

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Comprehensive (NC) Item Set

Section A	Identification Information
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A0050. Type of Record

Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider
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A0100. Facility Provider Numbers

	<p>A. National Provider Identifier (NPI):</p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> <p>B. CMS Certification Number (CCN):</p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table> <p>C. State Provider Number:</p> <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>																																																

A0200. Type of Provider

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

Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<p>A. Federal OBRA Reason for Assessment</p> <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<p>B. PPS Assessment</p> <p>PPS Scheduled Assessment for a Medicare Part A Stay</p> <ol style="list-style-type: none"> 01. 5-day scheduled assessment <p>PPS Unscheduled Assessment for a Medicare Part A Stay</p> <ol style="list-style-type: none"> 08. IPA - Interim Payment Assessment <p>Not PPS Assessment</p> <ol style="list-style-type: none"> 99. None of the above
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<p>E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</p> <ol style="list-style-type: none"> 0. No 1. Yes
Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<p>F. Entry/discharge reporting</p> <ol style="list-style-type: none"> 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code <input type="checkbox"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code <input type="checkbox"/>	G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes
Enter Code <input type="checkbox"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code <input type="checkbox"/>	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified
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A0500. Legal Name of Resident

	A. First name: <input type="text"/>		B. Middle initial: <input type="text"/>
	C. Last name: <input type="text"/>		D. Suffix: <input type="text"/>

A0600. Social Security and Medicare Numbers

	A. Social Security Number: <input type="text"/> - <input type="text"/> - <input type="text"/>
	B. Medicare number: <input type="text"/>

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

	<input type="text"/>
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A0800. Gender

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

	<input type="text"/> - <input type="text"/> - <input type="text"/>		Month	Day	Year
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Section A**Identification Information****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

A1010. Race

What is your race?

Check all that apply

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

A1110. Language**A. What is your preferred language?**

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

Enter Code

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

0. No
1. Yes
9. Unable to determine

Section A	Identification Information
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A1550. Conditions Related to ID/DD Status
 If the resident is 22 years of age or older, complete only if A0310A = 01
 If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

	ID/DD With Organic Condition
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
ID/DD Without Organic Condition	
<input type="checkbox"/>	E. ID/DD with no organic condition
No ID/DD	
<input type="checkbox"/>	Z. None of the above

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

	<table style="margin: auto;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 12px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 12px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center; font-size: 10px;">Month</td> <td></td> <td colspan="2" style="text-align: center; font-size: 10px;">Day</td> <td></td> <td colspan="4" style="text-align: center; font-size: 10px;">Year</td> </tr> </table>			-			-					Month			Day			Year			
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Month			Day			Year															

A1700. Type of Entry

Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<ol style="list-style-type: none"> 1. Admission 2. Reentry
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A1805. Entered From

Enter Code <input style="width: 20px; height: 20px;" type="checkbox"/>	<ol style="list-style-type: none"> 01. Home/Community (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) 02. Nursing Home (long-term care facility) 03. Skilled Nursing Facility (SNF, swing beds) 04. Short-Term General Hospital (acute hospital, IPPS) 05. Long-Term Care Hospital (LTCH) 06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit) 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) 08. Intermediate Care Facility (ID/DD facility) 09. Hospice (home/non-institutional) 10. Hospice (institutional facility) 11. Critical Access Hospital (CAH) 12. Home under care of organized home health service organization 99. Not listed
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A1900. Admission Date (Date this episode of care in this facility began)

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Month			Day			Year															

A2000. Discharge Date
 Complete only if A0310F = 10, 11, or 12

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		-			-																
Month			Day			Year															

Section A**Identification Information****A2105. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code <input type="checkbox"/>	<p>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</p> <p>02. Nursing Home (long-term care facility)</p> <p>03. Skilled Nursing Facility (SNF, swing beds)</p> <p>04. Short-Term General Hospital (acute hospital, IPPS)</p> <p>05. Long-Term Care Hospital (LTCH)</p> <p>06. Inpatient Rehabilitation Facility (IRF, free standing facility or unit)</p> <p>07. Inpatient Psychiatric Facility (psychiatric hospital or unit)</p> <p>08. Intermediate Care Facility (ID/DD facility)</p> <p>09. Hospice (home/non-institutional)</p> <p>10. Hospice (institutional facility)</p> <p>11. Critical Access Hospital (CAH)</p> <p>12. Home under care of organized home health service organization</p> <p>13. Deceased</p> <p>99. Not listed → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge</p>
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A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code <input type="checkbox"/>	<p>At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?</p> <p>0. No - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction</p> <p>1. Yes - Current reconciled medication list provided to the subsequent provider</p>
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A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

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

Complete only if A2121 = 1

Check all that apply	Route of Transmission
↓	
<input type="checkbox"/>	A. Electronic Health Record
<input type="checkbox"/>	B. Health Information Exchange
<input type="checkbox"/>	C. Verbal (e.g., in-person, telephone, video conferencing)
<input type="checkbox"/>	D. Paper-based (e.g., fax, copies, printouts)
<input type="checkbox"/>	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 <input type="checkbox"/>	<p>At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?</p> <p>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</p> <p>1. Yes - Current reconciled medication list provided to the resident, family and/or caregiver</p>
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Section A**Identification Information****A2124. Route of Current Reconciled Medication List Transmission to Resident**

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.

Complete only if A2123 = 1

Check all that apply**Route of Transmission****A. Electronic Health Record** (e.g., electronic access to patient portal)**B. Health Information Exchange****C. Verbal** (e.g., in-person, telephone, video conferencing)**D. Paper-based** (e.g., fax, copies, printouts)**E. Other methods** (e.g., texting, email, CDs)**A2200. Previous Assessment Reference Date for Significant Correction**

Complete only if A0310A = 05 or 06

		-			-				
Month			Day			Year			

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

		-			-				
Month			Day			Year			

A2400. Medicare Stay

Complete only if A0310G1 = 0

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?0. **No** → Skip to B0100, Comatose1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay**B. Start date of most recent Medicare stay:**

		-			-				
Month			Day			Year			

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

		-			-				
Month			Day			Year			

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

Section B Hearing, Speech, and Vision

B0100. Comatose

- Enter Code **Persistent vegetative state/no discernible consciousness**
0. **No** → Continue to 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. Vision

- 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

B1200. Corrective Lenses

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

Section B**Hearing, Speech, and Vision****B1300. Health Literacy**Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code

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

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

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Section C**Cognitive Patterns****C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**

Attempt to conduct interview with all residents

Enter Code

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

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

Enter Code

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

Number of words repeated after first attempt

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

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

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

Enter Code

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

A. Able to report correct year

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

Enter Code

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

B. Able to report correct month

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

Enter Code

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

C. Able to report correct day of the week

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

C0400. Recall

Enter Code

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

A. Able to recall "sock"

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

Enter Code

B. Able to recall "blue"

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

Enter Code

C. Able to recall "bed"

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

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)

Enter 99 if the resident was unable to complete the interview



Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code

- 0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
- 1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code

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

C0800. Long-term Memory OK

Enter Code

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

C0900. Memory/Recall Ability

↓ Check all that the resident was normally able to recall

- A. Current season**
- B. Location of own room**
- C. Staff names and faces**
- D. That they are in a nursing home/hospital swing bed**
- Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code

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

Delirium

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

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

A. Acute Onset Mental Status Change

Enter Code

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

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

↓ Enter Codes in Boxes

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

C. Disorganized Thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

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

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

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

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

Enter Code <input style="width:30px; height:20px;" type="checkbox"/>	<p>0. No (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)</p> <p>1. Yes → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)</p>
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D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
 If yes in column 1, then ask the resident: "About **how often** have you been bothered by this?"
 Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

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

A. Little interest or pleasure in doing things	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
B. Feeling down, depressed, or hopeless	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

C. Trouble falling or staying asleep, or sleeping too much	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
D. Feeling tired or having little energy	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
E. Poor appetite or overeating	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
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	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input style="width:30px; height:20px;" type="checkbox"/>	<input style="width:30px; height:20px;" type="checkbox"/>

D0160. Total Severity Score

Enter Score <input style="width:30px; height:20px;" type="text"/>	<p>Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).</p>
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Section D**Mood****D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)**

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

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

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

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

	1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2)	2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	1. Symptom Presence	2. Symptom Frequency
			↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things			<input type="text"/>	<input type="text"/>
B. Feeling or appearing down, depressed, or hopeless			<input type="text"/>	<input type="text"/>
C. Trouble falling or staying asleep, or sleeping too much			<input type="text"/>	<input type="text"/>
D. Feeling tired or having little energy			<input type="text"/>	<input type="text"/>
E. Poor appetite or overeating			<input type="text"/>	<input type="text"/>
F. Indicating that they feel bad about self, are a failure, or have let self or family down			<input type="text"/>	<input type="text"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television			<input type="text"/>	<input type="text"/>
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			<input type="text"/>	<input type="text"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self			<input type="text"/>	<input type="text"/>
J. Being short-tempered, easily annoyed			<input type="text"/>	<input type="text"/>

D0600. Total Severity Score

Enter Score

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

D0700. Social Isolation

Enter Code

How often do you feel lonely or isolated from those around you?

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



Section E**Behavior****E0100. Potential Indicators of Psychosis**

↓ Check all that apply

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

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

Note presence of symptoms and their frequency

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

E0300. Overall Presence of Behavioral Symptoms

Enter Code <input type="checkbox"/>	Were 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. Impact on Resident

Enter Code <input type="checkbox"/>	Did any of the identified symptom(s): A. Put the resident at significant risk for physical illness or injury? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Significantly interfere with the resident's care? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Significantly interfere with the resident's participation in activities or social interactions? 0. No 1. Yes

E0600. Impact on Others

Enter Code <input type="checkbox"/>	Did any of the identified symptom(s): A. Put others at significant risk for physical injury? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Significantly disrupt care or living environment? 0. No 1. Yes

E0800. Rejection of Care - Presence & Frequency

Enter Code <input type="checkbox"/>	Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days , but less than daily 3. Behavior of this type occurred daily
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Section E	Behavior
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E0900. Wandering - Presence & Frequency
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Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>Has the resident wandered?</p> <p>0. Behavior not exhibited → Skip to E1100, Change in Behavior or Other Symptoms</p> <p>1. Behavior of this type occurred 1 to 3 days</p> <p>2. Behavior of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p>
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E1000. Wandering - Impact

Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>B. Does the wandering significantly intrude on the privacy or activities of others?</p> <p>0. No</p> <p>1. Yes</p>

E1100. Change in Behavior or Other Symptoms
--

Consider all of the symptoms assessed in items E0100 through E1000	
Enter Code <input style="width: 30px; height: 20px;" type="checkbox"/>	<p>How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?</p> <p>0. Same</p> <p>1. Improved</p> <p>2. Worse</p> <p>3. N/A because no prior MDS assessment</p>

Section F**Preferences for Customary Routine and Activities**

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: "**While you are in this facility...**"

↓ Enter Codes in Boxes

Coding:

1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

A. how important is it to you to **choose what clothes to wear?**B. how important is it to you to **take care of your personal belongings or things?**C. how important is it to you to **choose between a tub bath, shower, bed bath, or sponge bath?**D. how important is it to you to **have snacks available between meals?**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 friend involved in discussions about your care?**G. how important is it to you to **be able to use the phone in private?**H. how important is it to you to **have a place to lock your things to keep them safe?****F0500. Interview for Activity Preferences**

Show resident the response options and say: "**While you are in this facility...**"

↓ Enter Codes in Boxes

Coding:

1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

A. how important is it to you to **have books, newspapers, and magazines 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 pets?**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 people?**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 the weather is good?**H. how important is it to you to **participate in religious services or practices?****F0600. Daily and Activity Preferences Primary Respondent**

Enter Code

Indicate **primary respondent** for Daily and Activity Preferences (F0400 and F0500)

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")



Section F**Preferences for Customary Routine and Activities****F0700. Should 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) → Skip to and complete GG0100, Prior Functioning: Everyday Activities
1. **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. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply

- | | |
|--------------------------|---|
| <input type="checkbox"/> | A. Choosing clothes to wear |
| <input type="checkbox"/> | B. Caring for personal belongings |
| <input type="checkbox"/> | C. Receiving tub bath |
| <input type="checkbox"/> | D. Receiving shower |
| <input type="checkbox"/> | E. Receiving bed bath |
| <input type="checkbox"/> | F. Receiving sponge bath |
| <input type="checkbox"/> | G. Snacks between meals |
| <input type="checkbox"/> | H. Staying up past 8:00 p.m. |
| <input type="checkbox"/> | I. Family or significant other involvement in care discussions |
| <input type="checkbox"/> | J. Use of phone in private |
| <input type="checkbox"/> | K. Place to lock personal belongings |
| <input type="checkbox"/> | L. Reading books, newspapers, or magazines |
| <input type="checkbox"/> | M. Listening to music |
| <input type="checkbox"/> | N. Being around animals such as pets |
| <input type="checkbox"/> | O. Keeping up with the news |
| <input type="checkbox"/> | P. Doing things with groups of people |
| <input type="checkbox"/> | Q. Participating in favorite activities |
| <input type="checkbox"/> | R. Spending time away from the nursing home |
| <input type="checkbox"/> | S. Spending time outdoors |
| <input type="checkbox"/> | T. Participating in religious activities or practices |
| <input type="checkbox"/> | Z. None of the above |

Section GG**Functional Abilities and Goals**

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding: 3. Independent - Resident completed all the activities by themselves, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Resident needed partial assistance from another person to complete any activities. 1. Dependent - A helper completed all the activities for the resident. 8. Unknown. 9. Not Applicable.	↓	Enter Codes in Boxes
	<input type="checkbox"/>	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.
	<input type="checkbox"/>	B. 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.
	<input type="checkbox"/>	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.
	<input type="checkbox"/>	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.

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

↓	Check all that apply
<input type="checkbox"/>	A. Manual wheelchair
<input type="checkbox"/>	B. Motorized wheelchair and/or scooter
<input type="checkbox"/>	C. Mechanical lift
<input type="checkbox"/>	D. Walker
<input type="checkbox"/>	E. Orthotics/Prosthetics
<input type="checkbox"/>	Z. None of the above

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
	<input type="checkbox"/>	A. Upper extremity (shoulder, elbow, wrist, hand)
	<input type="checkbox"/>	B. Lower extremity (hip, knee, ankle, foot)

GG0120. Mobility Devices

↓ **Check all that were normally used in the last 7 days**

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

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

If activity was not attempted, code reason:

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

1. Admission Performance	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.
□ □	□ □	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).

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.

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

If activity was not attempted, code reason:

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

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/>	<input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/>	<input type="text"/>	FF. Tub/shower transfer: The ability to get in and out of a tub/shower.
<input type="text"/>	<input type="text"/>	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.
<input type="text"/>	<input type="text"/>	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)
<input type="text"/>	<input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/>	<input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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

If activity was not attempted, code reason:

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

1. Admission Performance	2. Discharge 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 → 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.
□ □	□ □	<input type="checkbox"/> Q1. Does the resident use a wheelchair and/or scooter? 0. No → Skip to GG0130, Self Care (Discharge) 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.
□ □	□ □	<input type="checkbox"/> 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.
□ □	□ □	<input type="checkbox"/> SS1. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

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

If activity was not attempted, code reason:

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

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/> <input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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).

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

If activity was not attempted, code reason:

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

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/> <input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/> <input type="text"/>	FF. Tub/shower transfer: The ability to get in and out of a tub/shower.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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)
<input type="text"/> <input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/> <input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG**Functional Abilities and Goals - Discharge****GG0170. Mobility** (Assessment period is the last 3 days of the stay)**Complete 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.**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 themselves with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

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

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	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.
<input type="text"/>	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 → Skip to GG0170P, Picking up object
<input type="text"/>	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 → Skip to GG0170P, Picking up object
<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	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.
<input type="checkbox"/>	Q3. 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
<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="checkbox"/>	RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

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

If activity was not attempted, code reason:

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

5. OBRA/Interim Performance	
Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/> <input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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).

Section GG**Functional Abilities and Goals - OBRA/Interim****GG0170. Mobility** (Assessment period is the ARD plus 2 previous calendar days)**Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.****Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

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

If activity was not attempted, code reason:

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

5. OBRA/Interim Performance	
Enter Codes in Boxes ↓	
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	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.
<input type="text"/> <input type="text"/>	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
<input type="text"/> <input type="text"/>	F. Toilet transfer: The ability to get on and off a toilet or commode.
<input type="text"/> <input type="text"/>	FF. Tub/shower transfer: The ability to get in and out of a tub/shower.
<input type="text"/> <input type="text"/>	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?
<input type="text"/> <input type="text"/>	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
<input type="text"/> <input type="text"/>	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG**Functional Abilities and Goals - 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 themselves with no assistance from a helper.
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04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

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

5. OBRA/Interim Performance	
Enter Codes in Boxes ↓	
<input type="checkbox"/>	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
<input type="checkbox"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="checkbox"/>	RR5. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="checkbox"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="checkbox"/>	SS5. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

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

↓ Check all that apply

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

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 H0200B, Response
 9. **Unable to determine** → Skip to H0200C, Current toileting program or trial
- 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 bladder training) currently being used to manage the resident's urinary continence?**
 0. **No**
 1. **Yes**

H0300. Urinary Continence

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

H0400. Bowel Continence

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

H0500. Bowel Toileting Program

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

H0600. Bowel Patterns

- Enter Code **Constipation present?**
 0. **No**
 1. **Yes**

Section I**Active Diagnoses****I0020. Indicate the resident's primary medical condition category**

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code

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

I0020B. ICD Code

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

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

<input type="checkbox"/>	Cancer
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
<input type="checkbox"/>	Heart/Circulation
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
<input type="checkbox"/>	Genitourinary
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
<input type="checkbox"/>	Infections
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
<input type="checkbox"/>	Metabolic
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	I3900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	Neurological
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	I4800. 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)

Neurological Diagnoses continued on next page

Section I Active Diagnoses

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

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

Neurological - Continued																	
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis																
<input type="checkbox"/>	I5000. Paraplegia																
<input type="checkbox"/>	I5100. Quadriplegia																
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)																
<input type="checkbox"/>	I5250. Huntington's Disease																
<input type="checkbox"/>	I5300. Parkinson's Disease																
<input type="checkbox"/>	I5350. Tourette's Syndrome																
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy																
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)																
Nutritional																	
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition																
Psychiatric/Mood Disorder																	
<input type="checkbox"/>	I5700. Anxiety Disorder																
<input type="checkbox"/>	I5800. Depression (other than bipolar)																
<input type="checkbox"/>	I5900. Bipolar Disorder																
<input type="checkbox"/>	I5950. Psychotic Disorder (other than schizophrenia)																
<input type="checkbox"/>	I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)																
<input type="checkbox"/>	I6100. Post Traumatic Stress Disorder (PTSD)																
Pulmonary																	
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)																
<input type="checkbox"/>	I6300. Respiratory Failure																
Vision																	
<input type="checkbox"/>	I6500. Cataracts, Glaucoma, or Macular Degeneration																
None of Above																	
<input type="checkbox"/>	I7900. None of the above active diagnoses within the last 7 days																
Other																	
I8000. Additional active diagnoses																	
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.																	
A. _____	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
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Section J**Health Conditions****J0100. Pain Management** - Complete for all residents, regardless of current pain levelAt any time in the last **5** days, has the resident:

Enter Code <input type="checkbox"/>	A. Received scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Received non-medication intervention for pain? 0. No 1. Yes

J0200. Should Pain Assessment Interview be Conducted?

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

Enter Code <input type="checkbox"/>	0. No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain 1. Yes → Continue to J0300, Pain Presence
--	--

Pain Assessment Interview**J0300. Pain Presence**

Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	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 <input type="checkbox"/>	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 <input type="checkbox"/>	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
--	---



Section J**Health Conditions****Pain Assessment Interview - Continued****J0530. Pain Interference with Day-to-Day Activities**

Enter Code <input type="checkbox"/>	<p>Ask resident: <i>"Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"</i></p> <ol style="list-style-type: none"> 1. Rarely or not at all 2. Occasionally 3. Frequently 4. Almost constantly 8. Unable to answer
--	--

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

Enter Rating <input type="text"/>	<p>A. Numeric Rating Scale (00-10) Ask resident: <i>"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."</i> (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.</p>
Enter Code <input type="checkbox"/>	<p>B. Verbal Descriptor Scale Ask resident: <i>"Please rate the intensity of your worst pain over the last 5 days."</i> (Show resident verbal scale)</p> <ol style="list-style-type: none"> 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> 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
--	--

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

↓ Check all that apply

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) |
| <input type="checkbox"/> | B. Vocal complaints of pain (e.g., that hurts, ouch, stop) |
| <input type="checkbox"/> | C. Facial expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) |
| <input type="checkbox"/> | 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) |
| <input type="checkbox"/> | 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 <input type="checkbox"/>	<p>Frequency with which resident complains or shows evidence of pain or possible pain</p> <ol style="list-style-type: none"> 1. Indicators of pain or possible pain observed 1 to 2 days 2. Indicators of pain or possible pain observed 3 to 4 days 3. Indicators of pain or possible pain observed daily
--	---

Section J	Health Conditions
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Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring) |
| <input type="checkbox"/> | B. Shortness of breath or trouble breathing when sitting at rest |
| <input type="checkbox"/> | C. Shortness of breath or trouble breathing when lying flat |
| <input type="checkbox"/> | Z. None of the above |

J1300. Current Tobacco Use

Enter Code <input type="checkbox"/>	Tobacco use 0. No 1. Yes
--	---

J1400. Prognosis

Enter Code <input type="checkbox"/>	Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation) 0. No 1. Yes
--	--

J1550. Problem Conditions

↓ Check all that apply

- | | |
|--------------------------|-----------------------------|
| <input type="checkbox"/> | A. Fever |
| <input type="checkbox"/> | B. Vomiting |
| <input type="checkbox"/> | C. Dehydrated |
| <input type="checkbox"/> | D. Internal bleeding |
| <input type="checkbox"/> | Z. None of the above |

J1700. Fall History on Admission/Entry or Reentry Complete only if A0310A = 01 or A0310E = 1
--

Enter Code <input type="checkbox"/>	A. Did the resident have a fall any time in the last month prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	C. Did the resident have any fracture related to a fall in the 6 months prior to admission/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 <input type="checkbox"/>	Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent? 0. No → Skip to J2000, Prior Surgery 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)
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Section J	Health Conditions
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J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes						
	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; text-align: center; vertical-align: middle;"><input type="checkbox"/></td> <td style="padding-left: 5px;"> 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 </td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input type="checkbox"/></td> <td style="padding-left: 5px;"> B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain </td> </tr> <tr> <td style="text-align: center; vertical-align: middle;"><input type="checkbox"/></td> <td style="padding-left: 5px;"> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma </td> </tr> </table>	<input type="checkbox"/>	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall	<input type="checkbox"/>	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain	<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
<input type="checkbox"/>	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall						
<input type="checkbox"/>	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain						
<input type="checkbox"/>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma						

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code <input type="checkbox"/>	Did the resident have major surgery during the 100 days prior to admission ? 0. No 1. Yes 8. Unknown
--	---

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code <input type="checkbox"/>	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. No 1. Yes 8. Unknown
--	--

Section J**Health Conditions****Surgical Procedures** - Complete only if J2100 = 1

↓ Check all that apply

Major Joint 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 Surgery

- 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 Orthopedic Surgery

- J2500. **Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
- J2510. **Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
- J2520. **Repair but not replace joints**
- J2530. **Repair other bones** (such as hand, foot, jaw)
- J2599. **Other major orthopedic surgery**

Neurological Surgery

- J2600. **Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
- J2610. **Involving the peripheral or autonomic nervous system** - open or percutaneous
- J2620. **Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
- J2699. **Other major neurological surgery**

Cardiopulmonary Surgery

- J2700. **Involving the heart or major blood vessels** - open or percutaneous procedures
- J2710. **Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
- J2799. **Other major cardiopulmonary surgery**

Genitourinary Surgery

- J2800. **Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
- J2810. **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
- J2899. **Other major genitourinary surgery**

Other Major Surgery

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

Section K	Swallowing/Nutritional Status
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K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ Check all that apply

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

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

<input style="width: 20px; height: 20px;" type="text"/> inches	A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry
<input style="width: 20px; height: 20px;" type="text"/> pounds	B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

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

K0310. Weight Gain

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

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
1. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B 2. While Not a Resident Performed <i>while NOT a resident</i> 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 <i>while a resident</i> 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	↓	↓	↓	↓
	Check all that apply			
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section K	Swallowing/Nutritional Status
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K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B		
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i> 3. During Entire 7 Days Performed during the entire <i>last 7 days</i>	2. While a Resident	3. During Entire 7 Days
	↓	↓
	Enter Codes	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	<input type="checkbox"/>	<input type="checkbox"/>
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	<input type="checkbox"/>	<input type="checkbox"/>

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

Section M**Skin Conditions**

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

M0100. Determination of Pressure Ulcer/Injury Risk

↓ Check all that apply

- A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**
- 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
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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

Enter Number <input type="checkbox"/>	<p>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</p> <p>1. Number of Stage 1 pressure injuries</p>
Enter Number <input type="checkbox"/>	<p>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</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>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</p>
Enter Number <input type="checkbox"/>	<p>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</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> <p>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</p>
Enter Number <input type="checkbox"/>	<p>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</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device</p> <p>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</p>

M0300 continued on next page

Section M**Skin Conditions****M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued**

Enter Number <input type="text"/>	E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device
Enter Number <input type="text"/>	1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar
Enter Number <input type="text"/>	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 <input type="text"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number <input type="text"/>	1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury
Enter Number <input type="text"/>	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
Enter Number <input type="text"/>	G. Unstageable - Deep tissue injury:
Enter Number <input type="text"/>	1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers
Enter Number <input type="text"/>	2. Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

M1030. Number of Venous and Arterial Ulcers

Enter Number <input type="text"/>	Enter the total number of venous and arterial ulcers present
--------------------------------------	---

M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply	
	Foot Problems
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
	Other Problems
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
<input type="checkbox"/>	Z. None of the above were present

Section M**Skin Conditions****M1200. Skin and Ulcer/Injury Treatments**

↓ Check all that apply

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

Section N	Medications
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N0300. Injections

Enter Days <input style="width: 30px; height: 20px;" type="text"/>	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
---	---

N0350. Insulin

Enter Days <input style="width: 30px; height: 20px;" type="text"/>	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 <input style="width: 30px; height: 20px;" type="text"/>	B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days

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

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

Section N**Medications****N0450. Antipsychotic Medication Review**

Enter Code

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip N0450B, N0450C, N0450D, and N0450E
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

		-			-				
Month			Day			Year			

Enter Code

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip N0450E, Date physician documented GDR as clinically contraindicated
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

		-			-				
Month			Day			Year			

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

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

Section O**Special Treatments, Procedures, and Programs****O0110. Special Treatments, Procedures, and Programs**

Check all of the following treatments, procedures, and programs that were performed

a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B b. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i> c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	a. On Admission	b. While a Resident	c. At Discharge
	Check all that apply		
	↓	↓	↓
Cancer Treatments			
A1. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A2. IV	<input type="checkbox"/>		<input type="checkbox"/>
A3. Oral	<input type="checkbox"/>		<input type="checkbox"/>
A10. Other	<input type="checkbox"/>		<input type="checkbox"/>
B1. Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Treatments			
C1. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C2. Continuous	<input type="checkbox"/>		<input type="checkbox"/>
C3. Intermittent	<input type="checkbox"/>		<input type="checkbox"/>
C4. High-concentration	<input type="checkbox"/>		<input type="checkbox"/>
D1. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D2. Scheduled	<input type="checkbox"/>		<input type="checkbox"/>
D3. As needed	<input type="checkbox"/>		<input type="checkbox"/>
E1. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F1. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G1. Non-invasive Mechanical Ventilator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G2. BiPAP	<input type="checkbox"/>		<input type="checkbox"/>
G3. CPAP	<input type="checkbox"/>		<input type="checkbox"/>
Other			
H1. IV Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H2. Vasoactive medications	<input type="checkbox"/>		<input type="checkbox"/>
H3. Antibiotics	<input type="checkbox"/>		<input type="checkbox"/>
H4. Anticoagulant	<input type="checkbox"/>		<input type="checkbox"/>
H10. Other	<input type="checkbox"/>		<input type="checkbox"/>
I1. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 A2400B b. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i> c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	a. On Admission	b. While a Resident	c. At Discharge
	Check all that apply		
	↓	↓	↓
J1. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J2. Hemodialysis	<input type="checkbox"/>		<input type="checkbox"/>
J3. Peritoneal dialysis	<input type="checkbox"/>		<input type="checkbox"/>
K1. Hospice care		<input type="checkbox"/>	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		<input type="checkbox"/>	
O1. IV Access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O2. Peripheral	<input type="checkbox"/>		<input type="checkbox"/>
O3. Midline	<input type="checkbox"/>		<input type="checkbox"/>
O4. Central (e.g., PICC, tunneled, port)	<input type="checkbox"/>		<input type="checkbox"/>
None of the Above			
Z1. None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Enter Code <input type="checkbox"/>	A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? 0. No → Skip to O0250C, If influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date influenza vaccine received
	B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 10px;">Month</div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 10px;">Day</div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 10px;">Year</div> </div>
Enter Code <input type="checkbox"/>	C. If influenza vaccine not received, state reason: 1. Resident not in this facility during this year's influenza vaccination season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain influenza vaccine due to a declared shortage 9. None of the above

O0300. Pneumococcal Vaccine

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

Section O**Special Treatments, Procedures, and Programs****00400. Therapies****A. Speech-Language Pathology and Audiology Services**

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

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 of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, 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

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			

B. Occupational Therapy

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

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 of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, 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

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			

00400 continued on next page

Section O**Special Treatments, Procedures, and Programs****00400. Therapies - Continued**

Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/>	C. Physical Therapy <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days 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 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 <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <ol style="list-style-type: none"> 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 Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/>	D. Respiratory Therapy <ol style="list-style-type: none"> 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 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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/>	E. Psychological Therapy (by any licensed mental health professional) <ol style="list-style-type: none"> 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 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 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/>	F. Recreational Therapy (includes recreational and music therapy) <ol style="list-style-type: none"> 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 Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
00420. Distinct Calendar Days of Therapy	
Enter Number of Days <input type="text"/>	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**Special Treatments, Procedures, and Programs****O0425. Part A Therapies**

Complete only if A0310H = 1

Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter Number of Days <input type="text"/> <input type="text"/> <input type="text"/>	A. Speech-Language Pathology and Audiology Services <ol style="list-style-type: none"> 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) <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy</p> <ol style="list-style-type: none"> 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 <ol style="list-style-type: none"> 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) <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy</p> <ol style="list-style-type: none"> 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) C. Physical Therapy <ol style="list-style-type: none"> 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) <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy</p> <ol style="list-style-type: none"> 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)
O0430. Distinct Calendar Days of Part A Therapy Complete only if A0310H = 1 Enter Number of Days <input type="text"/> <input type="text"/> <input type="text"/>	Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes since the start date of the resident's most recent Medicare Part A stay (A2400B)

Section O**Special Treatments, Procedures, and Programs****O0500. Restorative Nursing Programs**

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

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

Section P	Restraints and Alarms
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P0100. Physical Restraints

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

<p>Coding:</p> <ul style="list-style-type: none"> 0. Not used 1. Used less than daily 2. Used daily 	<p style="text-align: center;">↓ Enter Codes in Boxes</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="background-color: #e0e0e0;">Used in Bed</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>A. Bed rail</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>B. Trunk restraint</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>C. Limb restraint</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>D. Other</td> </tr> <tr> <td></td> <td style="background-color: #e0e0e0;">Used in Chair or Out of Bed</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>E. Trunk restraint</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>F. Limb restraint</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>G. Chair prevents rising</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>H. Other</td> </tr> </table>		Used in Bed	<input type="checkbox"/>	A. Bed rail	<input type="checkbox"/>	B. Trunk restraint	<input type="checkbox"/>	C. Limb restraint	<input type="checkbox"/>	D. Other		Used in Chair or Out of Bed	<input type="checkbox"/>	E. Trunk restraint	<input type="checkbox"/>	F. Limb restraint	<input type="checkbox"/>	G. Chair prevents rising	<input type="checkbox"/>	H. Other
	Used in Bed																				
<input type="checkbox"/>	A. Bed rail																				
<input type="checkbox"/>	B. Trunk restraint																				
<input type="checkbox"/>	C. Limb restraint																				
<input type="checkbox"/>	D. Other																				
	Used in Chair or Out of Bed																				
<input type="checkbox"/>	E. Trunk restraint																				
<input type="checkbox"/>	F. Limb restraint																				
<input type="checkbox"/>	G. Chair prevents rising																				
<input type="checkbox"/>	H. Other																				

P0200. Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected

<p>Coding:</p> <ul style="list-style-type: none"> 0. Not used 1. Used less than daily 2. Used daily 	<p style="text-align: center;">↓ Enter Codes in Boxes</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>A. Bed alarm</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>B. Chair alarm</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>C. Floor mat alarm</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>D. Motion sensor alarm</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>E. Wander/elopement alarm</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>F. Other alarm</td> </tr> </table>		<input type="checkbox"/>	A. Bed alarm		<input type="checkbox"/>	B. Chair alarm		<input type="checkbox"/>	C. Floor mat alarm		<input type="checkbox"/>	D. Motion sensor alarm		<input type="checkbox"/>	E. Wander/elopement alarm		<input type="checkbox"/>	F. Other alarm
	<input type="checkbox"/>	A. Bed alarm																	
	<input type="checkbox"/>	B. Chair alarm																	
	<input type="checkbox"/>	C. Floor mat alarm																	
	<input type="checkbox"/>	D. Motion sensor alarm																	
	<input type="checkbox"/>	E. Wander/elopement alarm																	
	<input type="checkbox"/>	F. Other alarm																	

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

Q0310. Resident's Overall Goal

Complete only 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. Discharge 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

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

- Enter Code **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

Q0500. Return to Community

- Enter Code **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?"**
0. No
 1. Yes
 9. Unknown or uncertain

- 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

Section Q**Participation in Assessment and Goal Setting****Q0550. Resident's Preference to Avoid Being Asked Question Q0500B**

Enter Code

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**

Enter Code

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**

Q0610. Referral

Enter Code

A. Has a referral been made to the Local Contact Agency (LCA)?

0. **No**

1. **Yes**

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

Complete only if Q0610 = 0

Enter Code

Indicate reason why referral to LCA was not made

1. **LCA unknown**

2. **Referral previously made**

3. **Referral not wanted**

4. **Discharge date 3 or fewer months away**

5. **Discharge date more than 3 months away**

Section V**Care Area Assessment (CAA) Summary****V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment**Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01

Enter Code <input type="text"/> <input type="text"/>	A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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 <input type="text"/> <input type="text"/>	B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment) 01. 5-day scheduled assessment 08. IPA - Interim Payment Assessment 99. None of the above
Enter Score <input type="text"/> <input type="text"/>	C. Prior Assessment Reference Date (A2300 value from prior assessment) <div style="display: flex; align-items: center; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: 8px; margin-top: 2px;"> Month Day Year </div>
Enter Score <input type="text"/> <input type="text"/>	D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	E. Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

Section V**Care Area Assessment (CAA) Summary****V0200. CAAs and Care Planning**

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	
09. Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
10. Activities	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dehydration/Fluid Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	
15. Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	
16. Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychotropic Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
18. Physical Restraints	<input type="checkbox"/>	<input type="checkbox"/>	
19. Pain	<input type="checkbox"/>	<input type="checkbox"/>	
20. Return to Community Referral	<input type="checkbox"/>	<input type="checkbox"/>	

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

1. Signature _____

2. Date

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

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

1. Signature _____

2. Date

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

Section X**Correction Request****Complete Section X only if A0050 = 2 or 3**

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider (A0200 on existing record to be modified/inactivated)

Enter Code	Type of provider
<input type="checkbox"/>	1. Nursing home (SNF/NF)
	2. Swing Bed

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

	A. First name:
	<input type="text"/>
	C. Last name:
	<input type="text"/>

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

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

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

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code	A. Federal OBRA Reason for Assessment
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	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?
<input type="checkbox"/>	0. No
	1. Yes

Section 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

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

X0800. Correction Number

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

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

↓ Check all that apply

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

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

↓ Check all that apply

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

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

- -
 Month Day Year

Section Z**Assessment Administration****Z0100. Medicare Part A Billing****A. Medicare Part A HIPPS code:**

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

B. Version code:

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

Z0200. State Medicaid Billing (if required by the state)**A. Case Mix group:**

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

B. Version code:

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

Z0250. Alternate State Medicaid Billing (if required by the state)**A. Case Mix group:**

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

B. Version code:

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

Z0300. Insurance Billing**A. Billing code:**

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

B. Billing version:

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

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

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

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

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**A. Signature:****B. Date RN Assessment Coordinator signed assessment as complete:**

		-			-				
Month			Day			Year			

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