

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed OMRA (NO/SO) Item Set

Section A		Identification Information
A0050. Type of Record		
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<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 	
A0100. Facility Provider Numbers		
	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Provider Number:</p>	
A0200. Type of Provider		
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>Type of provider</p> <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed 	
A0310. Type of Assessment		
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<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 <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>B. PPS Assessment</p> <p><u>PPS Scheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment <p><u>PPS Unscheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <p><u>Not PPS Assessment</u></p> <ol style="list-style-type: none"> 99. None of the above 	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>C. PPS Other Medicare Required Assessment - OMRA</p> <ol style="list-style-type: none"> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment 	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<p>D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2</p> <ol style="list-style-type: none"> 0. No 1. Yes 	
Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px 0;"></div>	<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 	
A0310 continued on next page		

Section A	Identification Information
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A0310. Type of Assessment - Continued

Enter Code <input style="width: 100%;" type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input style="width: 100%;" type="text"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code <input style="width: 100%;" type="text"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code <input style="width: 100%;" type="text"/>	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: _____ B. Middle initial: _____ C. Last name: _____ D. Suffix: _____
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A0600. Social Security and Medicare Numbers

	A. Social Security Number: _____ - _____ - _____ B. Medicare number (or comparable railroad insurance number): _____
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A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

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A0800. Gender

Enter Code <input style="width: 100%;" type="text"/>	1. Male 2. Female
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A0900. Birth Date

	_____ - _____ - _____ Month Day Year
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A1000. Race/Ethnicity

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

Section A Identification Information

A1100. Language

Enter Code

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. Preferred language:

A1200. Marital Status

Enter Code

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

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

— —
Month Day Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

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

A1900. Admission Date (Date this episode of care in this facility began)

— —
Month Day Year

Section A	Identification Information
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A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

— —

Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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

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

— —

Month Day Year

A2400. Medicare Stay

Enter Code

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

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

B. Start date of most recent Medicare stay:

— —

Month Day Year

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

— —

Month Day Year

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

Section B	Hearing, Speech, and Vision
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B0100. Comatose

Enter Code

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0700, Makes Self Understood
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0700. Makes Self Understood

Enter Code

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

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

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

Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	<p>0. No (resident was able to complete Brief Interview for Mental Status) → Skip to D0100, Should Resident Mood Interview be Conducted?</p> <p>1. Yes (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK</p>
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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 <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	<p>Seems or appears to recall after 5 minutes</p> <p>0. Memory OK</p> <p>1. Memory problem</p>
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C1000. Cognitive Skills for Daily Decision Making
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Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	<p>Made decisions regarding tasks of daily life</p> <p>0. Independent - decisions consistent/reasonable</p> <p>1. Modified independence - some difficulty in new situations only</p> <p>2. Moderately impaired - decisions poor; cues/supervision required</p> <p>3. Severely impaired - never/rarely made decisions</p>
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Section D**Mood****D0100. Should Resident Mood Interview be Conducted?** - Attempt to conduct interview with all residents

Enter Code

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

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

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

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

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

1. Symptom Presence

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

2. Symptom Frequency

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

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

↓ Enter Scores in Boxes ↓

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

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.

Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

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

Enter Code

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

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



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

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

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

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

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

1. Symptom Presence

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**B. Feeling or appearing down, depressed, or hopeless****C. Trouble falling or staying asleep, or sleeping too much****D. Feeling tired or having little energy****E. Poor appetite or overeating****F. Indicating that s/he feels bad about self, is a failure, or has let self or family down****G. Trouble concentrating on things, such as reading the newspaper or watching television****H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual****I. States that life isn't worth living, wishes for death, or attempts to harm self****J. Being short-tempered, easily annoyed****D0600. Total Severity Score**

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.**D0650. Safety Notification** - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code

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

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

Section E	Behavior
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E0100. Potential Indicators of Psychosis

↓ Check all that apply

- | | |
|--------------------------|---|
| <input type="checkbox"/> | A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) |
| <input type="checkbox"/> | B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) |
| <input type="checkbox"/> | 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 style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/> <input style="width: 30px; height: 30px;" type="text"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"><input type="checkbox"/></td> <td style="padding: 5px;">A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 5px;">B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="padding: 5px;">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)</td> </tr> </table>	<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)
<input type="checkbox"/>	A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)							
<input type="checkbox"/>	B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)							
<input type="checkbox"/>	C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)							

E0800. Rejection of Care - Presence & Frequency
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Enter Code <input style="width: 30px; height: 30px;" type="text"/>	<p>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.</p> <p>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</p>
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E0900. Wandering - Presence & Frequency
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Enter Code <input style="width: 30px; height: 30px;" type="text"/>	<p>Has the resident wandered?</p> <p>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</p>
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Section G**Functional Status****G0110. Activities of Daily Living (ADL) Assistance**

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

Instructions for Rule of 3

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

If none of the above are met, code supervision.**1. ADL Self-Performance**Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time**Coding:****Activity Occurred 3 or More Times**

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

Activity Occurred 2 or Fewer Times

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

2. ADL Support ProvidedCode for **most support provided** over all shifts; code regardless of resident's self-performance classification**Coding:**

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture**B. Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)**H. Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)**I. Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag**Section H****Bladder and Bowel****H0200. Urinary Toileting Program**

Enter Code <input type="text"/>	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? <ol style="list-style-type: none"> 0. No → Skip to H0500, Bowel Toileting Program 1. Yes → Continue to H0200C, Current toileting program or trial 9. Unable to determine → Continue to H0200C, Current toileting program or trial
Enter Code <input type="text"/>	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? <ol style="list-style-type: none"> 0. No 1. Yes

H0500. Bowel Toileting Program

Enter Code <input type="text"/>	Is a toileting program currently being used to manage the resident's bowel continence? <ol style="list-style-type: none"> 0. No 1. Yes
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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

Infections☐ **I2000. Pneumonia**☐ **I2100. Septicemia****Metabolic**☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)**Neurological**☐ **I4400. Cerebral Palsy**☐ **I4900. Hemiplegia or Hemiparesis**☐ **I5100. Quadriplegia**☐ **I5200. Multiple Sclerosis (MS)**☐ **I5300. Parkinson's Disease****Pulmonary**☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)☐ **I6300. Respiratory Failure****Section J****Health Conditions****Other Health Conditions****J1100. Shortness of Breath (dyspnea)**

↓ Check all that apply

☐ **C. Shortness of breath** or trouble breathing **when lying flat****J1550. Problem Conditions**

↓ Check all that apply

☐ **A. Fever**☐ **B. Vomiting****Section K****Swallowing/Nutritional Status****K0300. Weight Loss**

Enter Code

Loss of 5% or more in the last month or loss of 10% or more in last 6 months0. **No** or unknown1. **Yes, on** physician-prescribed weight-loss regimen2. **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 months0. **No** or unknown1. **Yes, on** physician-prescribed weight-gain regimen2. **Yes, not on** physician-prescribed weight-gain regimen

Section K**Swallowing/Nutritional Status****K0510. Nutritional Approaches**Check all of the following nutritional approaches that were performed during the last **7 days**

1. While NOT a Resident Performed while NOT a resident of this facility and within the last 7 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed while a resident of this facility and within the last 7 days	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

1. While NOT a Resident Performed while NOT a resident of this facility and within the last 7 days . Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed while a resident of this facility and within the last 7 days 3. During Entire 7 Days Performed during the entire last 7 days	1. While NOT a Resident	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"/>	<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"/>	<input type="checkbox"/>

Section M**Skin Conditions****Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage****M0210. Unhealed Pressure Ulcer(s)**

Enter Code <input type="checkbox"/>	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage
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M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number <input type="checkbox"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. Number of Stage 2 pressure ulcers
Enter Number <input type="checkbox"/>	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling 1. Number of Stage 3 pressure ulcers
Enter Number <input type="checkbox"/>	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. Number of Stage 4 pressure ulcers
Enter Number <input type="checkbox"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

Section M Skin Conditions

M1030. Number of Venous and Arterial Ulcers

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

↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<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

M1200. Skin and Ulcer Treatments

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

Section N Medications

N0300. Injections

Enter Days <input type="text"/>	Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to O0100, Special Treatments, Procedures, and Programs
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N0350. Insulin

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

Section O		Special Treatments, Procedures, and Programs	
00100. Special Treatments, Procedures, and Programs			
Check all of the following treatments, procedures and programs that were performed during the last 14 days			
1. While NOT a Resident Performed while NOT a resident of this facility and within the last 14 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. While a Resident Performed while a resident of this facility and within the last 14 days		1. While NOT a Resident	2. While a Resident
		↓ Check all that apply ↓	
Cancer Treatments			
A. Chemotherapy			<input type="checkbox"/>
B. Radiation			<input type="checkbox"/>
Respiratory Treatments			
C. Oxygen therapy			<input type="checkbox"/>
E. Tracheostomy care			<input type="checkbox"/>
F. Ventilator or respirator			<input type="checkbox"/>
Other			
H. IV medications			<input type="checkbox"/>
I. Transfusions			<input type="checkbox"/>
J. Dialysis			<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)			<input type="checkbox"/>
00400. Therapies			
		A. Speech-Language Pathology and Audiology Services	
Enter Number of Minutes <input type="text"/>	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 00400A5, 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 <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div>		
Enter Number of Minutes <input type="text"/>			
Enter Number of Minutes <input type="text"/>			
Enter Number of Minutes <input type="text"/>			
Enter Number of Days <input type="text"/>	6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div>		
00400 continued on next page			

Section O

Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

B. Occupational Therapy	
Enter Number of Minutes <input type="text"/>	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days
Enter Number of Minutes <input type="text"/>	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days
Enter Number of Minutes <input type="text"/>	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days
If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date	
Enter Number of Minutes <input type="text"/>	3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days
Enter Number of Days <input type="text"/>	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 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
C. Physical Therapy	
Enter Number of Minutes <input type="text"/>	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days
Enter Number of Minutes <input type="text"/>	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days
Enter Number of Minutes <input type="text"/>	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days
If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date	
Enter Number of Minutes <input type="text"/>	3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days
Enter Number of Days <input type="text"/>	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 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
D. Respiratory Therapy	
Enter Number of Days <input type="text"/>	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
O0420. Distinct Calendar Days of Therapy	
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****O0450. Resumption of Therapy** - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code <input type="checkbox"/>	A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?
	0. No → Skip to O0500, Restorative Nursing Programs
	1. Yes
	B. Date on which therapy regimen resumed:
	<div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>

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

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

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 <input type="text"/>	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed
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X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

	A. First name: C. Last name:
--	---

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

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

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

	<div style="text-align: center;"> — — Month Day Year </div>
--	---

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

	<div style="text-align: center;"> — — — — — — </div>
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X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code <input type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input type="text"/>	B. PPS Assessment PPS Scheduled Assessments for a Medicare Part A Stay 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment PPS Unscheduled Assessments for a Medicare Part A Stay 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) Not PPS Assessment 99. None of the above
Enter Code <input type="text"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment

X0600 continued on next page

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

Enter Code <input type="text"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input type="text"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

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

	A. Assessment Reference Date (A2300 on existing record to be modified/inactivated - Complete only if X0600F = 99) <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	B. Discharge Date (A2000 on existing record to be modified/inactivated - Complete only if X0600F = 10, 11, or 12) <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>
	C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 <div style="display: flex; justify-content: space-around; width: 100%;"> — — </div> <div style="display: flex; justify-content: space-around; width: 100%;"> Month Day Year </div>

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

Enter Number <input type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
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X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

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

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

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

Section X		Correction Request	
X1100. RN Assessment Coordinator Attestation of Completion			
	A. Attesting individual's first name:		
	B. Attesting individual's last name:		
	C. Attesting individual's title:		
D. Signature			
E. Attestation date			
	<div> <div>—</div> <div>Month</div> </div>	<div> <div>—</div> <div>Day</div> </div>	<div> <div>—</div> <div>Year</div> </div>

Section Z		Assessment Administration	
Z0100. Medicare Part A Billing			
Enter Code <div></div>	A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):		
	B. RUG version code:		
	C. Is this a Medicare Short Stay assessment? 0. No 1. Yes		
Z0150. Medicare Part A Non-Therapy Billing			
	A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):		
	B. RUG version code:		
Z0300. Insurance Billing			
	A. RUG billing code:		
	B. RUG 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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