ely/never understood) → Sk o C0200, Repetition of Three | | 21000, Staff Assessment for | Mental Status |
| Brie | ef Inte | rview for Me | ntal Status (Bl | MS) | | |
| C020 | 00. Rep | etition of Three Wo | ords | | | |
| Enter Co | The Num | | ay three words for you to rer and bed. Now tell me the th after first attempt | • | words after I have said all th | ree. |
| | | the resident's first attem ords up to two more tim | | ues ("sock, something to we | ar; blue, a color; bed, a piec | e of furniture"). You may repeat |
| C030 | | · | orientation to year, month, ar | nd day) | | |
| Enter Co | de A. | esident: "Please tell me Able to report corr 0. Missed by > 5 yea 1. Missed by 2-5 yea 2. Missed by 1 year 3. Correct | rs or no answer | | | |
| Enter Co | B. | Able to report corr 0. Missed by > 1 mod 1. Missed by 6 days 2. Accurate within 5 | ect month nth or no answer to 1 month | | | |
| Enter Co | de C. | esident: "What day of th Able to report corr 0. Incorrect or no and 1. Correct | ect day of the week | | | |
| C040 | 00. Rec | all | | | | |
| Enter Co | If una | able to remember a word Able to recall "soc 0. No - could not reca | ll "something to wear") | | | |
| Enter Co | | Able to recall "blue 0. No - could not reca 1. Yes, after cueing (2. Yes, no cue requir | ll "a color") | | | |
| Enter Co |] | Able to recall "bed 0. No - could not reca 1. Yes, after cueing (2. Yes, no cue requir | ll "a piece of furniture") | | | |
| C050 | 00. BIM | S Summary Score | | | | |
| Enter Sco | | | 200-C0400 and fill in total so unable to complete the int | | | |



| Resident | | h | dentifier | Date |
|------------------------|----------------------|---|--|---------------------------------|
| Section | on C | - Cognitive Patterns | | |
| C0600. | Should | d the Staff Assessment for Mental Status (C0 | 700 - C1000) be Conducted? | |
| Enter Code | 0. 1. | No (resident was able to complete Brief Interview for Me Yes (resident was unable to complete Brief Interview for | | |
| Staff As | sessme | ent for Mental Status | | |
| Do not co | nduct if Br | rief Interview for Mental Status (C0200-C0500) was comple | eted | |
| C0700. | Short-f | term Memory OK | | |
| Enter Code | | s or appears to recall after 5 minutes Memory OK Memory problem | | |
| C0800. | Long-t | erm Memory OK | | |
| Enter Code | | s or appears to recall long past Memory OK Memory problem | | |
| C0900. | Memor | ry/Recall Ability | | |
| \downarrow | Check a | Il that the resident was normally able to recall | | |
| | A. Cui | rrent season | | |
| | B. Loc | cation of own room | | |
| | C. Sta | ff names and faces | | |
| | D. Tha | at they are in a nursing home/hospital swing bed | | |
| | Z. No | ne of the above were recalled | | |
| C1000. | Cognit | tive Skills for Daily Decision Making | | |
| Enter Code | | ecisions regarding tasks of daily life Independent - decisions consistent/reasonable Modified independence - some difficulty in new situatio Moderately impaired - decisions poor; cues/supervision Severely impaired - never/rarely made decisions | ns only required | |
| Deliriun C1310. | | and Symptoms of Delirium (from CAM©) | | |
| Code afte | r comple | ting Brief Interview for Mental Status or Staff Assessment, | and reviewing medical record | |
| A. Acute | e Onset | : Mental Status Change | | |
| Enter Code | 1s there 0. 1. | evidence of an acute change in mental status from the No Yes | resident's baseline? | |
| 1. Be | havior co | ot present ontinuously present, does not fluctuate resent, fluctuates (comes and goes, changes in severity) | | |
| Enter Code in Boxes | s | | | |
| | what C. Dis | ttention - Did the resident have difficulty focusing attention at was being said? sorganized Thinking - Was the resident's thinking disorgan of ideas, or unpredictable switching from subject to subjected Level of Consciousness - Did the resident have altered. | nized or incoherent (rambling or irrelevant cont)? | versation, unclear or illogical |
| | : | vigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being asked questions, t stuporous - very difficult to arouse and keep aroused for the in comatose - could not be aroused | | |

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

| eside | nt | Identifier | Date | |
|-----------------------|---|---|-----------------------|---------------|
| Se | ction D | - Mood | | |
| D0 | 100. Shoul | d Resident Mood Interview be Conducted? - Attempt to conduct interview with all r | esidents | |
| Enter | 0. 1. | No (resident is rarely/never understood) \rightarrow Skip to and complete D0500-D0600, Staff Assess Yes \rightarrow Continue to D0150, Resident Mood Interview (PHQ-2 to 9©) | sment of Resident Mod | od (PHQ-9-OV) |
| D0 | 150. Reside | ent Mood Interview (PHQ-2 to 9©) | | |
| If sy If ye Rea | mptom is prese s in column 1, d and show the Symptom I 0. No (ent 1. Yes (en | t: "Over the last 2 weeks, have you been bothered by any of the following ent, enter 1 (yes) in column 1, Symptom Presence. Then ask the resident: "About how often have you been bothered by this?" The resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Presence (er 0 in column 2) ter 0-3 in column 2) ter 0-3 in column 2 blank) | | |
| 2. | Symptom I | Frequency | 1. | 2. |
| | 0. Never of 1 2-6 day | or 1 day s (several days) | Symptom | Symptom |
| | 2. 7-11 da | ys (half or more of the days) | Presence | Frequency |
| | 3. 12-14 d | ays (nearly every day) | ↓ Enter Scores | in Boxes↓ |
| A. | Little intere | est or pleasure in doing things | | |
| B. | Feeling do | wn, depressed, or hopeless | | |
| If bo | oth D0150A1 a | nd D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ | interview; otherwise | , continue. |
| C. | Trouble fal | ling or staying asleep, or sleeping too much | | |
| D. | Feeling tire | ed or having little energy | | |
| E. | Poor appe | ite or overeating | | |
| F. | Feeling ba | d about yourself - or that you are a failure or have let yourself or your n | | |
| G. | Trouble co television | ncentrating on things, such as reading the newspaper or watching | | |
| H. | | speaking so slowly that other people could have noticed. Or the being so fidgety or restless that you have been moving around a lot usual | | |
| l. | Thoughts | hat you would be better off dead, or of hurting yourself in some way | | |
| D0 | 160. Total \$ | Severity Score | | |
| Enter | - Add Sc | ores for all frequency responses in Column 2, Symptom Frequency. Total score must be bet if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items | ween 00 and 27. | |



| t | Identifier | Date | |
|--|--|--|--|
| ction D - Mood | | | |
| · | | | |
| nptom is present, enter 1 (yes) in column 1, Symptom Presence. move to column 2, Symptom Frequency, and indicate symptom frequency Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) | | | |
| Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) | | 1. Symptom Presence | 2. Symptom Frequency |
| 12-14 days (nearly every day) Little interest or pleasure in doing things | | ↓ Enter Scores | in Boxes↓ |
| Feeling or appearing down, depressed, or hopeless | | | |
| Trouble falling or staying asleep, or sleeping too much | | | |
| Feeling tired or having little energy | | | |
| Poor appetite or overeating | | | |
| Indicating that they feel bad about self, are a failure, or have let se | elf or family down | | |
| Trouble concentrating on things, such as reading the newspaper | or watching television | | |
| Moving or speaking so slowly that other people have noticed. Or being so fidgety or restless that they have been moving around a | the opposite - lot more than usual | | |
| States that life isn't worth living, wishes for death, or attempts to | harm self | | |
| Being short-tempered, easily annoyed | | | |
| - | | | |
| | om Frequency. Total score must be be | tween 00 and 30. | |
| | | | |
| | mptom is present, enter 1 (yes) in column 1, Symptom Presence. In move to column 2, Symptom Frequency, and indicate symptom frequency Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 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) Little interest or pleasure in doing things Feeling or appearing down, depressed, or hopeless Trouble falling or staying asleep, or sleeping too much Feeling tired or having little energy Poor appetite or overeating Indicating that they feel bad about self, are a failure, or have let so Trouble concentrating on things, such as reading the newspaper Moving or speaking so slowly that other people have noticed. Or being so fidgety or restless that they have been moving around a States that life isn't worth living, wishes for death, or attempts to Being short-tempered, easily annoyed 3. Otten Add scores for all frequency responses in Column 2, Sympton of the source of the so | Cition D - Mood 300. Staff Assessment of Resident Mood (PHQ-9-OV*) of conduct if Resident Mood Interview (D0150-D0160) was completed or the last 2 weeks, did the resident have any of the following problems or behaviors reptom is present, enter 1 (yes) in column 1, Symptom Presence. In move to column 2, Symptom Frequency, and indicate symptom frequency. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) Symptom Frequency 1. 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) Little interest or pleasure in doing things Feeling or appearing down, depressed, or hopeless Trouble falling or staying asleep, or sleeping too much Feeling tired or having little energy Poor appetite or overeating Indicating that they feel bad about self, are a failure, or have let self or family down Trouble concentrating on things, such as reading the newspaper or watching television Moving or speaking so slowly that other people have noticed. Or the opposite being so fidgety or restless that they have been moving around a lot more than usual States that life isn't worth living, wishes for death, or attempts to harm self Being short-tempered, easily annoyed 100. Total Severity Score 100. Social Isolation How often do you feel lonely or isolated from those around you? 1 | Cition D - Mood 300. Staff Assessment of Resident Mood (PHQ-9-OV*) of conduct if Resident Mood Interview (D0150-D0160) was completed or the Iast 2 weeks, did the resident have any of the following problems or behaviors? ngbonis present, enter 1 (yes) in column 1, Symptom Presence. 1 move to column 2, Symptom Frequency, and indicate symptom frequency. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 1. Yes (enter 0-3 in column 2) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day) 1. Enter Scores 1. Ente |



| Resident | | Id | entifier | Date | | | | | |
|---------------------------|--|---|---|---|--|--|--|--|--|
| Section | Section E - Behavior | | | | | | | | |
| E0100. | E0100. Potential Indicators of Psychosis | | | | | | | | |
| ↓ Cł | ↓ Check all that apply | | | | | | | | |
| | A. | Hallucinations (perceptual experiences in the absence of real | external sensory stimuli) | | | | | | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, cont | rary to reality) | | | | | | |
| | Z. | None of the above | | | | | | | |
| Behavio | oral | Symptoms | | | | | | | |
| E0200. | Bel | navioral Symptom - Presence & Frequency | | | | | | | |
| Note pres | sence | of symptoms and their frequency | | | | | | | |
| 1. Be 2. Be | ehav ehav ehav | ior not exhibited ior of this type occurred 1 to 3 days ior of this type occurred 4 to 6 days, but less than da ior of this type occurred daily | aily | | | | | | |
| Enter Code | A. | Physical behavioral symptoms directed toward others (e.g. | g., hitting, kicking, pushing, scratching, grabbi | ng, abusing others sexually) | | | | | |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g., | threatening others, screaming at others, curs | ing at others) | | | | | |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e. rummaging, public sexual acts, disrobing in public, throwing or disruptive sounds) | g., physical symptoms such as hitting or scra smearing food or bodily wastes, or verbal/vo | tching self, pacing, cal symptoms like screaming, | | | | | |
| E0800. | Rej | ection of Care - Presence & Frequency | | | | | | | |
| Enter Code | goa | the resident reject evaluation or care (e.g., bloodwork, taking Is for health and well-being? Do not include behaviors that had dent or family), and determined to be consistent with resident va 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 tha 3. Behavior of this type occurred daily | ve already been addressed (e.g., by discussi llues, preferences, or goals. | sary to achieve the resident's on or care planning with the | | | | | |
| E0900. | Wa | ndering - Presence & Frequency | | | | | | | |
| Enter Code | Has | the resident wandered? 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less that 3. Behavior of this type occurred daily | n daily | | | | | | |

| Resident | | Id | entifie | er | Date |
|----------------------------|------------------------------|---|----------|-------------------------------------|--|
| Section | n (| GG - Functional Abilities and Go | als | | |
| exacerbatio | n, o | ior Functioning: Everyday Activities. Indicate the re- r injury f A0310B = 01 | siden | it's usual ability with everyday ac | tivities prior to the current illness, |
| without a Needed person to | an a I So to co | nt - Resident completed the activities by themself, with or assistive device, with no assistance from a helper. me Help - Resident needed partial assistance from another omplete activities. - A helper completed the activities for the resident. | 8. 9. | Unknown. Not Applicable. | |
| Enter Codes | in E | Boxes | | | |
| <i>'</i> | Α. | Self-Care: Code the resident's need for assistance with bathin or injury. | g, dre | essing, using the toilet, or eating | prior to the current illness, exacerbation |
| | В. | Indoor Mobility (Ambulation): Code the resident's need for a cane, crutch, or walker) prior to the current illness, exacerbatio | | <u> </u> | oom (with or without a device such as |
| | C. | Stairs: Code the resident's need for assistance with internal or to the current illness, exacerbation, or injury. | exte | rnal stairs (with or without a devi | ice such as cane, crutch, or walker) prior |
| | D. | Functional Cognition: Code the resident's need for assistanc medication prior to the current illness, exacerbation, or injury. | e witl | h planning regular tasks, such as | s shopping or remembering to take |
| | | ior Device Use. Indicate devices and aids used by the reside f A0310B = 01 | lent p | prior to the current illness, exace | rbation, or injury |
| Check all tha ↓ | ıt ap | pply | | | |
| | ۹. | Manual wheelchair | | | |
| | В. | Motorized wheelchair and/or scooter | | | |
| | С. | Mechanical lift | | | |
| | D. | Walker | | | |
| | Ε. | Orthotics/Prosthetics | | | |
| | Z. | None of the above | | | |
| GG0115. | Fu | nctional Limitation in Range of Motion | | | |
| Code for lir | mita | tion that interfered with daily functions or placed resident at risl | of i | njury in the last 7 days | |
| | nen | nent t on one side t on both sides | | | |
| Enter Codes | in E | Boxes | | | |
| | ۹. | Upper extremity (shoulder, elbow, wrist, hand) | | | |
| | В. | Lower extremity (hip, knee, ankle, foot) | | | |
| | | | | | |

| Resident | Identifier Date |
|---|---|
| Section GG - Fu | unctional Abilities and Goals - Admission |
| Complete column 1 when A | seessment period is the first 3 days of the stay) A0310A = 01. Complete columns 1 and 2 when A0310B = 01. begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| at the start of the stay (adn | performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted nission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of ermissible to code end of SNF PPS stay (discharge) goal(s). |
| amount of assistance provide Activities may be completed 06. Independent - Resid 05. Setup or clean-up a 04. Supervision or touc completes activity. As 03. Partial/moderate as the effort. 02. Substantial/maxima effort. 01. Dependent - Helper required for the resid If activity was not attempte 07. Resident refused 09. Not applicable - Not 10. Not attempted due to | with or without assistive devices. ent completes the activity by themself with no assistance from a helper. ssistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. hing assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident sistance may be provided throughout the activity or intermittently. sistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half I assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is ent to complete the activity. |
| 1. 2. Admission Discharge Performance Goal Enter Codes in Boxes | |
| A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. |
| B. | Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. |
| C. | Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. |
| E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. |
| F. | Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable. |
| G. | Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. |
| Н. | 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. |

| Resident _ | | | Identifier Date |
|---|--|--|--|
| Secti | on GG | - Fı | nctional Abilities and Goals - Admission |
| Comple | te column 1 v | when A | ssment period is the first 3 days of the stay) 0310A = 01. Complete columns 1 and 2 when A0310B = 01. begins on A2400B. When A0310B = 99, the stay begins on A1600. |
| at the st | tart of the sta | y (adn | erformance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted ission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use or rmissible to code end of SNF PPS stay (discharge) goal(s). |
| amount Activities 06. I 05. \$ 04. \$ 03. I 02. \$ 001. I | and Quality of of assistance of assistance of assistance of a sistance o | provide pleted Residen-up a pr touc vity. As ate as: axima | mance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to d. with or without assistive devices. ent completes the activity by themself with no assistance from a helper. sistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. ning assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident sistance may be provided throughout the activity or intermittently. istance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the loes ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is not to complete the activity. |
| 07. F 09. N 10. N | Resident refus Not applicable Not attempted | sed e - Not I due t | d, code reason: attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. b environmental limitations (e.g., lack of equipment, weather constraints) b medical condition or safety concerns |
| 1. Admissior Performand Enter Cod | • | | |
| | | A. | Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| | | В. | Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| | | C. | Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. |
| | | D. | Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| | | E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| | | F. | Toilet transfer: The ability to get on and off a toilet or commode. |
| | | G. | Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/clodoor or fasten seat belt. |
| | | l. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performances coded 07, 09, 10, or 88 \rightarrow Skip to GG0170M, 1 step (curb) |
| | | J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| | | K. | Walk 150 feet: Once standing the ability to walk at least 150 feet in a corridor or similar space |

| Resident | | | | | | | Identifier | Date | |
|---------------|---------|----------------------|----------------------|---------------------|-------------------------|---|--|--|---------------|
| Sec | tioı | n GC | 3 - F | uncti | ior | nal Abilities and G | oals - Admiss | ion | |
| Comp | lete c | olumn | 1 when | A0310A | = 01. | od is the first 3 days of the stay) Complete columns 1 and 2 who 2400B. When A0310B = 99, the st | | | |
| at the | start | of the s | stay (ad | lmission) | , coc | at the start of the stay (admissible the reason. Code the resident ocode end of SNF PPS stay (dis | t's end of SNF PPS stay | ng the 6-point scale. If activity was not attemp (discharge) goal(s) using the 6-point scale. U | pted se of |
| Codi | ng: | | | | | | | | |
| Safety | and | Quality | of Perf | ormance | - If h | elper assistance is required becar | use resident's performanc | e is unsafe or of poor quality, score according to | |
| | | ssistand | | | witho | ut assistive devices. | | | |
| | | | | | | s the activity by themself with no a | assistance from a helper. | | |
| 05. | Setu | p or cle | ean-up | assistand | ce - F | Helper sets up or cleans up; reside | ent completes activity. Help | per assists only prior to or following the activity. | |
| 04. | comp | ervision oletes a | or tou ctivity. A | cning as: | sista e may | nce - helper provides verbal cues be provided throughout the activi | s and/or touching/steadyin ity or intermittently. | g and/or contact guard assistance as resident | |
| 03. | | ial/mod | | | | | | or supports trunk or limbs, but provides less than | half |
| 02. | | stantial | /maxim | al assista | ance | - Helper does MORE THAN HALI | the effort. Helper lifts or | holds trunk or limbs and provides more than half | the |
| 01. | Depe | endent · | | | | he effort. Resident does none of the the activity. | ne effort to complete the a | ctivity. Or, the assistance of 2 or more helpers is | |
| lf activ | | | | | | • | | | |
| 11 activ | Resi | dent re | attempi fused | ted, code | reas | ion: | | | |
| | | | | | | nd the resident did not perform this ental limitations (e.g., lack of equ | | | |
| | | | | | | ondition or safety concerns | ipinent, weather constrain | (5) | |
| | | • | | | | | | | |
| 1. Admissi | on | 2. Discharge | е | | | | | | |
| Performai | | Goal n Boxes | | | | | | | |
| ↓ ↓ | oues ii | ↓ ↓ | | | 40 | | 1.111 | | |
| | | |] L. | turf or g | | | bility to walk 10 feet on un | even or sloping surfaces (indoor or outdoor), suc | ch as |
| | | | M. | 1 step If admis | (cur l ssion | b): The ability to go up and down a performance is coded 07, 09, 10, | a curb and/or up and down or $88 \rightarrow \text{Skip to GG0170}$ | n one step. P, Picking up object | |
| |] | |] N. | 4 steps If admis | s: Th ssion | e ability to go up and down four st performance is coded 07, 09, 10, | eps with or without a rail. or $88 \rightarrow Skip$ to GG0170 | P, Picking up object | |
| | | |] o. | 12 step | ps: T | he ability to go up and down 12 st | eps with or without a rail. | | |
| |] | |] P. | Picking the floo | | object: The ability to bend/stoop | from a standing position to | p pick up a small object, such as a spoon, from | |
| | | | | Q1. | Doe | s the resident use a wheelchair | and/or scooter? | | |
| | | | | | 0. 1. | $No \rightarrow Skip$ to GG0130, Self Care Yes \rightarrow Continue to GG0170R, W | e (Discharge) /heel 50 feet with two turn | S | |
| | | | R. | Wheel | 50 fe | et with two turns: Once seated | n wheelchair/scooter, the | ability to wheel at least 50 feet and make two tur | ns. |
| | | | | RR1. | Indic | cate the type of wheelchair or so | cooter used. | | |
| | | | | | 1. 2. | Manual Motorized | | | |
| | 1 | | S. | | | | cooter, the ability to whee | at least 150 feet in a corridor or similar space. | |
| | _ | | | SS1. | Indi | cate the type of wheelchair or so | cooter used. | | |
| | | | | | 1. | Manual | | | |
| | | | | | 2. | Motorized | | | |

| Resident | Ide | entifier | Date |
|--|--|---|---|
| Section | n GG - Functional Abilities and Goa | als - Discharge | |
| Complete co When A03100 For all other I | Self-Care (Assessment period is the last 3 days of the stay) olumn 3 when A0310F = 10 or 11 or when A0310H = 1. OG is not = 2 and A0310H = 1 and A2400C minus A2400B is greated Discharge assessments, the stay ends on A2000. | | |
| | sident's usual performance at the end of the stay for each active code the reason. | ity using the 6-point scale. If an activity | y was not attempted at the end |
| amount of ass Activities may 06. Indep 05. Setup 04. Super compl 03. Partia the eff 02. Subst effort. 01. Deper requir If activity wa 07. Resid 09. Not a 10. Not a | stantial/maximal assistance - Helper does MORE THAN HALF the | stance from a helper. completes activity. Helper assists only prior d/or touching/steadying and/or contact guar intermittently. rt. Helper lifts, holds, or supports trunk or l e effort. Helper lifts or holds trunk or limbs ffort to complete the activity. Or, the assist | to or following the activity. and assistance as resident imbs, but provides less than half and provides more than half the ance of 2 or more helpers is |
| 3. Discharge Performance | | | |
| Enter Codes in Bo | 3oxes | | |
| A. | a. Eating: The ability to use suitable utensils to bring food and/or l before the resident. | iquid to the mouth and swallow food and/o | or liquid once the meal is placed |
| В. | Gral hygiene: The ability to use suitable items to clean teeth. D from the mouth, and manage denture soaking and rinsing with the control of the control | | t and remove dentures into and |
| C. | Toileting hygiene: The ability to maintain perineal hygiene, adj managing an ostomy, include wiping the opening but not manag | | ring a bowel movement. If |
| E. | Shower/bathe self: The ability to bathe self, including washing, include transferring in/out of tub/shower. | rinsing, and drying self (excludes washing | g of back and hair). Does not |
| F. | . Upper body dressing: The ability to dress and undress above | the waist; including fasteners, if applicable |) . |
| G. | 6. Lower body dressing: The ability to dress and undress below | the waist, including fasteners; does not inc | clude footwear. |
| Н. | Putting on/taking off footwear: The ability to put on and take of including fasteners, if applicable. | off socks and shoes or other footwear that | is appropriate for safe mobility; |
| | | | |

| esident | | | Identifier | Date |
|---|--|---|---|---|
| Sec | tion | GG - Functional Abilities | and Goals - Dischar | ge |
| Comp When | lete colu A0310G | obility (Assessment period is the last 3 days of turn 3 when A0310F = 10 or 11 or when A0310H is not = 2 and A0310H = 1 and A2400C minus A2 scharge assessments, the stay ends on A2000. | = 1. | not = 04, the stay ends on A2400C. |
| | | dent's usual performance at the end of the stay de the reason. | for each activity using the 6-point | scale. If an activity was not attempted at the er |
| amour <i>Activiti</i> 06. 05. 04. 03. 02. | y and Quant of assistes may k Indepense Setup of Superv complete Partial/the effor Substate ffort. Depender required | rt. | olf with no assistance from a helper. The properties activity. Help werbal cues and/or touching/steadying at the activity or intermittently. The helper lifts, holds, oo that the helper lifts or helper lifts or helper lifts. | er assists only prior to or following the activity. g and/or contact guard assistance as resident r supports trunk or limbs, but provides less than ha nolds trunk or limbs and provides more than half the |
| 07. 09. 10. | Reside Not app Not atte | not attempted, code reason: nt refused blicable - Not attempted and the resident did not permeted due to environmental limitations (e.g., lempted due to medical condition or safety con | ack of equipment, weather constraint | |
| 3. Discha | arge | | | |
| | des in Box | es | | |
| <u> </u> | A . | Roll left and right: The ability to roll from lying o | n back to left and right side, and retu | rn to lying on back on the bed. |
| |] В. | Sit to lying: The ability to move from sitting on s | ide of bed to lying flat on the bed. | |
| | C. | Lying to sitting on side of bed: The ability to m support. | ove from lying on the back to sitting o | on the side of the bed and with no back |
| | D. | Sit to stand: The ability to come to a standing po | osition from sitting in a chair, wheelch | air, or on the side of the bed. |
| | E . | Chair/bed-to-chair transfer: The ability to transfer | fer to and from a bed to a chair (or wh | neelchair). |
| | F. | Toilet transfer: The ability to get on and off a toil | et or commode. | |
| | G. | Car transfer: The ability to transfer in and out of door or fasten seat belt. | a car or van on the passenger side. [| Does not include the ability to open/close |
| | l. | Walk 10 feet: Once standing, the ability to walk a is coded 07, 09, 10, or $88 \rightarrow \text{Skip to GG0170M}$, | | similar space. If discharge performance |
| | J. | Walk 50 feet with two turns: Once standing, the | e ability to walk at least 50 feet and m | ake two turns. |
| |] K. | Walk 150 feet: Once standing, the ability to walk | at least 150 feet in a corridor or simil | ar space. |
| | | | | |

| Resident | Identifier Date |
|--|---|
| | GG - Functional Abilities and Goals - Discharge Obility (Assessment period is the last 3 days of the stay) |
| Complete colo When A0310G | is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04, the stay ends on A2400C. scharge assessments, the stay ends on A2000. |
| | dent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end de the reason. |
| amount of assi Activities may 06. Indepe 05. Setup 04. Superv comple 03. Partial the effo 02. Substa effort. 01. Dependerequire If activity was 07. Reside 09. Not ap 10. Not att | intial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the dent - 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 d for the resident to complete the activity. not attempted, code reason: |
| Discharge Performance Enter Codes in Box | Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| M. | 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or $88 \rightarrow \text{Skip}$ to GG0170P, Picking up object |
| N. | 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or $88 \rightarrow Skip$ to GG0170P, Picking up object |
| O. | 12 steps: The ability to go up and down 12 steps with or without a rail. |
| P. | Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| | Q3. Does the resident use a wheelchair and/or scooter? |
| | No → Skip to H0100, Appliances Yes → Continue to GG0170R, Wheel 50 feet with two turns |
| R. | Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |
| | RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized |
| S. | Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |
| | SS3. Indicate the type of wheelchair or scooter used. |
| | 1. Manual 2. Motorized |
| | |

| Resident | | | Identifier | Date |
|--------------|------|---|--|---------------------------------|
| Section | on l | H - Bladder and Bowel | | |
| H0100. | Арр | liances | | |
| \downarrow | Che | ck all that apply | | |
| | A. | Indwelling catheter (including suprapubic catheter and nep | hrostomy tube) | |
| | B. | External catheter | | |
| | C. | Ostomy (including urostomy, ileostomy, and colostomy) | | |
| | D. | Intermittent catheterization | | |
| | Z. | None of the above | | |
| H0200. | Urii | nary Toileting Program | | |
| Enter Code | A. | Has a trial of a toileting program (e.g., scheduled toiletin or reentry or since urinary incontinence was noted in this fac No → Skip to H0300, Urinary Continence Yes → Continue to H0200C, Current toileting program Unable to determine → Continue to H0200C, Current | lity? | en attempted on admission/entry |
| Enter Code | | Current toileting program or trial - Is a toileting program (e used to manage the resident's urinary continence? 0. No 1. Yes | e.g., scheduled toileting, prompted voiding, or bl | adder training) currently being |
| H0300. | Urin | nary Continence | | |
| Enter Code | Urin | ary continence - Select the one category that best describes 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinent) 2. Frequently incontinent (7 or more episodes of urinary) 3. Always incontinent (no episodes of continent voiding) 9. Not rated, resident had a catheter (indwelling, condom) | ontinence) incontinence, but at least one episode of contin | 5 , |
| H0400. | Boy | wel Continence | | |
| Enter Code | Bow | continence - Select the one category that best describes Always continent Occasionally incontinent (one episode of bowel incontinent) Frequently incontinent (2 or more episodes of bowel incontinent) Always incontinent (no episodes of continent bowel median) Not rated, resident had an ostomy or did not have a box | tinence) ncontinence, but at least one continent bowel m ovements) | novement) |
| H0500. | | wel Toileting Program | | |
| Enter Code | ls a | toileting program currently being used to manage the res 0. No 1. Yes | sident's bowel continence? | |

| esident | | Identifier | Date |
|--------------------|--|---------------------------------------|-----------------|
| Section | on I - Active Diagnoses | | |
| I0020. Complete | Indicate the resident's primary medical condition only if A0310B = 01 or 08 $$ | category | |
| Enter Code | Indicate the resident's primary medical condition admission 01. Stroke 02. Non-Traumatic Brain Dysfunction 03. Traumatic Brain Dysfunction 04. Non-Traumatic Spinal Cord Dysfunction 05. Traumatic Spinal Cord Dysfunction 06. Progressive Neurological Conditions 07. Other Neurological Conditions 08. Amputation 09. Hip and Knee Replacement 10. Fractures and Other Multiple Trauma 11. Other Orthopedic Conditions 12. Debility, Cardiorespiratory Conditions 13. Medically Complex Conditions 10020B. ICD Code | category that best describes the prin | mary reason for |

| Resident | | Identifier | Date |
|------------|---|---|------------------------------------|
| Section | on I - Active Diagnoses | | |
| | Diagnoses in the last 7 days - Check all that apply s listed in parentheses are provided as examples and should not b | e considered as all-inclusive lists | |
| Cancer | | | |
| | I0100. Cancer (with or without metastasis) | | |
| Heart/Circ | culation | | |
| | 10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sid 10400. Coronary Artery Disease (CAD) (e.g., angina, myocardi 10600. Heart Failure (e.g., congestive heart failure (CHF) and pol 10700. Hypertension 10800. Orthostatic Hypotension 10900. Peripheral Vascular Disease (PVD) or Peripheral Arter | al infarction, and atherosclerotic heart disease (ulmonary edema) | ASHD)) |
| Gastroint | estinal | | |
| | I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory B | owel Disease | |
| Genitouri | nary | | |
| | I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal I1550. Neurogenic Bladder I1650. Obstructive Uropathy | Disease (ESRD) | |
| Infections | 3 | | |
| | 11700. Multidrug-Resistant Organism (MDRO) 12000. Pneumonia 12100. Septicemia 12200. Tuberculosis 12300. Urinary Tract Infection (UTI) (LAST 30 DAYS) 12500. Wound Infection (other than foot) | | |
| Metabolic | · · · · · · | | |
| | I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephro I3100. Hyponatremia I3200. Hyperkalemia I3300. Hyperlipidemia (e.g., hypercholesterolemia) | pathy, and neuropathy) | |
| Musculos | skeletal | | |
| | 13900. Hip Fracture - any hip fracture that has a relationship to othe trochanter and femoral neck) 14000. Other Fracture | urrent status, treatments, monitoring (e.g., sub- | capital fractures, and fractures o |
| Neurologi | ical | | |
| | 14300. Aphasia 14400. Cerebral Palsy 14500. Cerebrovascular Accident (CVA), Transient Ischemic A 14800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, v. as Pick's disease; and dementia related to stroke, Parkinson's or 14900. Hemiplegia or Hemiparesis 15000. Paraplegia 15100. Quadriplegia 15200. Multiple Sclerosis (MS) 15250. Huntington's Disease 15300. Parkinson's Disease 15350. Tourette's Syndrome | ascular or multi-infarct dementia; mixed dement | ia; frontotemporal dementia such |
| Neurologi | ical continued on next page | | |

| esident | | Identifier | Date | | | | | |
|------------|---|---|----------------------|---------|--------|-------|------|--|
| Sectio | on I - Active Diagnoses | | | | | | | |
| | Diagnoses in the last 7 days - Check all that apply slisted in parentheses are provided as examples and should not b | e considered as all-inclusive lists | | | | | | |
| Neurologi | cal - Continued | | | | | | | |
| | I5400. Seizure Disorder or Epilepsy I5500. Traumatic Brain Injury (TBI) | | | | | | | |
| Nutritiona | 1 | | | | | | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | | | | | | |
| Psychiatr | ic/Mood Disorder | | | | | | | |
| | I5700. Anxiety Disorder I5800. Depression (other than bipolar) I5900. Bipolar Disorder I5950. Psychotic Disorder (other than schizophrenia) I6000. Schizophrenia (e.g., schizoaffective and schizophreniforr I6100. Post Traumatic Stress Disorder (PTSD) | n disorders) | | | | | | |
| Pulmonar | y | | | | | | | |
| | I6200. Asthma, Chronic Obstructive Pulmonary Disease (CO diseases such as asbestosis) I6300. Respiratory Failure | PD), or Chronic Lung Disease (e.g., chronic | bronchi | tis and | restri | ctive | lung | |
| Other | . , | | | | | | | |
| | 18000. Additional active diagnoses Enter diagnosis on line and ICD code in boxes. Include the decin | nal for the code in the appropriate box. | | | | | | |
| | A | | \coprod | | | | | |
| | B | | | | | | | |
| | C | | Щ | | | | | |
| | D | <u>_</u> | Щ | | | | _ | |
| | E | | Щ | | | | | |
| | F | <u>_</u> | $\perp \perp$ | | | | | |
| | G | <u>_</u> | $\perp \!\!\! \perp$ | | | | | |
| | Н. | | Щ | | | | _ | |
| | I | | \coprod | | | | | |
| | J. | | | | | | | |

| Resident | Identifier Date |
|-------------|--|
| Section | n J - Health Conditions |
| J0100. | Pain Management - Complete for all residents, regardless of current pain level |
| At any time | in the last 5 days, has the resident: |
| Enter Code | A. Received scheduled pain medication regimen?0. No1. Yes |
| Enter Code | B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes |
| Enter Code | C. Received non-medication intervention for pain? 0. No 1. Yes |
| | Should Pain Assessment Interview be Conducted? conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea) |
| Enter Code | No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain Yes → Continue to J0300, Pain Presence |
| Pain As | sessment 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 J0410, Pain Frequency |
| 10.440 | 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain |
| J0410. | Pain Frequency |
| Enter Code | Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 9. Unable to answer |
| J0510. | Pain Effect on Sleep |
| Enter Code | Ask resident: "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer |
| J0520. | Pain Interference with Therapy Activities |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" 0. Does not apply - I have not received rehabilitation therapy in the past 5 days 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 9. Unable to answer |



| esident | | | Identifier | Date |
|--------------------|----------------------|---|--|-------------------------------------|
| Section | n J | J - Health Conditions | | |
| Pain As | sessı | ment Interview - Continued | | |
| J0530. | Pain | n Interference with Day-to-Day Activities | | |
| Enter Code | becat | resident: "Over the past 5 days, how often have you limit nuse of pain?" 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer | ed your day-to-day activities (<u>excluding</u> rehal | oilitation therapy sessions) |
| J0600. | Pain | n Intensity - Administer ONLY ONE of the follow | ing pain intensity questions (A or B) | |
| Enter Rating | <i>(</i> (| Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 can imagine." (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer. | | ain and ten as the worst pain you |
| Enter Code | # 1 2 3 | Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain of your worst pain of your worst pain of your worst pain of the intensity of your worst pain of your | over the last 5 days." (Show resident verbal scale | e) |
| J0700. | Sho | uld the Staff Assessment for Pain be Conduc | cted? | |
| Enter Code | | No (J0410 = 1 thru 4) → Skip to J1100, Shortness of Yes (J0410 = 9) → Continue to J0800, Indicators of F | | |
| Staff As J0800. | | sment for Pain ators of Pain or Possible Pain in the last 5 days | | |
| \downarrow | Chec | k all that apply | | |
| | A. 1 | Non-verbal sounds (e.g., crying, whining, gasping, moani | ng, or groaning) | |
| | B. \ | Vocal complaints of pain (e.g., that hurts, ouch, stop) | | |
| | C. F | Facial expressions (e.g., grimaces, winces, wrinkled fore | head, furrowed brow, clenched teeth or jaw) | |
| | | Protective body movements or postures (e.g., bracing, during movement) | guarding, rubbing or massaging a body part/area | a, clutching or holding a body part |
| | Z. I | None of these signs observed or documented \rightarrow If che | cked, skip to J1100, Shortness of Breath (dyspn | ea) |
| J0850. | Freq | quency of Indicator of Pain or Possible Pain i | n the last 5 days | |
| Enter Code | 1 | uency with which resident complains or shows evidence of 1. Indicators of pain or possible pain observed 1 to 2 c 2. Indicators of pain or possible pain observed 3 to 4 c 3. Indicators of pain or possible pain observed daily | lays | |



| Resident | | Identifier Date |
|--------------|-----|--|
| Section | on | J - Health Conditions |
| | | th Conditions ortness of Breath (dyspnea) |
| \downarrow | Che | eck all that apply |
| | A. | Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring) |
| | В. | 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. | Pro | ognosis |
| Enter Code | | es the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician cumentation) 0. No |
| | | 1. Yes |
| J1550. | Pro | oblem Conditions |
| \downarrow | Che | eck all that apply |
| | A. | Fever |
| | B. | Vomiting |
| | C. | Dehydrated |
| | D. | Internal bleeding |
| | | None of the above |
| J1700. | | II History on Admission/Entry or Reentry |
| Enter Code | • | A0310A = 01 or A0310E = 1 |
| Litter code | A. | Did the resident have a fall any time in the last month prior to admission/entry or reentry? |
| | | 0. No 1. Yes |
| Enter Code | | 9. Unable to determine |
| | В. | Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? |
| | | 0. No 1. Yes |
| Enter Code | _ | 9. Unable to determine |
| | C. | Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry? O. No 1. Yes 9. Unable to determine |
| J1800. | | y Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), chever is more recent |
| Enter Code | | s the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more ent? |
| | | No → Skip to J2000, Prior Surgery Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) |

| Resident | | | | Identifier | Date | |
|---------------------------------|-------------------------|---|--|---|---|------------------|
| Section | on J | - Health Condition | S | | | |
| J1900. more rece | | ber of Falls Since Admission | n/Entry or Reentry | or Prior Assessment | (OBRA or Scheduled PPS), | whichever is |
| Coding: 0. None 1. One 2. Two o | | | | | | |
| Enter Code | s in Bo | oxes | | | | |
| | A. N | lo injury - no evidence of any injury by the resident; no change in the resid | s noted on physical as dent's behavior is noted | sessment by the nurse or pr d after the fall | imary care clinician; no complaints of | f pain or injury |
| | | njury (except major) - skin tears, ab he resident to complain of pain | rasions, lacerations, su | perficial bruises, hematoma | s and sprains; or any fall-related inju | ry that causes |
| | C. N | lajor injury - bone fractures, joint dis | slocations, closed head | l injuries with altered conscio | ousness, subdural hematoma | |
| J2000. | Prior | Surgery - Complete only if A0310 |)B = 01 | | | |
| Enter Code | Did the 0 1 8 | . Yes | the 100 days prior to | admission? | | |
| J2100. | Rece | ent Surgery Requiring Active | SNF Care - Comple | ete only if A0310B = 01 or 08 | 3 | |
| Enter Code | Did the 0 1 8 | . No . Yes | edure during the prior | inpatient hospital stay that re | equires active care during the SNF st | ay? |
| Surgica | l Proc | cedures - Complete only if J2100 = | :1 | | | |
| ↓ Maia: 1ai | | call that apply | | | | |
| Major Joi | - | iacement I. Knee Replacement - partial or tota | sl | | | |
| | J2310 J2320 | Hip Replacement - partial or total Ankle Replacement - partial or total Shoulder Replacement - partial or | al | | | |
| Spinal Su | ırgery | | | | | |
| | J2410 J2420 | Involving the spinal cord or majo Involving fusion of spinal bones Involving lamina, discs, or facets Other major spinal surgery | | | | |
| Other Ort | hopedi | ic Surgery | | | | |
| | J2510 J2520 J2530 | Repair fractures of the shoulder Repair fractures of the pelvis, hip Repair but not replace joints Repair other bones (such as hand) Other major orthopedic surgery | o, leg, knee, or ankle | • • • | nd) | |
| Neurolog | | | | | | |
| | J2610 J2620 | Involving the brain, surrounding Involving the peripheral or auton Insertion or removal of spinal or Other major neurological surger | omic nervous systen brain neurostimulato | n - open or percutaneous | , | |

| esident | | | Identifier | Date | |
|---|--|--|--|---|----------|
| Section | on J - | Health Conditions | | | |
| Surgica | I Proced | dures - Complete only if J2100 = 1 | | | |
| \downarrow | Check al | ll that apply | | | |
| Cardiopu | Imonary S | Surgery | | | |
| | J2710. lr | nvolving the heart or major blood vessels - open on nvolving the respiratory system, including lungs, Other major cardiopulmonary surgery | · · | ocal cords - open or endoscopic | |
| Genitouri | inary Surg | gery | | | |
| | J2810. lr n | nvolving genital systems (such as prostate, testes, nvolving the kidneys, ureters, adrenal glands, or nephrostomies or urostomies) Other major genitourinary surgery | | • | |
| | jor Surger | | | | |
| | | nvolving tendons, ligaments, or muscles | | | |
| | J2910. Ir | nvolving the gastrointestinal tract or abdominal concreas, or spleen - open or laparoscopic (including | ontents from the esophagus to creation or removal of ostomie | o the anus, the biliary tree, gall bladder, liver, s or percutaneous feeding tubes, or hernia repai | , ir) |
| | J2930. Ir | nvolving the endocrine organs (such as thyroid, pan nvolving the breast Repair of deep ulcers, internal brachytherapy, bon | | • | • |
| | | Other major surgery not listed above | c marrow or stem central ves | tor transplant | |
| | | | | | |
| | | - Swallowing/Nutritional Sta | ntus | | |
| K0100. | Swallov | - Swallowing/Nutritional Stawing Disorder s of possible swallowing disorder | ntus | | |
| K0100. Signs and ↓ | Swallow symptoms Check al | wing Disorder s of possible swallowing disorder Il that apply | | | |
| K0100. Signs and ↓ | Swallow symptoms Check al | wing Disorder s of possible swallowing disorder | | | |
| K0100. Signs and ↓ | Swallov symptoms Check al | wing Disorder s of possible swallowing disorder Il that apply | nking | | |
| K0100. Signs and ↓ | Swallow symptoms Check al A. Los B. Hold | wing Disorder s of possible swallowing disorder II that apply s of liquids/solids from mouth when eating or dri | nking outh after meals | | |
| K0100. Signs and | Swallow symptoms Check al A. Los B. Hold C. Cou | wing Disorder s of possible swallowing disorder Il that apply ss of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in mo | nking outh after meals | | |
| K0100. Signs and ↓ □ □ | Swallow symptoms Check al A. Los B. Hold C. Cou | wing Disorder s of possible swallowing disorder II that apply s of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in mo | nking outh after meals | | |
| K0100. Signs and | Swallow symptoms Check al A. Los B. Hold C. Cou D. Con Z. Non | wing Disorder s of possible swallowing disorder II that apply s of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in mo ughing or choking during meals or when swallow mplaints of difficulty or pain with swallowing | nking outh after meals ing medications | ater round up | |
| K0100. Signs and ↓ □ □ □ □ □ □ □ □ □ □ □ □ | Swallow symptoms Check al A. Los B. Hold C. Cou D. Con Z. Non | wing Disorder s of possible swallowing disorder Il that apply as of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in mo ughing or choking during meals or when swallow mplaints of difficulty or pain with swallowing ne of the above and Weight - While measuring, if the number is a | nking outh after meals ing medications (.1 - X.4 round down; X.5 or gre | • | |
| K0100. Signs and | Swallow Symptoms Check al A. Los B. Hold C. Cou D. Con Z. Non Height | wing Disorder s of possible swallowing disorder Il that apply as of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in mo ughing or choking during meals or when swallow mplaints of difficulty or pain with swallowing me of the above and Weight - While measuring, if the number is a | nking outh after meals ing medications X.1 - X.4 round down; X.5 or gre sure since the most recent adm heasure in last 30 days; measure | ission/entry or reentry | ity |
| K0100. Signs and | Swallow Symptoms Check al A. Los B. Hold C. Cou D. Con Z. Non Height A. | wing Disorder s of possible swallowing disorder Il that apply as of liquids/solids from mouth when eating or dri ding food in mouth/cheeks or residual food in moughing or choking during meals or when swallow mplaints of difficulty or pain with swallowing ne of the above and Weight - While measuring, if the number is a Height (in inches). Record most recent height measuring with the swallowing measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent height measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent measuring in the number is a second most recent m | nking outh after meals ing medications X.1 - X.4 round down; X.5 or gre sure since the most recent adm heasure in last 30 days; measure | ission/entry or reentry | ity |

| esident _ | Identifier | | D | ate | |
|---|---|--------------------|---------------------------|---------------------|------------------------------|
| Secti | on K - Swallowing/Nutritional Status | | | | |
| K0310 | Weight Gain | | | | |
| Enter Code | Gain of 5% or more in the last month or gain of 10% or more in last 6 months No or unknown Yes, on physician-prescribed weight-gain regimen Yes, not on physician-prescribed weight-gain regimen | | | | |
| K0520 | Nutritional Approaches | | | | |
| Check a | ll of the following nutritional approaches that apply | | | | |
| Asse 2. Whi Perfo Only 3. Whi Perfo 4. At D | Admission essment period is days 1 through 3 of the SNF PPS Stay starting with A2400B e Not a Resident formed while NOT a resident of this facility and within the last 7 days. The check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If refer a Resident formed while a resident of this facility and within the last 7 days ischarge essment period is the last 3 days of the SNF PPS Stay ending on A2400C | sident last entere | ed 7 or more da | ys ago, leave | column 2 blank |
| | | 1. | 2. | 3. | 4. |
| | | On Admission | While Not a Resident | While a Resident | At Discharge |
| | | | ↓ Check all | that apply↓ | |
| A. Par | enteral/IV feeding | | | | |
| B. Fee | ding tube (e.g., nasogastric or abdominal (PEG)) | | | | |
| | chanically altered diet - require change in texture of food or liquids (e.g., pureed d, thickened liquids) | | | | |
| D. The | erapeutic diet (e.g., low salt, diabetic, low cholesterol) | | | | |
| Z. No | ne of the above | | | | |
| | Percent Intake by Artificial Route - Complete K0710 only if Column 2 and | or Column 3 are | e checked for K(|)520A and/or I | K0520B |
| Per 3. Du | ile a Resident formed while a resident of this facility and within the last 7 days ring Entire 7 Days formed during the entire last 7 days | | 2. While a Resident | Dເ Enter Codes∫ | 3. uring Entire 7 Days |
| A. Pro 1. 2. 3. | portion of total calories the resident received through parenteral or tube feeding 25% or less 26-50% 51% or more | | | Linei Oodes | |
| B. Ave 1. 2. | rage fluid intake per day by IV or tube feeding 500 cc/day or less 501 cc/day or more | | | | |
| | | | | | |

| Section | // I | wi - Skin Conditions |
|--------------|-------|---|
| | | Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage |
| M0100. | Def | ermination of Pressure Ulcer/Injury Risk |
| \downarrow | Che | ck all that apply |
| | A. | Resident has a pressure ulcer/injury, 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. | Ris | k of Pressure Ulcers/Injuries |
| Enter Code | ls th | nis resident at risk of developing pressure ulcers/injuries? |
| | | 0. No 1. Yes |
| M0210. | Uni | healed Pressure Ulcers/Injuries |
| Enter Code | | s this resident have one or more unhealed pressure ulcers/injuries? |
| | | No → Skip to M1030, Number of Venous and Arterial Ulcers |
| | | Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| M0300. | Cu | rrent Number of Unhealed Pressure Ulcers/Injuries at Each Stage |
| Enter Number | A. | 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 |
| | | 1. Number of Stage 1 pressure injuries |
| Enter Number | В. | Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister |
| | | 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 |
| Enter Number | | 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| 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 |
| Enter Number | | 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling |
| | | 1. Number of Stage 4 pressure ulcers - If $0 \rightarrow$ Skip to M0300E, Unstageable - Non-removable dressing/device |
| Enter Number | | 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| M03 | 00 c | ontinued on next page |

Identifier _

Resident _

| Resident | | | Identifier Date |
|---------------|------|--------|--|
| Section | on | М - | - Skin Conditions |
| M0300 (| Curr | ent | Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued |
| File North | E. | Uns | stageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device |
| Enter Number | | 1. | Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If $0 \rightarrow$ Skip to M0300F, Unstageable Slough and/or eschar |
| Enter Number | | 2. | Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Enter Number | F. | Uns | stageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar |
| Litter Number | | 1. | Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If $0 \rightarrow Skip$ to M0300G, Unstageable - Deep tissue injury |
| Enter Number | | 2. | Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry |
| Fatas Novahaa | G. | Uns | stageable - Deep tissue injury: |
| Enter Number | | 1. | Number of unstageable pressure injuries presenting as deep tissue injury - If $0 \rightarrow Skip$ to M1030, Number of Venous and Arter Ulcers |
| Enter Number | | 2. | Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were not at the time of admission/entry or reentry |
| M1030. | Nu | mbe | er of Venous and Arterial Ulcers |
| Enter Number | Ent | er the | e total number of venous and arterial ulcers present |
| M1040. | Oth | ner l | Jicers, Wounds and Skin Problems |
| \downarrow | Che | ck al | ll that apply |
| | F | oot F | Problems |
| | A. | Infe | ction of the foot (e.g., cellulitis, purulent drainage) |
| | В. | Dial | betic foot ulcer(s) |
| | C. | Oth | er open lesion(s) on the foot |
| | C | ther | Problems |
| | D. | Оре | en lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) |
| | E. | Sur | gical wound(s) |
| | F. | Bur | n(s) (second or third degree) |
| | G. | Skir | n tear(s) |
| | H. | Moi | sture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) |
| | N | one | of the Above |
| | Z. | Non | ne of the above were present |

| Resident | | Identifier Date |
|----------------|-------------------|---|
| Section | on | M - Skin Conditions |
| M1200. | Sk | in and Ulcer/Injury Treatments |
| \ | Che | eck all that apply |
| | Α. | Pressure reducing device for chair |
| | В. | Pressure reducing device for bed |
| | C. | Turning/repositioning program |
| | D. | Nutrition or hydration intervention to manage skin problems |
| | E. | Pressure ulcer/injury care |
| | F. | Surgical wound care |
| | G. | Application of nonsurgical dressings (with or without topical medications) other than to feet |
| | Н. | Applications of ointments/medications other than to feet |
| | l. | Application of dressings to feet (with or without topical medications) |
| | | |
| Section N0300. | | N - Medications ections |
| Enter Days | Red day | cord the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 as. If $0 \rightarrow \text{Skip}$ to N0415, High-Risk Drug Classes: Use and Indication |
| N0350. | Ins | sulin |
| Enter Days | A. | Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days |
| Enter Days | В. | Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days |

| 1. 2. | Is taking Check if the resident is taking any medications by pharmacological classification, not how it is used, during to reentry if less than 7 days Indication noted | he last 7 days or sinc | e admission/entry |
|----------|---|------------------------|-------------------|
| ۷. | If Column 1 is checked, check if there is an indication noted for all medications in the drug class | | |
| | | 1. | 2. |
| | | Is taking | Indication noted |
| | | ↓ Check all | that apply↓ |
| A. | Antipsychotic | | |
| В. | Antianxiety | | |
| C. | Antidepressant | | |
| D. | Hypnotic | | |
| E. | Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) | | |
| F. | Antibiotic | | |
| G. | Diuretic | | |
| H. | Opioid | | |
| I. | Antiplatelet | | |
| J. | Hypoglycemic (including insulin) | | |
| Z. | None of the above | | |
| | | | |

Identifier _

Resident _

Section N - Medications

N0415. High-Risk Drug Classes: Use and Indication

| esident | | | | Identifier | Date | | |
|------------|--|---|---|------------------------------------|------|--|--|
| Sectio | n N | - M | edications | | | | |
| N2001. | Drug F | Regin | nen Review - Complete only if A0310B = 01 | | | | |
| Enter Code | Did a co | mple | te drug regimen review identify potential clinica | lly significant medication issues? | | | |
| | 0. 1. 9. | Yes | No issues found during review - Issues found during review Resident is not taking any medications | | | | |
| N2003. | Medica | ation | Follow-up - Complete only if N2001 = 1 | | | | |
| Enter Code | Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues? | | | | | | |
| | 0. 1. | No Yes | | | | | |
| N2005. | Medica | ation | Intervention - Complete only if A0310H = 1 | | | | |
| Enter Code | Did the calenda | 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? | | | | | |
| Ш | 0. | No | | | | | |

NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

| Resident | ldentifier | | Date | |
|--|-------------------------|--------------------|--|--------------------|
| Section O - Special Treatments, | Procedures, an | d Program | S | |
| O0110. Special Treatments, Procedures, and F Check all of the following treatments, procedures, and progra | | | | |
| a. On Admission Assessment period is days 1 through 3 of the SNF PPS b. While a Resident Performed while a resident of this facility and within c. At Discharge Assessment period is the last 3 days of the SNF PPS St | the <i>last 14 days</i> | a. On Admission | b. While a Resident Check all that apply | c. At Discharge |
| · · | ay onang on 712 1000 | * | * | + |
| Cancer Treatments | | | | |
| A1. Chemotherapy | | <u> </u> | Ш | Ц |
| A2. IV | | | | |
| A3. Oral A10. Other | | | | |
| B1. Radiation | | | | |
| Respiratory Treatments | | | | Ш |
| C1. Oxygen therapy | | | | |
| C2. Continuous | | | | |
| C3. Intermittent | | | | |
| C4. High-concentration | | | | |
| D1. Suctioning | | | | |
| D2. Scheduled | | | | |
| D3. As needed | | | | |
| E1. Tracheostomy care | | | | |
| F1. Invasive Mechanical Ventilator (ventilator or respirator | -) | | | |
| G1. Non-invasive Mechanical Ventilator | | | | |
| G2. BiPAP | | | | |
| G3. CPAP | | | | |
| Other | | | | |
| H1. IV Medications | | | | |
| H2. Vasoactive medications | | | | |
| H3. Antibiotics | | | | |
| H4. Anticoagulant | | | | |
| H10. Other | | | | |
| I1. Transfusions | | | | |
| O0110 continued on next page | | | | |

| Reside | ent | | Identifier | | Date | |
|--------|---------|-------|--|--------------------------|--------------------------|--------------------|
| Se | ectio | on | O - Special Treatments, Procedures, a | nd Program | IS | |
| | | _ | pecial Treatments, Procedures, and Programs - Continued the following treatments, procedures, and programs that were performed | | | |
| | While | ssme | Int period is days 1 through 3 of the SNF PPS Stay starting with A2400B esident While a resident of this facility and within the last 14 days | a. On Admission | b. While a Resident | c. At Discharge |
| C. | At Dis | scha | · · · · · · · · · · · · · · · · · · · | ↓ | Check all that apply | \downarrow |
| J1. | Dialy | sis | | | | П |
| | | | odialysis | | | |
| | J3. F | Perit | oneal dialysis | | | |
| K1. | Hosp | ice C | Care | | | |
| M1. | | | or quarantine for active infectious disease include standard body/fluid precautions) | | | |
| 01. | IV Ac | cess | | | | |
| | O2. F | Perip | heral | | | |
| | O3. I | Midli | ne | | | |
| | | | ral (e.g., PICC, tunneled, port) | | | |
| Non | e of th | ne Ak | pove | | | |
| Z1. | None | of th | ne above | | | |
| 00 | 250. | Inf | fluenza Vaccine - Refer to current version of RAI manual for current infl | uenza vaccination sea | son and reporting period | |
| Ente | r Code | A. | Did the resident receive the influenza vaccine <i>in this facility</i> for this 0. No → Skip to O0250C, If influenza vaccine not received, state reas 1. Yes → Continue to O0250B, Date influenza vaccine received | | nation season? | |
| | | B. | Date influenza vaccine received → Complete date and skip to O0300A Month Day Year | a, Is the resident's Pne | umococcal vaccination u | p to date? |
| | | C. | If influenza vaccine not received, state reason: | | | |
| Ente | r Code | | Resident not in this facility during this year's influenza vaccination Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | season | | |
| 003 | 300. | Pn | neumococcal Vaccine | | | |
| Ente | r Code | A. | Is the resident's Pneumococcal vaccination up to date? | | | |
| L | | | 0. No \rightarrow Continue to O0300B, If Pneumococcal vaccine not received, 1. Yes \rightarrow Skip to O0400, Therapies | state reason | | |
| Ento | r Code | В. | If Pneumococcal vaccine not received, state reason: | | | |
| Line | . Code | | Not eligible - medical contraindication Offered and declined Not offered | | | |
| | | | | | | |

| Resident | Identifier Date | |
|--|--|-------|
| Section O - | ecial Treatments, Procedures, and Programs | |
| O0400. Therapic | OB = 01 | |
| | 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 last 7 days | the |
| 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 in the last 7 days | |
| 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 residents in the last 7 days | of |
| | If the sum of individual, concurrent, and group minutes is zero, \rightarrow skip to O0400A5, Therapy start date | |
| Enter Number of Minutes | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatments in the last 7 days | nent |
| 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 | |
| | Month Day Year | |
| | Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dash therapy is ongoing | es if |
| | Month Day Year | |
| | Occupational Therapy | |
| Enter Number of Minutes Enter Number of Minutes | Individual minutes - record the total number of minutes this therapy was administered to the resident individually in last 7 days | the |
| 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 in the last 7 days | |
| | 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group residents in the last 7 days | of |
| | If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date | |
| Enter Number of Minutes Enter Number of Days | 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days | nent |
| Liner 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 | |
| | Month Day Year | |
| | 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dash therapy is ongoing | es if |
| | Month Day Year | |
| O0400 continued | • | |

| Resident | | | | Identifier | | Date |
|-------------------------|--------|--|---------------------------|----------------------|---------------------------------------|---|
| Section O - | Speci | al Treatments | s, Proced | lures, and | l Programs | |
| O0400. Therapid | | | | | | |
| Enter Number of Minutes | C. Phy | sical Therapy | | | | |
| Enter Number of Minutes | 1. | Individual minutes - re last 7 days | cord the total nun | nber of minutes thi | s therapy was administered to | o the resident individually in the |
| Enter Number of Minutes | 2. | Concurrent minutes - r with one other residen | | | his therapy was administered | to the resident concurrently |
| Enter Number of Minutes | 3. | Group minutes - record residents in the last 7 d | the total number ays | r of minutes this th | erapy was administered to the | e resident as part of a group of |
| | If the | sum of individual, conc | urrent, and grou | p minutes is zero | ho, ightarrow skip to O0400C5, Thera | py start date |
| Enter Number of Minutes | 3A. | Co-treatment minutes sessions in the last 7 days | - record the total | number of minutes | this therapy was administere | ed to the resident in co-treatment |
| Enter Number of Days | 4. | | • | nerapy was admin | stered for at least 15 minute | s a day in the last 7 days |
| | 5. | Therapy start date - rec | cord the date the | most recent thera | by regimen (since the most re | cent entry) started |
| | | Month Day | Year | | | , |
| | 6. | Therapy end date - rec therapy is ongoing | ord the date the r | nost recent therap | y regimen (since the most rec | eent entry) ended - enter dashes if |
| | | Month Day | Year |] | | |
| | D. Res | piratory Therapy | | | | |
| Enter Number of Days | 2. | Days - record the numb | er of days this th | nerapy was admini | stered for at least 15 minute | s a day in the last 7 days |
| | | | | | | |

| Resident | | Identifier | Date |
|--|--------|--|---|
| Section O - S | Speci | al Treatments, Procedures, and Programs | |
| O0425. Part A The Complete only if A0310 | - | | |
| | A. Spe | ech-Language Pathology and Audiology Services | |
| Enter Number of Minutes Enter Number of Minutes | 1. | Individual minutes - record the total number of minutes this therapy was administered the start date of the resident's most recent Medicare Part A stay (A2400B) | to the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered with one other resident since the start date of the resident's most recent Medicare Parameters. | ed to the resident concurrently art A stay (A2400B) |
| | 3. | Group minutes - record the total number of minutes this therapy was administered to tresidents since the start date of the resident's most recent Medicare Part A stay (A240) | |
| Enter Number of Minutes | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occu | pational Therapy |
| Enter Number of Days | 4. | Co-treatment minutes - record the total number of minutes this therapy was administe sessions since the start date of the resident's most recent Medicare Part A stay (A240) | 0B) |
| | 5. | Days - record the number of days this therapy was administered for at least 15 minuresident's most recent Medicare Part A stay (A2400B) | tes a day since the start date of the |
| | B. Occ | cupational Therapy | |
| Enter Number of Minutes Enter Number of Minutes | 1. | Individual minutes - record the total number of minutes this therapy was administered the start date of the resident's most recent Medicare Part A stay (A2400B) | to the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administere with one other resident since the start date of the resident's most recent Medicare Pa | ed to the resident concurrently art A stay (A2400B) |
| | 3. | Group minutes - record the total number of minutes this therapy was administered to tresidents since the start date of the resident's most recent Medicare Part A stay (A240) | |
| | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physi | cal Therapy |
| Enter Number of Minutes | 4. | Co-treatment minutes - record the total number of minutes this therapy was administed sessions since the start date of the resident's most recent Medicare Part A stay (A240) | |
| Enter Number of Days | 5. | Days - record the number of days this therapy was administered for at least 15 minur resident's most recent Medicare Part A stay (A2400B) | tes a day since the start date of the |
| | C. Phy | sical Therapy | |
| Enter Number of Minutes Enter Number of Minutes | 1. | Individual minutes - record the total number of minutes this therapy was administered the start date of the resident's most recent Medicare Part A stay (A2400B) | to the resident individually since |
| Enter Number of Minutes | 2. | Concurrent minutes - record the total number of minutes this therapy was administered with one other resident since the start date of the resident's most recent Medicare Parameters. | |
| | 3. | Group minutes - record the total number of minutes this therapy was administered to tresidents since the start date of the resident's most recent Medicare Part A stay (A240) | the resident as part of a group of 0B) |
| | If the | sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct | t Calendar Days of Part A Therapy |
| Enter Number of Minutes Enter Number of Days | 4. | Co-treatment minutes - record the total number of minutes this therapy was administed sessions since the start date of the resident's most recent Medicare Part A stay (A240) | ered to the resident in co-treatment 0B) |
| Enter Number of Days | 5. | Days - record the number of days this therapy was administered for at least 15 minuresident's most recent Medicare Part A stay (A2400B) | tes a day since the start date of the |

| Resident | | Identifier | Date | |
|------------------------|--------------|--|---|----------|
| Section | on | O - Special Treatments, Procedures, and Progra | ams | |
| | | stinct Calendar Days of Part A Therapy y if A0310H = 1 | | |
| Enter Number | r of Da | Record the number of calendar days that the resident received Speech-Language Therapy, or Physical Therapy for at least 15 minutes since the start date of the resid (A2400B) | Pathology and Audiology Services, Occudent's most recent Medicare Part A stay | upationa |
| O0500. | Re | estorative Nursing Programs | | |
| Record the none or les | nun s tha | mber of days each of the following restorative programs was performed (for at least 15 minute an 15 minutes daily) | es a day) in the last 7 calendar days (ent | er 0 if |
| Number of Days | Tec | chnique | | |
| | Α. | Range of motion (passive) | | |
| | В. | Range of motion (active) | | |
| | C. | Splint or brace assistance | | |
| Number of Days | Tra | nining and Skill Practice In: | | |
| | D. | Bed mobility | | |
| | Ε. | Transfer | | |
| | F. | Walking | | |
| | G. | Dressing and/or grooming | | |
| | Н. | Eating and/or swallowing | | |
| | I. | Amputation/prostheses care | | |
| | J. | Communication | | |

| esider | nt | | Identifier _ | | Date |
|---------------|-------------------|---------------|--|---|------------------------------|
| Se | ctic | on | P - Restraints and Alarms | | |
| P01 | 00. | Phy | ysical Restraints | | |
| Phys indiv | sical r ⁄idual | estra cann | ints are any manual method or physical or mechanical device, material of tremove easily which restricts freedom of movement or normal access | or equipment attached or adjacent to s to one's body | the resident's body that the |
| 0. 1. | ding N U | ot us sed | sed less than daily daily | | |
| Enter | Cod | es in | Boxes | | |
| ļ | Use | ed in | Bed | | |
| | Α. | Bed | rail | | |
| | В. | Trui | nk restraint | | |
| | C. | Lim | b restraint | | |
| | D. | Oth | er | | |
| | Use | ed in | Chair or Out of Bed | | |
| | E. | Trui | nk restraint | | |
| | F. | Lim | b restraint | | |
| | G. | Cha | ir prevents rising | | |
| | H. | Oth | er | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Sec | ctic | on · | Q - Participation in Assessment and | Goal Setting | |
| | | | ticipation in Assessment and Goal Setting re participants in the assessment process | | |
| ļ | | Che | ck all that apply | | |
| | | A. | Resident | | |
| | | B. | Family | | |
| | | C. | Significant other | | |
| | | D. | Legal guardian | | |
| | | E. | Other legally authorized representative | | |
| Г | 1 | 7 | None of the above | | |

| Resident | | | Identifier | Date |
|------------|--------|-------------------------------|--|------------------------------|
| Section | n (| Q - | Participation in Assessment and Goal Setting | |
| Q0310. | Res | side | nt's Overall Goal | |
| Complete | only i | f A03 | 10E = 1 | |
| Enter Code | Α. | Res 1. 2. 3. 9. | dent's overall goal for discharge established during the assessment process Discharge to the community Remain in this facility Discharge to another facility/institution Unknown or uncertain | |
| Enter Code | B. | 1. 2. 3. 4. | cate information source for Q0310A Resident Family Significant other Legal guardian Other legally authorized representative None of the above | |
| Q0400. | Dis | cha | ge Plan | |
| Enter Code | A. | Is a 0. 1. | tive discharge planning already occurring for the resident to return to the community? No Yes → Skip to Q0610, Referral | |
| Q0490. | Res | side | nt's Documented Preference to Avoid Being Asked Question Q0500B | |
| Complete | • | | 10A = 02, 06, or 99 | |
| Enter Code | Does | 0. | ident's clinical record document a request that this question (Q0500B) be asked only on a comp No Yes \rightarrow Skip to Q0610, Referral | rehensive assessment? |
| Q0500. | Ret | urn | to Community | |
| Enter Code | B. | resp | the resident (or family or significant other or guardian or legally authorized representative only if resident (or family or significant other or guardian or legally authorized representative only if residence on the possibility of leaving this facility and returning community?" No Yes Unknown or uncertain | |
| Enter Code | C. | 1. 2. 3. 4. | cate information source for Q0500B Resident Family Significant other Legal guardian Other legally authorized representative None of the above | |
| Q0550. | Res | side | nt's Preference to Avoid Being Asked Question Q0500B | |
| Enter Code | A. | Doe spor 0. 1. 8. | s resident (or family or significant other or guardian or legally authorized representative only if resident d) want to be asked about returning to the community on all assessments? (Rather than on comp No - then document in resident's clinical record and ask again only on the next comprehensive assess Yes Information not available | rehensive assessments alone) |
| Enter Code | C. | 1. 2. 3. | cate information source for Q0550A Resident Family Significant other Legal guardian Other legally authorized representative None of the above | |



| esident | | Identifier | Date |
|------------|--|--------------------|------|
| Section | on Q - Participation in Assessment | t and Goal Setting | |
| Q0610. | Referral | | |
| Enter Code | A. Has a referral been made to the Local Contact Agency (L 0. No 1. Yes | .CA)? | |
| | Reason Referral to Local Contact Agency (LCA) Nonly if Q0610 = 0 | ot Made | |
| Enter Code | Indicate reason why referral to LCA was not made 1. LCA unknown 2. Referral previously made 3. Referral not wanted 4. Discharge date 3 or fewer months away 5. Discharge date more than 3 months away | | |

| esident Identifier Date | | | |
|--------------------------|--------------|---|---|
| Section | n Ì | X - Correction Request | |
| Identific section, re | atio prod | Section X only if A0050 = 2 or 3 ion of Record to be Modified/Inactivated - The following items is duce the information EXACTLY as it appeared on the existing erroneous re ion is necessary to locate the existing record in the National MDS Database | s record, even if the information is incorrect. |
| X0150. | Тур | pe of Provider (A0200 on existing record to be modified/inactivated) | i) |
| Enter Code | Тур | ype of provider 1. Nursing home (SNF/NF) 2. Swing Bed | |
| X0200. | Naı | ame of Resident (A0500 on existing record to be modified/inactivated) | ed) |
| | A. | First name: | |
| | | | |
| | C. | Last name: | |
| | | | |
| X0300. | Ge | ender (A0800 on existing record to be modified/inactivated) | |
| Enter Code | | 1. Male 2. Female | |
| X0400. | Bir | irth Date (A0900 on existing record to be modified/inactivated) | |
| | | Month Day Year | |
| X0500. | Soc | ocial Security Number (A0600A on existing record to be modified/ina | /inactivated) |
| | | | |
| X0600. | Тур | pe of Assessment (A0310 on existing record to be modified/inactivate | vated) |
| Enter Code | Α. | Federal OBRA Reason for Assessment O1. Admission assessment (required by day 14) O2. Quarterly review assessment O3. Annual assessment O4. Significant change in status assessment O5. Significant correction to prior comprehensive assessment O6. Significant correction to prior quarterly assessment O9. None of the above | |
| Enter Code | B. | PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay | |
| | | 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | |
| Enter Code | F. | Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | |
| Enter Code | Н. | Is this a SNF Part A PPS Discharge Assessment? No Yes | |

| Resident | | Identifier Date | | | |
|--------------|---|--|--|--|--|
| Section | n. | X - Correction Request | | | |
| X0700. | Dat | te on existing record to be modified/inactivated - Complete one only | | | |
| | A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99 | | | | |
| | | Month Day Year | | | |
| | B. | Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12 | | | |
| | Month Day Year | | | | |
| | C. | Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 | | | |
| | | Month Day Year | | | |
| Correcti | on A | Attestation Section - Complete this section to explain and attest to the modification/inactivation request | | | |
| X0800. | Со | rrection Number | | | |
| Enter Number | Ent | er the number of correction requests to modify/inactivate the existing record, including the present one | | | |
| X0900. | Rea | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | |
| \ | Che | eck all that apply | | | |
| | A. | Transcription error | | | |
| | В. | Data entry error | | | |
| | C. | Software product error | | | |
| | D. | Item coding error | | | |
| | Z. | Other error requiring modification | | | |
| | | If "Other" checked, please specify: | | | |
| X1050. | Rea | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | |
| \downarrow | Che | ck 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: | | | |
| | | | | | |
| | В. | Attesting individual's last name: | | | |
| | D. | Attesting individual's last fiame. | | | |
| | | | | | |
| | C. | Attesting individual's title: | | | |
| | D. | Signature | | | |
| | <u>E.</u> | Attestation date | | | |
| | | Month Day Year | | | |

| Resident | | Identifier | Date |
|----------|---------------------------------------|------------|------|
| Section | on Z - Assessment Administration | | |
| Z0100. | Medicare Part A Billing | | |
| | A. Medicare Part A HIPPS code: | | |
| | B. Version code: | | |
| Z0300. | Insurance Billing | | |
| | A. Billing code: B. Billing version: | | |
| | | | |

| I certify that the accompanying information accurately re of this information on the dates specified. To the best of | | | |
|--|--|--|---|
| requirements. I understand that this information is used from federal funds. I further understand that payment of | as a basis for ensuring that residents rec such federal funds and continued partici | ceive appropriate and quality care, ipation in the government-funded h | and as a basis for payment nealth care programs is |
| conditioned on the accuracy and truthfulness of this info civil, and/or administrative penalties for submitting false | ormation, and that I may be personally su information. I also certify that I am autho | bject to or may subject my organiz prized to submit this information by | ation to substantial criminal, this facility on its behalf. |
| Signature | Title | Sections | Date Section Completed |
| A. | | | |
| В. | | | |
| C . | | | |
| D. | | | _ |
| E | | | |
| F | | | |
| <u>G</u> . | | | _ |
| Н. | | | |
| <u>I.</u> | | | _ |
| J. | | | _ |
| <u>K.</u> | | | _ |
| L. | | | |
| Z0500. Signature of RN Assessment Co | ordinator Verifying Assessmen | • | |
| A. Signature: | | B. Date RN Assessment assessment as complete. | |
| | | Month Day | Year |
| | | Monut Day | r Gai |
| | | | |

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Section Z - Assessment Administration

| Resident | 1.1 | D-1- |
|----------|------------|------|
| Resident | Identitier | Date |
| | | |

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

| Section | n . | A - Identification Information |
|------------|----------------|---|
| A0050. | Typ | pe of Record |
| Enter Code | | Add new record → Continue to A0100, Facility Provider Numbers Modify existing record → Continue to A0100, Facility Provider Numbers Inactivate existing record → Skip to X0150, Type of Provider |
| A0100. | Fac | cility Provider Numbers |
| | A. B. C. | National Provider Identifier (NPI): CMS Certification Number (CCN): State Provider Number: |
| A0200. | Тур | pe of Provider |
| Enter Code | Тур | pe of provider 1. Nursing home (SNF/NF) 2. Swing Bed |
| A0310. | Тур | pe of Assessment |
| Enter Code | A. | Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above |
| Enter Code | B. | PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above |
| Enter Code | E. | Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes |
| Enter Code | F. | Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record |

A0310 continued on next page

99. None of the above

| Resident | ldentifier | | Date | | |
|------------|--|---|--------------------------|--|--|
| Section | Section A - Identification Information | | | | |
| A0310. |). Type of Assessment - Continued | | | | |
| Enter Code | G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned | | | | |
| Enter Code | G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes | | | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | | | |
| A0410. |). Unit Certification or Licensure Designation | | | | |
| Enter Code | Unit is neither Medicare nor Medicaid certified and MDS data Unit is neither Medicare nor Medicaid certified but MDS data Unit is Medicare and/or Medicaid certified | is not required by the State is required by the State | | | |
| A0500. |). Legal Name of Resident | | | | |
| | A. First name: C. Last name: | В. D. | Middle initial: Suffix: | | |
| A0600. |). Social Security and Medicare Numbers | | | | |
| | A. Social Security Number: B. Medicare number: | | | | |
| A0700. | D. 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 | | | | |

| Resident | | Identifier Date | |
|------------|--------|--|--|
| Section | on | A - Identification Information | |
| A1005. | | | |
| Are you of | f Hisp | spanic, Latino/a, or Spanish origin? | |
| | Che | heck all that apply | |
| | A. | . No, not of Hispanic, Latino/a, or Spanish origin | |
| | B. | . Yes, Mexican, Mexican American, Chicano/a | |
| | C. | . Yes, Puerto Rican | |
| | D. | . Yes, Cuban | |
| | E. | Yes, another Hispanic, Latino/a, or Spanish origin | |
| | X. | . Resident unable to respond | |
| | Y. | | |
| A1010. | | | |
| What is yo | | | |
| | Cne | heck all that apply | |
| | A. | | |
| | В. | | |
| | C. | . American Indian or Alaska Native | |
| | D. | . Asian Indian | |
| | E. | . Chinese | |
| | F. | Filipino | |
| | G. | . Japanese | |
| | Н. | . Korean | |
| | l. | Vietnamese | |
| | J. | Other Asian | |
| | K. | . Native Hawaiian | |
| | L. | Guamanian or Chamorro | |
| | M. | | |
| | N. | . Other Pacific Islander | |
| | X. | Resident unable to respond | |
| | Y. | Resident declines to respond | |
| | Z. | | |
| A1200. | Ма | arital Status | |
| Enter Code | | Never married Married Widowed Separated Divorced | |

| Resident | | Identifier Date |
|----------------|--|---|
| Section | n . | A - Identification Information |
| Has lack of | of trar | nsportation (from NACHC©) sportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? if A0310G = 1 and A0310H = 1 |
| \downarrow | Che | ck all that apply |
| | A. | Yes, it has kept me from medical appointments or from getting my medications |
| | B. | Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| | C. | No |
| | X. | Resident unable to respond |
| | Y. | Resident declines to respond |
| and its resour | ces ai | ssociation of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE re proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute art or whole without written consent from NACHC. |
| A1300. | Op | tional Resident Items |
| | A. | Medical record number: |
| | _ | |
| | В. | Room number: |
| | • | News brookish weidert neufon to be addressed: |
| | C. | Name by which resident prefers to be addressed: |
| | _ | |
| | D. | Lifetime occupation(s) - put "/" between two occupations: |
| | | |
| | | nt Admission/Entry or Reentry into this Facility |
| A1600. | Ent | Try Date |
| | | |
| | | Month Day Year |
| A1700. | | Type of Entry |
| Enter Code | | 1. Admission 2. Reentry |
| A1805. | | tered From |
| Enter Code | 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. | Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing facility or unit) Inpatient Psychiatric Facility (psychiatric hospital or unit) Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health service organization Not listed |



| Resident | | | Identifier | Date |
|--------------------|---|--|---|------------------------|
| Section | n A | A - Identification Information | | |
| A1900. | Adı | mission Date (Date this episode of care in this t | facility began) | |
| | | Month Day Year | | |
| | | charge Date If A0310F = 10, 11, or 12 | | |
| | | Month Day Year | | |
| | | charge Status if A0310F = 10, 11, or 12 | | |
| Enter Code | 02. 03. 04. 05. 06. 07. 08. 09. 10. 11. 12. | Home/Community (e.g., private home/apt., board/care, arrangements) → Skip to A2123, Provision of Current Recorn Nursing Home (long-term care facility) Skilled Nursing Facility (SNF, swing beds) Short-Term General Hospital (acute hospital, IPPS) Long-Term Care Hospital (LTCH) Inpatient Rehabilitation Facility (IRF, free standing Inpatient Psychiatric Facility (psychiatric hospital or Intermediate Care Facility (ID/DD facility) Hospice (home/non-institutional) Hospice (institutional facility) Critical Access Hospital (CAH) Home under care of organized home health se Deceased Not listed → Skip to A2123, Provision of Current Reconc | facility or unit) unit) rvice organization | other residential care |
| | Pro | evision of Current Reconciled Medication List to | • | |
| Enter Code | • | ne time of discharge to another provider, did your facility provident. No - Current reconciled medication list not provided to the second reconciled medication list provided reconciled medi | he subsequent provider \rightarrow Skip to A2300, Asse | |
| | e rou | ute of Current Reconciled Medication List Trans te(s) of transmission of the current reconciled medication list if A2121 = 1 | | |
| ↓ Che | eck a | Il that apply Route of Transmission | | |
| | A. | Electronic Health Record | | |
| | В. | Health Information Exchange | | |
| | C. | Verbal (e.g., in-person, telephone, video conferencing) | | |
| | D. | Paper-based (e.g., fax, copies, printouts) | | |
| | E. | Other methods (e.g., texting, email, CDs) | | |
| A2123. Complete | | vision of Current Reconciled Medication List to f A0310H = 1 and A2105 = 01, 99 | Resident at Discharge | |
| Enter Code | At th | ne time of discharge, did your facility provide the resident's cur 1. No - Current reconciled medication list not provided to to Date 1. Yes - Current reconciled medication list provided to the | he resident, family and/or caregiver $ ightarrow$ Skip to | • |

| Resident | | ldentifier | | Date |
|-------------|--------|--|--------------|------|
| Section | on. | A - Identification Information | | |
| Indicate th | ne roi | oute of Current Reconciled Medication List Transmission to Residuate(s) of transmission of the current reconciled medication list to the resident/family/or y if A2123 = 1 | | |
| ↓ Cł | neck | k all that apply | | |
| | | Route of Transmission | | |
| | A. | . Electronic Health Record (e.g., electronic access to patient portal) | | |
| | В. | . Health Information Exchange | | |
| | C. | . Verbal (e.g., in-person, telephone, video conferencing) | | |
| | D. | . Paper-based (e.g., fax, copies, printouts) | | |
| | E. | , , , | | |
| A2300. | As | ssessment Reference Date | | |
| | Ob | bservation end date: Month Day Year | | |
| A2400. | Ме | edicare Stay | | |
| Enter Code | A. | Has the resident had a Medicare-covered stay since the most red No → Skip to B0100, Comatose Yes → Continue to A2400B, Start date of most recent Medicare stay | ecent entry? | |
| | В. | 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 | <u>j</u> : | |

| Look | back period for all items is 7 days unless another time frame is indicated |
|------------|---|
| Section | on B - Hearing, Speech, and Vision |
| B0100. | Comatose |
| Enter Code | Persistent vegetative state/no discernible consciousness 0. No → Continue to B1300, Health Literacy 1. Yes → Skip to GG0130, Self-Care |
| | Health Literacy only if A0310B = 01 or A0310G = 1 and A0310H = 1 |
| Enter Code | How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? O. Never Rarely Sometimes Often Always Resident declines to respond Resident unable to respond |

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

Date _

Resident _

| Resident | Id | entifier | Date |
|-------------|---|---|-----------------------------------|
| Section | on C - Cognitive Patterns | | |
| | Should Brief Interview for Mental Status (C0200-C05 = 2 skip to C0700. Otherwise, attempt to conduct interview with all re | | |
| Enter Code | No (resident is rarely/never understood) → Skip to and of the second sec | omplete C0700-C1000, Staff Assessment for | Mental Status |
| Brief Int | terview for Mental Status (BIMS) | | |
| C0200. | Repetition of Three Words | | |
| Enter Code | Ask resident: "I am going to say three words for you to remember. F The words are: sock , blue , and bed . Now tell me the three words Number of words repeated after first attempt | · | ree. |
| Ш | 0. None 1. One 2. Two 3. Three | | |
| | After the resident's first attempt, repeat the words using cues ("sock the words up to two more times. | , something to wear; blue, a color; bed, a piec | ce of furniture"). You may repeat |
| 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 If unable to remember a word, give cue (something to wear; a color; 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 (00-19). Enter 99 if the resident was unable to complete the interview | 5) | |



| Resident | | | Identifier | Date |
|---------------------|------------|---|--|--|
| Section | on C | - Cognitive Patterns | | |
| | Should | d the Staff Assessment for Mental S | Status (C0700 - C1000) be C | onducted? |
| Enter Code | 0. 1. | No (resident was able to complete Brief Inte Yes (resident was unable to complete Brief | | |
| Staff As | sessm | ent for Mental Status | | |
| Do not co | nduct if B | rief Interview for Mental Status (C0200-C0500 | 0) was completed | |
| C0700. | Short- | term Memory OK | | |
| Enter Code | | or appears to recall after 5 minutes Memory OK Memory problem | | |
| C1000. | Cognit | ive Skills for Daily Decision Making | g | |
| Enter Code | 0. 1. | ecisions regarding tasks of daily life Independent - decisions consistent/reason Modified independence - some difficulty ir Moderately impaired - decisions poor; cue Severely impaired - never/rarely made dec | n new situations only es/supervision required | |
| Deliriun | n | | | |
| C1310. | Signs | and Symptoms of Delirium (from C | AM©) | |
| Code afte | er comple | ting Brief Interview for Mental Status or Staff | Assessment, and reviewing medical | record |
| A. Acut | e Onset | Mental Status Change | | |
| Enter Code | | evidence of an acute change in mental sta No Yes | atus from the resident's baseline? | |
| 1. Be | ehavior c | ot present ontinuously present, does not fluctuate resent, fluctuates (comes and goes, change | es in severity) | |
| Enter Code in Boxes | | · · · · · | | |
| | | | | |
| | | ttention - Did the resident have difficulty focu at was being said? | using attention, for example, being ea | asily distractible or having difficulty keeping track of |
| | C. Dis | | | mbling or irrelevant conversation, unclear or illogical |
| | D. Alt | ered Level of Consciousness - Did the residuigilant - startled easily to any sound or touch lethargic - repeatedly dozed off when being ask stuporous - very difficult to arouse and keep are comatose - could not be aroused | ed questions, but responded to voice or | ness, as indicated by any of the following criteria? |

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

| Reside | nt | Identifier | Date | |
|-----------------------|--|---|------------------------|---------------|
| Se | ction D - Mood | | | |
| D0 | 100. Should Resident Mood Interview be Conducted? | | | |
| If A | 0310G = 2 skip to D0700. Otherwise, attempt to conduct interview with a | all residents. | | |
| Enter | No (resident is rarely/never understood) → Skip to an Yes → Continue to D0150, Resident Mood Interview (| | sment of Resident Mod | od (PHQ-9-OV) |
| D0 | 150. Resident Mood Interview (PHQ-2 to 9©) | | | |
| If sy If ye Rea | 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) | | | |
| 2. | No response (leave column 2 blank) Symptom Frequency | | 1. | 2. |
| | 0. Never or 1 day1. 2-6 days (several days) | | Symptom | Symptom |
| | 2. 7-11 days (half or more of the days) | | Presence | Frequency |
| | 3. 12-14 days (nearly every day) | | ↓ Enter Scores | n Boxes↓ |
| A. | Little interest or pleasure in doing things | | | |
| В. | Feeling down, depressed, or hopeless | | | |
| If bo | oth D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D01 | 50B2 are coded 0 or 1, END the PHQ | interview; otherwise | , continue. |
| C. | Trouble falling or staying asleep, or sleeping too muc | h | | |
| D. | Feeling tired or having little energy | | | |
| E. | Poor appetite or overeating | | | |
| F. | Feeling bad about yourself - or that you are a failure of family down | r have let yourself or your | | |
| G. | Trouble concentrating on things, such as reading the television | newspaper or watching | | |
| H. | Moving or speaking so slowly that other people could opposite - being so fidgety or restless that you have be more than usual | | | |
| I. | Thoughts that you would be better off dead, or of hurt | ing yourself in some way | | |
| D0 | 160. Total Severity Score | | | |
| Enter | Add scores for all frequency responses in Column 2, Sympton Enter 99 if unable to complete interview (i.e., Symptom Frequency | om Frequency. Total score must be bet cy is blank for 3 or more required items | ween 00 and 27. s). | |



| Section D - Mood | Resident | Identifier | Date | |
|---|--|--|---------------------|-------------------|
| Do not conduct if Resident Mood Interview (Do150-D0160) was completed Over the last 2 weeks, did the resident have any of the following problems or behaviors? If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency. 1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0 3 in column 2) 2. Symptom Frequency 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day) 4. Little interest or pleasure in doing things B. Feeling or appearing down, depressed, or hopeless C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the opposite being so flidgety or restless that they have been moving around a lot more than usual 1. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score 1. Severity Score 2. New Yellow of the do you lee lonely or isolated from those around you? 2. New Yellow of the do you lee lonely or isolated from those around you? 3. New Yellow of the do you lee lonely or isolated from those around you? 3. Resident declines to respond | Section D - Mood | | | |
| If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Prequency, and indicate symptom frequency. 1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0 Sin column 2) 2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 (days (haif or more of the days) 3. 12-14 days (nearly every day) 4. Little interest or pleasure in doing things B. Feeling or appearing down, depressed, or hopeless C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the opposite being so flogety or restless that they have been moving around a lot more than usual 1. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed DD700. Social Isolation Complete only if A0310G = 1 | · | | | |
| 2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day) A. Little interest or pleasure in doing things B. Feeling or appearing down, depressed, or hopeless C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the oppositebeing so flidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Towler only if A0310G = 1 Enter Cole How often do you feel lonely or isolated from those around you? O. Never 1. Rarely 2. Somettimes 3. Often 4. Always 7. Resident declines to respond | 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) | | s? | |
| B. Feeling or appearing down, depressed, or hopeless C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the oppositebeing so flidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Core How often do you feel lonely or isolated from those around you? 1. Rarely 2. Sometimes 3. Often 4. Allways 7. Resident declines to respond | 2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) | | Symptom Presence | Symptom Frequency |
| C. Trouble falling or staying asleep, or sleeping too much D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the oppositebieng so fidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Cote How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | A. Little interest or pleasure in doing things | | | |
| D. Feeling tired or having little energy E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the opposite being so fidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | B. Feeling or appearing down, depressed, or hopeless | | | |
| E. Poor appetite or overeating F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? O. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | C. Trouble falling or staying asleep, or sleeping too much | | | |
| F. Indicating that they feel bad about self, are a failure, or have let self or family down G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual l. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | D. Feeling tired or having little energy | | | |
| G. Trouble concentrating on things, such as reading the newspaper or watching television H. Moving or speaking so slowly that other people have noticed. Or the oppositebeing so fidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | E. Poor appetite or overeating | | | |
| H. Moving or speaking so slowly that other people have noticed. Or the opposite being so fidgety or restless that they have been moving around a lot more than usual I. States that life isn't worth living, wishes for death, or attempts to harm self J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | F. Indicating that they feel bad about self, are a failure, or have let | self or family down | | |
| States that life isn't worth living, wishes for death, or attempts to harm self | G. Trouble concentrating on things, such as reading the newspape | r or watching television | | |
| J. Being short-tempered, easily annoyed D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | | | | |
| D0600. Total Severity Score Enter Score Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | I. States that life isn't worth living, wishes for death, or attempts to | o harm self | | |
| Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | J. Being short-tempered, easily annoyed | | | |
| Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. D0700. Social Isolation Complete only if A0310G = 1 Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | D0600. Total Severity Score | | | |
| Complete only if A0310G = 1 Enter Code | | otom Frequency. Total score must be be | ween 00 and 30. | |
| Enter Code How often do you feel lonely or isolated from those around you? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | D0700. Social Isolation | | | |
| 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | Complete only if A0310G = 1 | | | |
| | 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond | ? | | |



| Resident | | Ider | ntifier | Date |
|---------------------------|----------------------|--|---|---|
| Section | n E | E - Behavior | | |
| E0100. | Pote | ential Indicators of Psychosis | | |
| Check all ↓ | that a | apply | | |
| | A. | $\textbf{Hallucinations} \ (\text{perceptual experiences in the absence of real experiences}) \\$ | external sensory stimuli) | |
| | В. | Delusions (misconceptions or beliefs that are firmly held, contra | ary to reality) | |
| | Z. | None of the above | | |
| Behavio | oral S | Symptoms | | |
| E0200. | Beh | avioral Symptom - Presence & Frequency | | |
| Note pres | ence | of symptoms and their frequency | | |
| 1. Be 2. Be | havi havi havi | or not exhibited or of this type occurred 1 to 3 days or of this type occurred 4 to 6 days, but less than dail or of this type occurred daily | у | |
| Enter Code | A. | Physical behavioral symptoms directed toward others (e.g., | hitting, kicking, pushing, scratching, grabbi | ng, abusing others sexually) |
| Enter Code | В. | Verbal behavioral symptoms directed toward others (e.g., th | reatening others, screaming at others, curs | ing at others) |
| Enter Code | C. | Other behavioral symptoms not directed toward others (e.g rummaging, public sexual acts, disrobing in public, throwing or s disruptive sounds) | ., physical symptoms such as hitting or scra mearing food or bodily wastes, or verbal/vo | tching self, pacing, cal symptoms like screaming, |
| E0800. | Reje | ection of Care - Presence & Frequency | | |
| Enter Code | goal resid | the resident reject evaluation or care (e.g., bloodwork, taking resident reject evaluation or care (e.g., bloodwork, taking resident have ent or family), and determined to be consistent with resident valuation. Behavior not exhibited Behavior of this type occurred 1 to 3 days Behavior of this type occurred 4 to 6 days, but less than Behavior of this type occurred daily | e already been addressed (é.g., by discussinues, preferences, or goals. | |
| E0900. | War | ndering - Presence & Frequency | | |
| Enter Code | | the resident wandered? Behavior not exhibited Behavior of this type occurred 1 to 3 days Behavior of this type occurred 4 to 6 days, but less than Behavior of this type occurred daily | daily | |

| Resident | ldentifier | Date |
|--|--|--|
| Section | n GG - Functional Abilities and Goals - Disc | charge |
| GG0130. S Complete when | Self-Care (Assessment period is the last 3 days of the Stay) hen A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than | 2 and A2105 is not = 04. |
| | sident's usual performance at the end of the stay for each activity using the ϵ code the reason. | 3-point scale. If an activity was not attempted at the end |
| amount of assi Activities may 06. Indepe 05. Setup 04. Superv comple 03. Partial the effo 02. Substa effort. 01. Depender require If activity was 07. Reside 09. Not ap 10. Not att | stantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper I | elper. ty. Helper assists only prior to or following the activity. eadying and/or contact guard assistance as resident holds, or supports trunk or limbs, but provides less than half ifts or holds trunk or limbs and provides more than half the e the activity. Or, the assistance of 2 or more helpers is |
| 3. Discharge Performance | | |
| Enter Codes in Box | 3oxes | |
| A. | Eating: The ability to use suitable utensils to bring food and/or liquid to the mode before the resident. | uth and swallow food and/or liquid once the meal is placed |
| B. | B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if appl from the mouth, and manage denture soaking and rinsing with use of equipment | icable): The ability to insert and remove dentures into and nt. |
| C. | C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before managing an ostomy, include wiping the opening but not managing equipment. | ore and after voiding or having a bowel movement. If |
| E. | Shower/bathe self: The ability to bathe self, including washing, rinsing, and dr include transferring in/out of tub/shower. | ying self (excludes washing of back and hair). Does not |
| F. | : Upper body dressing: The ability to dress and undress above the waist; include | ding fasteners, if applicable. |
| G. | 6. Lower body dressing: The ability to dress and undress below the waist, include | ding fasteners; does not include footwear. |
| Н. | Putting on/taking off footwear: The ability to put on and take off socks and sh including fasteners, if applicable. | noes or other footwear that is appropriate for safe mobility; |
| | | |

| esident | | Identifier Date |
|--|---|--|
| Sect | tion | GG - Functional Abilities and Goals - Discharge |
| GG01 Comple | I 70. M ete whei | bility (Assessment period is the last 3 days of the Stay) A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04. |
| | | ent's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the ele the reason. |
| amoun Activitie 06. 05. 04. 03. 02. 01. If activ 07. | and Quit of assi es may Indepe Setup of Superv comple Partial/ the effor Substa effort. Depender required rity was Reside | tial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the entry - 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 for the resident to complete the activity. Not attempted, code reason: It refused |
| 09. 10. | Not appoint and Not atte | icable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. npted due to environmental limitations (e.g., lack of equipment, weather constraints) npted due to medical condition or safety concerns |
| Discha Perform | arge lance les in Box | s Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| Ì | В. | Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| | C. | Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support. |
| | D. | Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| |] E. | Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| |] F. | Toilet transfer: The ability to get on and off a toilet or commode. |
| | G. | Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. |
| |] I. | Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb) |
| |] J. | Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| |] K. | Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
| | | |

| Resident | Identifier | Date | | |
|--|---|--|--|--|
| Section GG - Functional Abilities and | d Goals - Dischar | -ge | | |
| GG0170. Mobility (Assessment period is the last 3 days of the Stay) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04. | | | | |
| Code the resident's usual performance at the end of the stay for e of the stay, code the reason. | each activity using the 6-point | t scale. If an activity was not attempted at the end | | |
| Coding: Safety and Quality of Performance - If helper assistance is required amount of assistance provided. Activities may be completed with or without assistive devices. 06. Independent - Resident completes the activity by themself with 05. Setup or clean-up assistance - Helper sets up or cleans up; r 04. Supervision or touching assistance - Helper provides verbal completes activity. Assistance may be provided throughout the 03. Partial/moderate assistance - Helper does LESS THAN HALI the effort. 02. Substantial/maximal assistance - Helper does MORE THAN effort. 01. Dependent - Helper does ALL of the effort. Resident does non 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 perfor 10. Not attempted due to environmental limitations (e.g., lack of the condition or safety concerns | n no assistance from a helper. resident completes activity. Help cues and/or touching/steadying activity or intermittently. F the effort. Helper lifts, holds, or HALF the effort. Helper lifts or lie of the effort to complete the activity prior to the currer of equipment, weather constrain | per assists only prior to or following the activity. g and/or contact guard assistance as resident or supports trunk or limbs, but provides less than half holds trunk or limbs and provides more than half the ctivity. Or, the assistance of 2 or more helpers is nt illness, exacerbation, or injury. | | |
| 3. Discharge Performance Enter Codes in Boxes ↓ L. Walking 10 feet on uneven surfaces: The ability to v | valk 10 feet on uneven or slopin | ng surfaces (indoor or outdoor), such as turf or gravel. | | |
| M. 1 step (curb): The ability to go up and down a curb ar If discharge performance is coded 07, 09, 10, or 88 — | | object | | |
| N. 4 steps: The ability to go up and down four steps with If discharge performance is coded 07, 09, 10, or 88 — | | object | | |
| O. 12 steps: The ability to go up and down 12 steps with | or without a rail. | | | |
| P. Picking up object: The ability to bend/stoop from a st | tanding position to pick up a sm | all object, such as a spoon, from the floor. | | |
| Q3. Does the resident use a wheelchair and/or s | cooter? | | | |
| 0. No \rightarrow Skip to H0100, Appliances 1. Yes \rightarrow Continue to GG0170R, Wheel 50 | feet with two turns | | | |
| R. Wheel 50 feet with two turns: Once seated in wheel | chair/scooter, the ability to whee | el at least 50 feet and make two turns. | | |
| RR3. Indicate the type of wheelchair or scooter us | sed. | | | |
| 1. Manual 2. Motorized | | | | |
| S. Wheel 150 feet: Once seated in wheelchair/scooter, to | he ability to wheel at least 150 f | eet in a corridor or similar space. | | |
| SS3. Indicate the type of wheelchair or scooter us | ed. | | | |
| 1. Manual | | | | |

| Resident | | Identifier | Date |
|--------------|---|--|-----------|
| Section | on H - Bladder and Bowel | | |
| H0100. | Appliances | | |
| \downarrow | Check all that apply | | |
| | A. Indwelling catheter (including suprapubic catheter and ne | phrostomy tube) | |
| | B. External catheter | | |
| | C. Ostomy (including urostomy, ileostomy, and colostomy) | | |
| | D. Intermittent catheterization | | |
| | Z. None of the above | | |
| H0300. | Urinary Continence | | |
| Enter Code | Urinary continence - Select the one category that best describe O. Always continent Cocasionally incontinent (less than 7 episodes of incomplete incontinent) Frequently incontinent (7 or more episodes of urinar Always incontinent) (no episodes of continent voiding) Not rated, resident had a catheter (indwelling, condontinent) | continence) y incontinence, but at least one episode of conti l) | - |
| H0400. | Bowel Continence | | |
| Enter Code | Bowel continence - Select the one category that best describes Always continent Occasionally incontinent (one episode of bowel inco Frequently incontinent (2 or more episodes of bowel Always incontinent (no episodes of continent bowel Not rated, resident had an ostomy or did not have a b | entinence) I incontinence, but at least one continent bowel r movements) | novement) |

| esident | Identifier | Date | |
|-----------|---|------|-------------------|
| Section | on I - Active Diagnosis | | |
| | Diagnoses in the last 7 days - Check all that apply s listed in parentheses are provided as examples and should not be considered as all-inclusive lists culation | | |
| | 10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) | | |
| Genitour | inary | | |
| | I1550. Neurogenic Bladder I1650. Obstructive Uropathy | | |
| Infection | s | | |
| | I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS) | | |
| Metaboli | С | | |
| | 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy) | | |
| Neurolog | jical | | |
| | I5250. Huntington's Disease I5350. Tourette's Syndrome | | |
| Nutrition | al | | |
| | I5600. Malnutrition (protein or calorie) or at risk for malnutrition | | |
| | ric/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 | | | |
| | Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate both A. B. C. D. E. F. G. H. | | |
| | | | $\overline{\Box}$ |
| | I | | Ħ |
| | J | | Ш |
| | | | |

| Resident | lo | dentifier | Date |
|-------------|---|---|---------------------------|
| Section | on J - Health Conditions | | |
| J0100. | Pain Management - Complete for all residents, regardless of of | current pain level | |
| At any time | ne in the last 5 days, has the resident: | | |
| Enter Code | A. Received scheduled pain medication regimen? 0. No 1. Yes | | |
| Enter Code | B. Received PRN pain medications OR was offered 0. No 1. Yes | d and declined? | |
| Enter Code | C. Received non-medication intervention for pain? 0. No 1. Yes | , | |
| | Should Pain Assessment Interview be Conducted? It is comatose or if A0310G = 2, skip to J1100, Shortness of Breath (d | yspnea). Otherwise, attempt to conduct interv | iew with all residents |
| Enter Code | No (resident is rarely/never understood) → Skip to and of the state o | | |
| Pain Ass | ssessment Interview | | |
| J0300. | Pain Presence | | |
| Enter Code | Ask resident: "Have you had pain or hurting at any time in the la | ast 5 davs?" | |
| | 0. No → Skip to J1100, Shortness of Breath | | |
| <u> </u> | Yes → Continue to J0510, Pain Effect on Sleep Unable to answer → Skip to J1100, Shortness of Breath | n (dyspnea) | |
| J0510. | Pain Effect on Sleep | | |
| Enter Code | Ask resident: "Over the past 5 days, how much of the time has pa | ain made it hard for you to sleep at night?" | |
| | 1. Rarely or not at all | , | |
| | 2. Occasionally | | |
| | 3. Frequently | | |
| | 4. Almost constantly | | |
| | 8. Unable to answer | | |
| J0520. | Pain Interference with Therapy Activities | | |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited y | our participation in rehabilitation therapy | sessions due to pain?" |
| | Does not apply - I have not received rehabilitation the | erapy in the past 5 days | |
| | Rarely or not at all Occasionally | | |
| | 3. Frequently | | |
| | 4. Almost constantly | | |
| | 8. Unable to answer | | |
| J0530. | Pain Interference with Day-to-Day Activities | | |
| Enter Code | Ask resident: "Over the past 5 days, how often have you limited y | our day-to-day <i>activities</i> (excluding rehabil | itation therapy sessions) |
| | because of pain?" | | , |
| _ | 1. Rarely or not at all | | |
| | 2. Occasionally | | |
| | 3. Frequently | | |
| | 4. Almost constantly8. Unable to answer | | |



| Resident | | Identifier Date | | | |
|---|-------------|--|--|--|--|
| Section | n | J - Health Conditions | | | |
| Other H J1100. | | n Conditions rtness of Breath (dyspnea) | | | |
| ↓ | Che | ck all that apply | | | |
| | A. | Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring) | | | |
| | В. | 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. | Pro | gnosis | | | |
| Enter Code | | s the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician mentation) 0. No 1. Yes | | | |
| J1550. | Pro | blem Conditions | | | |
| ↓ | Che | ck all that apply | | | |
| | A. | Fever | | | |
| | B. | Vomiting | | | |
| | C. | Dehydrated | | | |
| | D. | Internal bleeding | | | |
| | Z. | None of the above | | | |
| J1800. | | r Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), hever is more recent | | | |
| Enter Code | Has rece | the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more nt? | | | |
| | | No → Skip to K0200, Height and Weight Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) | | | |
| J1900. | Nur | ber of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent | | | |
| Coding: 0. None 1. One 2. Two or more | | | | | |
| Enter Code | s in | Boxes | | | |
| | A. | No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall | | | |
| | В. | 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 | | | |
| | | | | | |

| Residen | | Identifier | Date |
|---------|---|--|--------------------------------------|
| Sec | ction K - Swallowing/Nutritional Sta | atus | |
| K020 | 0. Height and Weight - While measuring, if the number is X.1 - | X.4 round down; X.5 or greater round up | |
| Inches | A. Height (in inches). Record most recent height mea | asure since admission/entry or reentry | |
| Pounds | B. Weight (in pounds). Base weight on most recent r practice (e.g., in a.m. after voiding, before meal, w | neasure in last 30 days; measure weight consisten ith shoes off, etc.) | tly, according to standard facility |
| K03 | 00. Weight Loss | | |
| Enter C | Loss of 5% or more in the last month or loss of 10% or m 0. No or unknown | nore in last 6 months | |
| _ | Yes, on physician-prescribed weight-loss regimen Yes, not on physician-prescribed weight-loss regimen | nen | |
| K03 | 10. Weight Gain | | |
| Enter C | 0. No or unknown1. Yes, on physician-prescribed weight-gain regimen | | |
| K05 | Yes, not on physician-prescribed weight-gain regir Nutritional Approaches | nen | |
| | k all of the following nutritional approaches that apply | | |
| | t Discharge ssessment period is the last 3 days of the SNF PPS Stay ending or | n A2400C | |
| | | | 4. At Discharge Check all that apply |
| A. | Parenteral/IV feeding | | ↓ |
| В. | Feeding tube (e.g., nasogastric or abdominal (PEG)) | | |
| | Mechanically altered diet - require change in texture of food or liq food, thickened liquids) | uids (e.g., pureed | |
| D. | Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | | |
| Z. | None of the above | | |
| | | | |

| Section M - Skin Conditions | | | | |
|-----------------------------|------|---|--|--|
| | | Report based on highest stage of existing ulcers/injuries at their worst; do not "reverse" stage | | |
| M0100. | De | termination of Pressure Ulcer/Injury Risk | | |
| ↓ | Che | eck all that apply | | |
| | A. | Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device | | |
| M0210. | Un | healed Pressure Ulcers/Injuries | | |
| Enter Code | Doe | es this resident have one or more unhealed pressure ulcers/injuries? | | |
| | | No → Skip to N0415, High-Risk Drug Classes: Use and Indication Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | |
| M0300. | Cu | rrent Number of Unhealed Pressure Ulcers/Injuries at Each Stage | | |
| Enter Number | B. | Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister | | |
| Ш | | 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 | | |
| Enter Number | | 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | |
| Enter Number | C. | Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling | | |
| | | 1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 | | |
| Enter Number | | 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | |
| Enter Number | D. | Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling | | |
| | | 1. Number of Stage 4 pressure ulcers - If $0 \rightarrow$ Skip to M0300E, Unstageable - Non-removable dressing/device | | |
| Enter Number | | 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | |
| | E. | Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device | | |
| Enter Number | | Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar | | |
| Enter Number | | 2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | |
| Ed. N. ob. | F. | Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar | | |
| Enter Number | | Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury | | |
| Enter Number | | 2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry | | |
| M0300 d | cont | tinued on next page | | |
| | | | | |

Identifier

Resident _

| Sec | tion | M · | · Skin Conditions | | |
|------------------|-----------------|---|--|------------------------------|-------------------|
| M030 | 00 - Con | tinue | | | |
| | G. | Uns | tageable - Deep tissue injury: | | |
| Enter Num | nber | 1. | Number of unstageable pressure injuries presenting as deep tissue injury - If $0 \to \text{Skip}$ to and Indication | N0415, High-Risk [| Orug Classes: Use |
| Enter Num | nber | 2. | Number of these unstageable pressure injuries that were present upon admission/entry of at the time of admission/entry or reentry | or reentry - enter ho | w many were noted |
| | | | | | |
| | | | | | |
| | | | | | |
| Sec | tion | N - | Medications | | |
| N041 | 15. Hig | gh-R | isk Drug Classes: Use and Indication | | |
| 1. 2. | or reen | if the itry if I t ion n | | e last 7 days or sinc | e admission/entry |
| | II Colui | IIII I I | s checked, check if there is an indication noted for all medications in the drug class | 1. | 2. |
| | | | | Is taking | Indication noted |
| | | | | ↓ Check all | that apply↓ |
| A. | Antips | ycho | ic | | |
| В. | Antian | xiety | | | |
| C. | Antide | press | ant | | |
| D. | Hypno | tic | | | |
| E. | Antico | agula | nt (e.g., warfarin, heparin, or low-molecular weight heparin) | | |
| F. | Antibio | otic | | | |
| G. | Diureti | | | | |
| H. | Opioid | | | | |
| | | | | | |
| l. | Antipla | | | | |
| J. | Hypog | lycen | nic (including insulin) | | |
| | | lycen | , | | |
| J. Z. | Hypog None o | lycen of the | , | | |
| J. Z. | Hypog None o | lycen of the edica I the t enda | above tion Intervention - Complete only if A0310H = 1 acility contact and complete physician (or physician-designee) prescribed/recommended day each time potential clinically significant medication issues were identified since the a | actions by midnigladmission? | |
| J. Z. N200 | Hypog None o | lycen of the edica | above tion Intervention - Complete only if A0310H = 1 acility contact and complete physician (or physician-designee) prescribed/recommended | admission? | nt of the next |

Resident _

| eside | nt Identifier | Date |
|-------------|--|-----------------------------------|
| | ction O - Special Treatments, Procedures, and Progra | ams |
| Che | eck all of the following treatments, procedures, and programs that were performed | |
| C. | At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C | c. At Discharge |
| | | Check all that apply \downarrow |
| Can | ncer Treatments | |
| A 1. | Chemotherapy | |
| | A2. IV | |
| | A3. Oral | |
| | A10. Other | |
| B1. | Radiation | |
| Res | piratory Treatments | |
| C1. | Oxygen therapy | |
| | C2. Continuous | |
| | C3. Intermittent | |
| | C4. High-concentration | |
| D1. | Suctioning | |
| | D2. Scheduled | |
| | D3. As needed | |
| | Tracheostomy care | |
| | Invasive Mechanical Ventilator (ventilator or respirator) | |
| G1. | Non-invasive Mechanical Ventilator | |
| | G2. BiPAP | |
| 041 | G3. CPAP | Ш |
| Oth | | |
| H1. | IV Medications | |
| | H2. Vasoactive medications | |
| | H3. Antibiotics | |
| | H4. Anticoagulant | |
| | H10. Other | |
| 11. | Transfusions | |
| O0 | 110 continued on next page | |

| Resident | | Identifier Date | |
|------------|------------------|---|------------------------|
| | | O - Special Treatments, Procedures, and Programs ecial Treatments, Procedures, and Programs - Continued | |
| | | | |
| Check all | of the | following treatments, procedures, and programs that were performed | |
| | oischa Sessme | arge ent period is the last 3 days of the SNF PPS Stay ending on A2400C | c. At Discharge |
| | | | Check all that apply ↓ |
| J1. Dialys | sis | | |
| J2. H | łemo | dialysis | |
| J3. F | Perito | neal dialysis | |
| K1. Hosp | ice ca | ire . | |
| | | r quarantine for active infectious disease clude standard body/fluid precautions) | |
| O1. IV Ac | cess | | |
| O2. F | Periph | eral | |
| O3. N | /lidlin | е | |
| O4. (| Centra | al (e.g., PICC, tunneled, port) | |
| None of th | e Ab | ove | |
| Z1. None | of th | e above | |
| O0250. | Infl | uenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting per | riod |
| Enter Code | A. | Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? No → Skip to O0250C, If influenza vaccine not received, state reason Yes → Continue to O0250B, Date influenza vaccine received | |
| | B. | Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination Month Day Year | n up to date? |
| | C. | If influenza vaccine not received, state reason: | |
| Enter Code | | Resident not in this facility during this year's influenza vaccination season Received outside of this facility Not eligible - medical contraindication Offered and declined Not offered Inability to obtain influenza vaccine due to a declared shortage None of the above | |
| O0300. | Pne | eumococcal Vaccine | |
| Enter Code | A. | Is the resident's Pneumococcal vaccination up to date? No → Continue to O0300B, If Pneumococcal vaccine not received, state reason Yes → Skip to O0425, Part A Therapies | |
| Enter Code | B. | If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered | |

| A. Speech-Language Pathology and Audiology Services 1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the residents most recent Medicare Part A stay (A2400B) 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 residents most recent Medicare Part A stay (A2400B) 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 residents most recent Medicare Part A stay (A2400B) If the sum of individual, concurrent, and group minutes is zero, — skip to 00425B, Occupational Therapy 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 Enter Number of Minutes 1. Individual 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) B. Occupational Therapy 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) B. Occupational Therapy 1. Individual 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) B. Occupational Therapy 1. Individual 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) If the sum of individual, concurrent, and group minutes is zero, — | Section O - S | Special Treatments, Procedures, and Programs |
|--|--------------------------|---|
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| 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 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) 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) 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 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 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 | |
| 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) 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) 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 00425C, Physical Therapy 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) 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) Physical Therapy 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 | |
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| 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) 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 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 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 Windles | |
| 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 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 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 |
| 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 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 | 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of |
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| resident's most recent Medicare Part A stay (A2400B) C. Physical Therapy 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 | sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| 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) | шш | resident's most recent Medicare Part A stay (A2400B) |
| the start date of the resident's most recent Medicare Part A stay (A2400B) Enter Number of Minutes | Enter Number of Minutes | C. Physical Therapy |
| 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently | Enter Number of Minutes | 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) |
| with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B) | Enter Number of Wilnutes | |
| 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) | Enter Number of Minutes | |
| If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy | | If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy |
| 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 | Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B) |
| Enter Number of Days | Enter Number of Days | 5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the |

| esident | | | | Identifier | | Date |
|-------------------|---------------------------|--|---|---|--|--|
| Sect | tio | n O - S | Special Treatments, Proce | edures, and F | Programs | |
| O043 | 0. | Distinct C | Calendar Days of Part A Therapy | | | |
| Compl | ete o | only if A0310 |)H = 1 | | | |
| nter Nun | nber o | of Days | Record the number of calendar days that the re Therapy, or Physical Therapy for at least 15 min (A2400B) | esident received Speech- utes since the start date | Language Pathology and A of the resident's most rece | Audiology Services, Occupationa nt Medicare Part A stay |
| Sect | tio | n P - F | Restraints and Alarms | | | |
| P010 | 0 . | Physical | Restraints | | | |
| Codin 0. 1. | ual c g: Not Use | estraints are cannot remo t used ed less thar ed daily | any manual method or physical or mechanical de ve easily which restricts freedom of movement or n daily | vice, material or equipme normal access to one's b | ent attached or adjacent to body | the resident's body that the |
| Enter C | odes | s in Boxes | | | | |
| , | Used | d in Bed | | | | |
| | Α. | Bed rail | | | | |
| i | В. | Trunk restr | raint | | _ | |
| | C. | Limb restra | aint | | _ | |
| | D. | Other | | | | |
| | Used | d in Chair o | r Out of Bed | | | |
| ı | E. ' | Trunk restr | raint | | | |
| □ · | F. | Limb restra | aint | | _ | |
| | G. | Chair preve | ents rising | | _ | |
| | Н. | Other | | | | |
| | | | | | | |

| Resident | | Ide | ntifier | Date |
|--------------------------------|---------------|--|--|--|
| | | Q - Participation in Assessment a | and Goal Setting | |
| Enter Code | A. | Is active discharge planning already occurring for the resid 0. No 1. Yes | ent to return to the community? | |
| Q0610. | Ref | erral | | |
| Enter Code | | Has a referral been made to the Local Contact Agency (LCA 0. No 1. Yes | N)? | |
| | | son Referral to Local Contact Agency (LCA) Not f Q0610 = 0 | Made | |
| Enter Code | Indi | 1. LCA unknown 2. Referral previously made 3. Referral not wanted 4. Discharge date 3 or fewer months away 5. Discharge date more than 3 months away | | |
| | | | | |
| Section X - Correction Request | | | | |
| Identific section, re | atio produ | ection X only if A0050 = 2 or 3 n of Record to be Modified/Inactivated - The followin uce the information EXACTLY as it appeared on the existing erro n is necessary to locate the existing record in the National MDS I | neous record, even if the information is in- | ecord that is in error. In this correct. |
| X0150. | Тур | e of Provider (A0200 on existing record to be modified/inaction | ivated) | |
| Enter Code | Тур | e of provider 1. Nursing home (SNF/NF) 2. Swing Bed | | |
| X0200. | Nar | ne of Resident (A0500 on existing record to be modified/inac | ctivated) | |
| | A. | First name: | | |
| | C. | Last name: | | |
| | | | 1 1 1 1 7 | |

| Resident | Identific | er | Date |
|--------------|--|---|----------|
| Section | on X - Correction Request | | |
| X0300. | Gender (A0800 on existing record to be modified/inactivated) | | |
| Enter Code | Male Female | | |
| X0400. | Birth Date (A0900 on existing record to be modified/inactivated) | | |
| | Month Day Year | | |
| X0500. | Social Security Number (A0600A on existing record to be modified | d/inactivated) | |
| | | | |
| X0600. | Type of Assessment (A0310 on existing record to be modified/inac | ctivated) | |
| Enter Code | A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above | t | |
| Enter Code | B. PPS Assessment PPS Scheduled Assessment for a Medicare Part A Stay 01. 5-day scheduled assessment PPS Unscheduled Assessment for a Medicare Part A Stay 08. IPA - Interim Payment Assessment Not PPS Assessment 99. None of the above | | |
| Enter Code | F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above | | |
| Enter Code | H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes | | |
| X0700. | Date on existing record to be modified/inactivated - Complete one | only | |
| | A. Assessment Reference Date (A2300 on existing record to be mode Month Day Year | lified/inactivated) - Complete only if X060 | 00F = 99 |
| | B. Discharge Date (A2000 on existing record to be modified/inactivated) - 0 Month Day Year | Complete only if X0600F = 10, 11, or 12 | |
| | C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete Month Day Year | ete only if X0600F = 01 | |
| Correct | tion Attestation Section - Complete this section to explain and attest | st to the modification/inactivation request | |
| X0800. | Correction Number | | |
| Enter Number | Enter the number of correction requests to modify/inactivate the ex | isting record, including the present o | ne |

| Resident | | Identifier Date | | | | |
|--------------|--------------------------------------|---|--|--|--|--|
| Section | on | X - Correction Request | | | | |
| X0900. | Re | asons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2) | | | | |
| \downarrow | Che | ck 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. | Re | asons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3) | | | | |
| \downarrow | Che | ck all that apply | | | | |
| | A. | Event did not occur | | | | |
| | Z. | Other error requiring inactivation If "Other" checked, please specify: | | | | |
| X1100. | RN | Assessment Coordinator Attestation of Completion | | | | |
| | A. | Attesting individual's first name: | | | | |
| | B. Attesting individual's last name: | | | | | |
| | C. Attesting individual's title: | | | | | |
| | | | | | | |
| | D. Signature | | | | | |
| | E. | Attestation Date Month Day Year | | | | |

| esident | Identifier | Date |
|---|--|---|
| Section Z - Assessment Administra | tion | |
| Z0300. Insurance Billing | | |
| A. Billing code: | | |
| | | |
| B. Billing version: | | |
| | | |
| | | |
| Z0400. Signature of Persons Completing the Asses | • | d that I callosted as according to dead as 110 of ion |
| certify that the accompanying information accurately reflects resident f this information on the dates specified. To the best of my knowledge | this information was collected in accordance | ce with applicable Medicare and Medicaid |
| equirements. I understand that this information is used as a basis for e om federal funds. I further understand that payment of such federal fu | ensuring that residents receive appropriate a | and quality care, and as a basis for payment rnment-funded health care programs is |
| onditioned on the accuracy and truthfulness of this information, and the vil, and/or administrative penalties for submitting false information. I a | nat I may be personally subject to or may sul | bject my organization to substantial criminal |
| Signature | • | etions Date Section |
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| Z0500. Signature of RN Assessment Coordinator V | | Nanagaman (|
| a. Signature: | | Assessment Coordinator signed ent as complete: |
| | | |
| | Month | Day Year |

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