

## APPENDIX A: GLOSSARY AND COMMON ACRONYMS

### Glossary

Term	Abbreviation	Definition
<b>5% Weight Loss in 30 Days</b>		Start with the resident's weight from 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.
<b>9-Item Patient Health Questionnaire</b>	<b>PHQ-9©</b>	A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.
<b>10% Weight Loss in 180 Days</b>		Start with the resident's weight from 180 days ago and multiply it by .90 (or 90%). This figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.
<b>Ability to Understand Others</b>		Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.
<b>Active Assisted Range of Motion</b>		A type of active range of motion in which assistance is provided by an outside force, either manually or mechanically because the prime mover muscles need assistance to complete the motion. This type of range of motion is used when muscles are weak or when joint movement causes discomfort; resident is able to move his or her limbs, but requires help to perform entire movement.
<b>Active Disease Diagnosis</b>		A diagnosis with a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

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Term	Abbreviation	Definition
<b>Active Range of Motion</b>		Movement within the unrestricted range of motion for a segment, which is produced by active contraction of the muscles crossing that joint. This type of range of motion occurs when a resident can move his or her limbs without assistance.
<b>Activities of Daily Living</b>	<b>ADLs</b>	Activities of daily living are those needed for self-care: bathing, dressing, mobility, toileting, eating, and transferring. The late-loss ADLs (eating, toileting, bed mobility, and transferring) are used to classify a patient into a RUG-IV group.
<b>Acute Change in Mental Status</b>		Alteration in mental status during the 7-day look-back period (e.g., orientation, inattention, organization of thought, level of consciousness, psychomotor behavior, change in cognition) that was new or worse for this resident, usually over hours to days.
<b>Adequate Light</b>		Lighting that is sufficiently or comfortably allows a person with normal vision to see fine detail.
<b>ADL Activity</b>		Tasks related to personal care; any of the tasks listed in item G0110A-J.
<b>ADL Subtasks</b>		Components of an ADL activity. These are listed next to the activity in the item set. For example, the subtasks of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition, and IV fluids for hydration.
<b>ADL Self-Performance</b>		A set of items that measure what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.
<b>ADL Support Provided</b>		Measures the highest level of support provided by staff over the last 7 days, even if that level of support only occurred once.

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Term	Abbreviation	Definition
<b>Adverse Consequence</b>		<p>An unpleasant symptom or event that is caused by or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease).</p> <p>Note: adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis or treatment. The term "side effect" is often used interchangeable with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.</p>
<b>Alaska Native or American Indian</b>		A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
<b>Altered Level of Consciousness</b>		<p>Vigilant: startles easily to any sound or touch.</p> <p>Lethargic: repeatedly dozes off when you are asking questions but responds to voice or touch.</p> <p>Stupor: very difficult to arouse and keep aroused for the interview.</p> <p>Comatose: cannot be aroused despite shaking and shouting.</p>
<b>Application of Dressings to the Feet (with or without Topical Medication)</b>		Includes any intervention for treating diabetic foot ulcers (Code M1040B) or arterial ulcers of the foot (Code M1030). Do NOT code dressing for pressure ulcer on the foot in this item; use item M1200E.
<b>Application of Dressings (with or without Topical Medications) Other than to Feet</b>		Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

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Term	Abbreviation	Definition
<b>Application of Ointments/ Medications (Other than to Feet)</b>		Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain) or ointments used to prevent skin problems.
<b>Arterial Ulcers</b>		Ulcers caused by peripheral arterial disease and commonly occur on the tips of toes, tops of the foot, or distal to the medial malleolus.
<b>Asian</b>		A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<b>Assessment Period</b>		The time period during which the assessment coordinator starts the assessment until it is signed as complete.
<b>Assessment Reference Date</b>	<b>ARD</b>	The specific end point for look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the ARD. Most frequently, this look-back period, also called the observation or assessment period, is a 7-day period ending on the ARD. Look-back periods may cover the 7 days ending on this date, 14 days ending on this date, etc.
<b>Assessment Window</b>		The period of time defined by Medicare regulations that specifies when the ARD must be set.
<b>Audiology Services</b>		Services provided by an audiologist. Audiology services include the testing of hearing and balance; recommending assistive listening equipment; managing hearing screening programs; providing education regarding the effects of noise on hearing and the prevention of hearing loss; managing cochlear implants; and providing counseling and aural rehabilitation. Audiologist is defined in regulation (42 CFR 484).

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Term	Abbreviation	Definition
<b>Autism</b>		A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.
<b>Baseline</b>		The resident's typical cognitive state prior to the 7-day look-back. If the resident has had a recent acute illness, his or her baseline may be their cognitive state prior to illness or hospitalization.
<b>Bath</b>		<p>Bed bath: bath taken in bed using washcloths and water basin or other method in bed.</p> <p>Shower: bath taken standing or using gurney or shower chair in a shower room or stall.</p> <p>Sponge bath: bath taken sitting or standing at sink.</p> <p>Tub bath: bath taken in bathtub.</p>
<b>Bathing</b>		How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.
<b>Bladder Rehabilitation/ Bladder Retraining</b>		A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.
<b>Black or African American</b>		A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
<b>Board and Care/Assisted Living/Group Home</b>		A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
<b>Body Mass Index</b>	<b>BMI</b>	Number calculated from a person's weight and height. BMI is a reliable indicator of body fatness for people. BMI is used as a screening tool to identify possible weight problems for adults.

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Term	Abbreviation	Definition
<b>Burns (Second or Third Degree)</b>		Second- and third-degree burns are skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
<b>Broken Natural Teeth or Tooth Fragment</b>		Very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).
<b>Browser</b>		A program, such as Internet Explorer or Netscape, that allows access to the Internet or a private intranet site. A browser with 128-bit encryption is necessary to access the Centers for Medicare & Medicaid Services (CMS) intranet to submit data or report retrieval.
<b>Care Area Assessment</b>	<b>CAA</b>	The Resident Assessment Instrument (RAI) consists of two basic components: the MDS 3.0 and the CAA process. The MDS identifies actual or potential problem areas, CAAs provide for further assessment of “triggered” areas by guiding staff to look for causal or confounding factors (some of which may be reversible) for certain presenting conditions/issues.
<b>Care Area Triggers</b>	<b>CAT</b>	Care Area Triggers (CATs) are a set of items and responses from the MDS that are indicators of particular issues and conditions that affect nursing home residents. The triggers identify those potential issues and conditions that need additional assessment and review and therefore form a critical link between the MDS and care planning.
<b>Case Mix Index</b>	<b>CMI</b>	Weight or numeric score assigned to each Resource Utilization Group–III (RUG-III) group that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
<b>Case Mix Reimbursement System</b>		A payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.
<b>Cavity</b>		A tooth with a discolored hole or area of decay that may have debris in it.

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Term	Abbreviation	Definition
<b>Center for Health Systems Research and Analysis, University of Wisconsin–Madison</b>	<b>CHSRA</b>	Researchers, funded by CMS, who have developed and tested a set of indicators of quality care in nursing facilities and a quality monitoring system for using the indicators for internal and external quality review and improvement.
<b>CMS Certification Number</b>	<b>CCN</b>	Replaces the term “Medicare/Medicaid Provider Number” in survey and certification, and assessment-related activities.
<b>Centers for Medicare &amp; Medicaid Services</b>	<b>CMS</b>	Formerly known as Health Care Financing Administration (HCFA), CMS is the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.
<b>CMS MDS 2.0 Data Collection System</b>		Software and hardware that has been provided to each state by CMS to collect Minimum Data Set (MDS) information in a standardized method and format. Each state is then charged with administering and supporting the system.
<b>Check and Change</b>		Involves checking the resident’s dry/wet status at regular intervals and using incontinence devices and products.
<b>Code of Federal Regulations</b>	<b>CFR</b>	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government. The CFR is divided into 50 titles that represent broad areas subject to Federal regulation. Each title is divided into chapters that usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level.
<b>Cognitive Performance Scale</b>	<b>CPS</b>	The measure of cognitive status used in the MDS and in the RUG Classification system.
<b>Colostomy</b>		A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.
<b>Comatose (Coma)</b>		Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak, and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

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Term	Abbreviation	Definition
<b>Completed Interview</b>		The pain interview is successfully completed if the resident reported no pain (J0300 = no), or if the resident reported pain (J0300 = yes) and the follow-up question J0400 is answered.
<b>Comprehensive Assessment</b>		Requires completion of the MDS and review of CAAs, followed by development or review of the comprehensive care plan.
<b>Condition or Chronic Disease That May Result in Life Expectancy of Less than 6 Months</b>		In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.
<b>Constipation</b>		If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).
<b>Continence</b>		Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or prompted toileting.
<b>Current Medicare Stay</b>		New admission: day 1 of Medicare Part A stay. Readmission: day 1 of Medicare Part A coverage after readmission following a discharge.
<b>Daily Decision Making</b>		Includes: choosing clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.

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Term	Abbreviation	Definition
<b>Data Assessment and Verification</b>	<b>DAVE</b>	A program administered by CMS designed to ensure accuracy of MDS data accomplished through data analysis, off-site review, on-site review, and provider education.
<b>Deep Tissue Injury</b>		Purple or maroon localized area of discolored intact skin or blood-filled blister caused by damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.
<b>Delirium</b>		A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.
<b>Delusion</b>		A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
<b>Designated Local Contact Agency</b>		Each state has designated a local contact agency that will be responsible for contacting the individual with information about community living options. This local contact agency may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state contractor.
<b>Diabetic Foot Ulcers</b>		Ulcers caused by the neuropathic and small blood vessel complications of diabetes. These neuropathic changes combined with the small blood vessel changes in diabetes puts the diabetic at high risk for foot ulcers. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.
<b>Discharge</b>		For the purposes of MDS and Swing Bed-MDS, a discharge is reported when a resident leaves the facility for more than 24 hours for other than a temporary home visit or therapeutic leave, or is admitted to the hospital. Can be to home or another community setting. A prognosis of death should not be considered as an expected discharge.

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Term	Abbreviation	Definition
<b>Disorganized Thinking</b>		Evidenced by rambling, irrelevant, or incoherent speech.
<b>Dose</b>		Total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the “daily dose.”
<b>Down Syndrome</b>		A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, mental retardation, low muscle tone, and other possible effects.
<b>Dually Certified Facilities</b>		Nursing facilities that participate in both the Medicare and Medicaid programs.
<b>Duplicate Assessment</b>		A fatal record error that results from a resubmission of a record previously accepted into the State MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.
<b>End of Therapy OMRA</b>		The End of Therapy Other Medicare-required Assessment (OMRA) is a required assessment that is only completed if the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and will continue to need Part A skilled nursing facility (SNF)–level services after discontinuation of all therapies. The last day therapy treatment was furnished is day 0. The End of Therapy OMRA must have an ARD (item A2300) set day 1, 2, or 3 after all rehabilitation therapies have been discontinued (item O0400A6 or O0400B6 or O0400C6), whichever is the latest. The End of Therapy OMRA will establish a new non-therapy RUG classification and Medicare payment rate (item Z0150A), which begins the day after the last day of therapy.
<b>Entry Date</b>		The initial date of admission to the nursing home, or the date on which the resident most recently returned to the nursing home after being discharged (whether or not the return was anticipated).

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Term	Abbreviation	Definition
<b>Epilepsy</b>		A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.
<b>Epithelial Tissue</b>		New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
<b>Eschar Tissue</b>		Thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue that has lost its usual physical properties and biological activity. Eschar may be loose or firmly adhered to the wound.
<b>External (Condom) Catheter</b>		Device attached to the shaft of the penis like a condom and connected to a drainage bag.
<b>Facial Expressions That May Be Indicators of Pain</b>		Grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.
<b>Facility ID</b>	<b>FAC_ID</b>	The facility identification number is assigned to each nursing facility by the State agency. The FAC_ID must be placed in the header record in each MDS file, and in the individual MDS and tracking form records. This normally is completed as a function within the facility's MDS data entry software.
<b>Fall</b>		Unintentional change in position coming to rest on the ground or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. This fall definition should include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Includes falls caused by slipping and tripping, and impact of another person or object against the resident.
<b>Family</b>		A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; also, a partner, housemate, legal guardian, primary community caregiver, or close friend. Family does not, however, include staff at the nursing home.

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Term	Abbreviation	Definition
<b>Fatal File</b>		An MDS file that has an error in the format and causes the entire file to be rejected. The individual records are not validated or stored in the database. The facility must contact its software support to resolve the problem with the submission file.
<b>Fatal Record</b>		An MDS record that has an error severe enough to result in record rejection. A fatal record is not saved in the CMS database. The facility must correct the error that caused the rejection and resubmit a corrected original record.
<b>Fecal Impaction</b>		A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.
<b>Federal Register</b>		The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.
<b>Feeding Tube</b>		Presence of any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.
<b>Fever</b>		A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature. The baseline temperature should be established prior to the ARD.
<b>Final Validation Reports</b>	<b>FVR</b>	A report generated after the successful submission of MDS 2.0 assessment data. This report lists all of the residents for whom assessments have been submitted in a particular submission batch, and displays all errors and/or warnings that occurred during the validation process. An FVR with a submission type of "production" is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.

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Term	Abbreviation	Definition
<b>First Time in This Nursing Home</b>		Newly admitted resident who has not been admitted to this nursing home before.
<b>Fiscal Intermediary</b>	<b>FI</b>	An organization designated by CMS to process Medicare claims for payment that are submitted by a nursing facility.
<b>Fluctuation</b>		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).
<b>Fracture Related to a Fall</b>		Any documented bone fracture (in a problem list from a medical record, an X-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents.
<b>F-Tag</b>		Numerical designations for criteria reviewed during the nursing facility survey.
<b>Functional Limitation in Range of Motion</b>		Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.
<b>Grace Days</b>		Additional days that may be added to the assessment window for Medicare assessments without incurring financial penalty. These may be used in situations such as an absence/illness of the registered nurse (RN) assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.
<b>Gradual Dose Reduction (GDR)</b>		Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.
<b>Granulation Tissue</b>		Red tissue with “cobblestone” or bumpy appearance bleeds easily when injured.

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Term	Abbreviation	Definition
<b>Habit Training/ Scheduled Voiding</b>		A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.
<b>Hallucination</b>		The perception of the presence of something that is not actually there. May be auditory or visual or involve smells, tastes, or touch.
<b>Header</b>		The first record in an MDS file submitted to the CMS MDS 2.0 Data Collection System. This record contains facility and software vendor information for the subsequent records within the file.
<b>Healed Pressure Ulcer</b>		A pressure ulcer that is completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.
<b>Healthcare Common Procedure Coding System</b>	<b>HCPCS</b>	A uniform coding system that describes medical services, procedures, products, and supplies. These codes are used primarily for billing.
<b>Health Care Finance Administration</b>	<b>HCFA</b>	Former name for CMS (see CMS).
<b>Health Insurance Portability and Accountability Act of 1996</b>	<b>HIPAA</b>	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.
<b>Health Insurance Prospective Payment System</b>	<b>HIPPS</b>	Billing codes used when submitting claims to the FI for Medicare payment. Codes comprise the RUG category calculated by the assessment followed by an indicator to indicate which assessment was completed.
<b>Hierarchy</b>		The ordering of groups within the RUG Classification system. A hierarchy begins with groups with the highest resource use and descends to those groups with the lowest resource use. The RUG-IV Classification system has eight hierarchical groups: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions.

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Term	Abbreviation	Definition
<b>Hispanic or Latino</b>		A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. The term Spanish Origin can be used in addition to Hispanic or Latino.
<b>Hospice Services</b>		A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.
<b>Ileostomy</b>		A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.
<b>Inactivation</b>		A type of correction allowed under the MDS Correction Policy. When an invalid record has been accepted into the database, a correction record is submitted with inactivation selected as the type of correction.
<b>Inattention</b>		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).
<b>Index Maximizing</b>		The process of RUG Classification where the RUG category with the highest case mix index (CMI) is selected from all of the possible groups in which a resident's assessment is classified.
<b>Indwelling Catheter</b>		A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
<b>Initial Feedback Report</b>	<b>IFR</b>	The first report generated by the CMS MDS Data Collection System after an MDS data file is electronically submitted. This report validates the file structure, provides the submission batch ID, and indicates whether the file has been accepted or rejected. If the file has been accepted, each record will go through the edit process and be reported on the final validation report. If the file is rejected, there will be no final validation report.
<b>Injury (Except Major)</b>		Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains or any fall-related injury that causes the resident to complain of pain.

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Term	Abbreviation	Definition
<b>Injury Related to Any Fall</b>		Any documented injury (in a problem list from a medical record or an X-ray report) that occurred as a direct result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.
<b>Interdisciplinary Team</b>		Nurses, certified nursing assistants, physical and occupational therapists, physicians, nurse practitioners, and physician assistants.
<b>Intermittent Catheterization</b>		Sterile insertion and removal of a catheter through the urethra every 3-6 hours for bladder drainage.
<b>Internal Assessment ID</b>		A sequential numeric identifier assigned to each record submitted to the CMS MDS Data Collection System.
<b>International Classification of Diseases, Ninth Revision, Clinical Modification</b>	<b>ICD-9-CM</b>	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.
<b>Invalid Record</b>		As defined by the MDS Correction Policy, a record that was accepted into the CMS MDS Data Collection System that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.
<b>Legally Authorized Representative/Guardian</b>		Someone appointed by the court who is authorized to make decisions for the resident, including giving and withholding consent for medical treatment.
<b>Legal Name</b>		Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a government-issued document (i.e., driver's license, birth certificate, social security card).
<b>Login ID</b>		A State-assigned facility identifier required to access the CMS MDS Data Collection System. This may or may not be the same as the Facility ID.

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Term	Abbreviation	Definition
<b>Look Back Period</b>		A period of time in the past 5, 7, 14, 30, or 60 days from the ARD that is used when completing certain sections of the MDS.
<b>Major Error</b>		As defined by the MDS Correction Policy, an error in an MDS assessment in which the resident's overall clinical status has been misrepresented, or the current care plan does not suit the resident's needs.
<b>Major Injury</b>		Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematoma.
<b>Makes Self Understood</b>		Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.
<b>MDS Completion Date</b>		The date at which the RN assessment coordinator attests that all portions of the MDS have been completed. For MDS, this is the date recorded at A2300.
<b>Mechanically Altered Diet</b>		A diet specifically prepared to alter the texture or consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.
<b>Medicaid</b>		A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.

(continued)

Term	Abbreviation	Definition
<b>Medicare</b>		<p>A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities.</p> <p>Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices.</p> <p>Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.</p>
<b>Medicare Covered Stay</b>		<p>Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.</p> <p>New admission: day 1 of Medicare Part A stay.</p> <p>Readmission: day 1 of Medicare Part A coverage after readmission following a discharge.</p>
<b>Medicare Data Communications Network</b>	<b>MDCN</b>	A secure dial-up connection that is used to transmit MDS data to the National repository. A user ID and password is issued and maintained by the MDCN Help Desk for each person who requires access to the CMS MDS intranet through this network.
<b>Medicare Number (or Comparable Railroad Insurance Number)</b>		A number assigned to an individual for participation in national health insurance program. The first 9 characters must be numbers. The Medicare Health Insurance number may be different from the resident's social security number (SSN). For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.
<b>Medicare Prospective Payment Assessment Form</b>	<b>MPAF</b>	A shortened assessment form designed to reduce the burden of completing the full MDS assessment for Medicare-only assessments. The MPAF contains the items necessary for resident identification, RUG Classification, and quality indicator calculations.

(continued)

Term	Abbreviation	Definition
<b>Medication Interaction</b>		The impact of another substance (such as another medication, nutritional supplement including herbal products, food or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.
<b>Medication Regimen</b>		Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections, or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.
<b>Metropolitan Statistical Area</b>	<b>MSA</b>	A statistical standard classification designated and defined by the Federal Office of Management and Budget following a set of official published standards. These urban areas are used to adjust the Federal Medicare rates to account for differences in area wage levels.
<b>Minimum Data Set</b>	<b>MDS</b>	A core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.
<b>Modification</b>		A type of correction allowed under the MDS Correction Policy. A modification is required when a valid MDS record has been accepted by the CMS MDS database, but the information in the record contains errors. A modification is not done when a record has been rejected.
<b>Monitoring</b>		The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal. Monitoring can detect any complications or adverse consequences of the condition or of the treatments; and support decisions about modifying, discontinuing, or continuing any interventions.

(continued)

Term	Abbreviation	Definition
<b>Most Recent Medicare Stay</b>		This is a Medicare Part A covered stay that has started on or after the most recent entry (admission or reentry) to the nursing home.
<b>Music Therapy</b>		Music therapy is an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and promote physical rehabilitation. Services must be provided or directly supervised by a qualified professional.
<b>National Drug Code</b>	<b>NDC</b>	A unique 10-digit number assigned to each drug product listed under Section 510 of the Federal Food, Drug and Cosmetic Act. The NDC code identifies the vendor, drug name, dosage, and form of the drug.
<b>National Provider Identifier</b>	<b>NPI</b>	A unique federal number that identifies providers of health care services. The NPI applies to the nursing home for all of its residents.
<b>Native Hawaiian or Other Pacific Islander</b>		A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<b>Near Fall</b>		Intercepted fall. The resident would have fallen if he or she had not caught themselves or had not been intercepted by another person. This should not be considered a fall for purposes of this item.
<b>Necrotic Tissue (Eschar)</b>		Hard or soft in texture; usually brown, grey, or black in color. Eschar is usually firm or hard with brown or black color and may appear scab-like. Necrotic tissue can also present as soft soggy black or brown tissue. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.
<b>Nephrostomy Tube</b>		A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or bladder.

(continued)

Term	Abbreviation	Definition
<b>News</b>		<p>News about local, state, national, or international current events.</p> <p>Keep up with the news: stay informed by reading, watching, or listening.</p> <p>Newspapers and magazines: any type, such as journalistic, professional, and trade publications in script, Braille, or audio recorded format.</p>
<b>New Admission</b>		Day 1 of Medicare Part A stay.
<b>Non-blanchable</b>		Reddened areas of tissue that do not lose skin color when firmly pressed with a finger.
<b>Non-medication Pain Intervention</b>		<p>Scheduled and implemented interventions for which a plan of care is in place. Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.</p> <p>Interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound, and acupuncture. Herbal medications are not included in this category.</p>
<b>Non-pharmacological Intervention</b>		Approaches to care that do not involve medication, generally directed towards stabilizing or improving a resident's mental, physical and/or psychosocial well-being.
<b>Non-removable Dressing/Device</b>		Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.
<b>Nonsensical Response</b>		Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being coded.
<b>Non-verbal Sounds</b>		Crying, whining, gasping, moaning, groaning, or other audible indications associated with pain.

(continued)

Term	Abbreviation	Definition
<b>Nursing Facility</b>	<b>NF</b>	A facility that primarily provides to resident's skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
<b>Nutrition or Hydration Intervention to Manage Skin Problems</b>		Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions (e.g., wheat-free diet to prevent allergic dermatitis, high-calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing). Vitamins and minerals, such as vitamin C and zinc, which are used to manage a potential or active skin problem, should be coded here.
<b>OBRA Assessments</b>		A term used when referring to assessments mandated by Omnibus Budget Reconciliation Act (OBRA) regulations. These are assessments completed to meet clinical requirements. The OBRA assessments are: Admission, Quarterly, Annual, Significant Change in Status, Significant Correction of Prior Full, and Significant Correction of Prior Quarterly. The tracking forms for discharge and reentry are also required under OBRA regulations.
<b>Observation Period</b>		The time period, ending with the ARD, which is used by all staff for gathering information for an MDS assessment.
<b>Occupational Therapy</b>		Services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed occupational therapist. Occupational therapist and occupational therapy assistant are defined in regulations (42 CFR 484.4). Occupational therapy interventions address deficits in physical, cognitive, psychosocial, sensory, and other aspects of performance in order to support engagement in everyday life activities that affect health, well-being, and quality of life.

(continued)



Term	Abbreviation	Definition
<b>Omnibus Budget Reconciliation Act of 1987</b>	<b>OBRA '87</b>	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
<b>Open Lesion Other than Ulcers, Rashes, and Cuts</b>		Open lesions other than ulcers, rashes, or cuts are most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.
<b>Oral Lesions</b>		A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.
<b>Oral Mass</b>		A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.
<b>Ostomy</b>		Any type of excretory ostomy of the gastrointestinal or genitourinary tract.
<b>Other Medicare Required Assessment</b>	<b>OMRA</b>	There are two types of Other Medicare-required Assessments (OMRAs) that are completed based on the provision or cessation of rehabilitation services (occupational therapy [OT], physical therapy [PT], speech-language pathology [SLP])—Start of Therapy OMRA and End of Therapy OMRA. AA8b is coded 8 for these assessments.
<b>Other Organic Condition Related to Mental Retardation/Developmental Delay (MR/DD)</b>		Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.
<b>Other State-required Assessment</b>	<b>OSRA</b>	A specific assessment required by a state in addition to assessments required by OBRA regulation or for Medicare. These assessments are defined by State regulations and are usually used for State Medicaid reimbursement systems. AA8b is coded 6 for OSRA assessments.
<b>Outside</b>		Any outdoor area in the proximity of the facility, including patio, porch, balcony, sidewalk, courtyard, or garden.

(continued)

<b>Term</b>	<b>Abbreviation</b>	<b>Definition</b>
<b>Pain</b>		Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.
<b>Parenteral/intravenous (IV) Feeding</b>		Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).
<b>Passive Range of Motion</b>		Movement within the unrestricted range of motion for a segment, which is provided entirely by an external force. There is no voluntary muscle contraction. This type of range of motion is used when a resident is not able to perform the movement at all; no effort is required from them.
<b>Peer Review Organization</b>	<b>PRO</b>	See Quality Improvement Organization.
<b>Persistent Vegetative State</b>		Sometimes residents who were comatose after an anoxic-ischemic injury (i.e., injury caused by not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.
<b>Personal Belongings or Things</b>		Possessions such as eyeglasses, hearing aids, clothing, jewelry, books, toiletries, knickknacks, and pictures.
<b>Physical Restraints</b>		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 (42 CFR §483.13(a)).

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Term	Abbreviation	Definition
<b>Physical Therapy</b>		Services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed physical therapist. Physical therapist and physical therapist assistant are defined in regulation 42 CFR 484.4. Physical therapists (PTs) are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status for people of all ages. PTs alleviate impairments and activity limitations and participation restrictions, promote and maintain optimal fitness, physical function, and quality of life, and reduce risk as it relates to movement and health. Following an evaluation of an individual with impairments, activity limitations, and participation restrictions or other health-related conditions, the physical therapist designs an individualized plan of physical therapy care and services for each patient. Physical therapists use a variety of interventions to treat patients. Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, physical agents, and electrotherapeutic modalities.
<b>Physician Prescribed Weight-loss Regimen</b>		A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight-loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.
<b>Post-acute Care</b>	<b>PAC</b>	Refers to residents who are admitted to a facility following an acute care hospitalization. Their stay is usually of short duration, about 30 days or less.
<b>Pressure Relieving Device(s) for Bed</b>		Equipment that aims to redistribute pressure from areas of high risk. Includes air fluidized, low air loss therapy beds, flotation, water or alternating air mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices.

(continued)

Term	Abbreviation	Definition
<b>Pressure Relieving Device(s) for Chair</b>		Equipment that aims to redistribute pressure. Includes gel, air, or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices.
<b>Pressure Ulcer</b>	<b>PU</b>	A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissues.
<b>Pressure Ulcer (PU) Risk Tools</b>		Screening tools that are designed to help identify residents who might develop a pressure ulcer. Common risk assessment tools are the Norton Scale and the Braden Scale for Predicting Pressure Ulcer Risk.
<b>Prior Assessment</b>		Most recent MDS assessment that reported on falls.
<b>Private Home or Apartment</b>		Any house, condominium, or apartment in the community, whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.
<b>Private Telephone Conversation</b>		A telephone conversation to which no one, other than the resident, can listen.
<b>PRN Pain Medication</b>		Pain medication order that specifies dose and indicates that pain medication may be given on an as-needed basis, including a time interval, such as “every 4 hours as needed for pain” or “every 6 hours as needed for pain.”
<b>Program Memos</b>		Official agency transmittals used for communicating reminder items, request for action or information of a one-time only, non-recurring nature. Program Memos can be found at the following Web site: <a href="http://new.cms.hhs.gov/Transmittals/CMSPM/List.asp">http://new.cms.hhs.gov/Transmittals/CMSPM/List.asp</a>
<b>Program Transmittal</b>		Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added, or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following Web site: <a href="http://new.cms.hhs.gov/Transmittals/CMSPM/List.asp">http://new.cms.hhs.gov/Transmittals/CMSPM/List.asp</a>

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Term	Abbreviation	Definition
<b>Prompted Voiding</b>		Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) prompting to toilet on a scheduled basis, and (3) praise and positive feedback when the resident is continent and attempts to toilet.
<b>Prospective Payment System</b>	<b>PPS</b>	A payment system, developed for Medicare skilled nursing facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
<b>Prospective Payment System (PPS) Assessments</b>		Those assessments required by Medicare Prospective Payment Regulations for residents in a Medicare Part A stay. Each Medicare assessment is classified into a RUG group based on the clinical resource needs as recorded on the MDS assessment and is used to determine the Medicare reimbursement rate. These assessments are performed in addition to those assessments required by OBRA regulations. PPS assessments are: 5-day, 14-day, 30-day, 60-day, 90-day, OMRA, and return/readmission.
<b>Protective Body Movements or Postures</b>		Bracing, guarding, rubbing, or massaging a body part/area, clutching or holding a body part during movement, etc.
<b>Psychological Therapy</b>		Provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a master's degree and/or certification from the American Nurses Association. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the state does not license a certain category of professionals working in your facility, you may not count the services of those unlicensed therapists in this item.
<b>Psychomotor Retardation</b>		Greatly reduced or slowed level of activity or mental processing. Psychomotor retardation differs from altered level of consciousness. Resident need not be lethargic (altered level of consciousness) to have slowness of response. Psychomotor retardation may be present with normal level of consciousness; also residents with lethargy or stupor do not necessarily have psychomotor retardation.

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<b>Term</b>	<b>Abbreviation</b>	<b>Definition</b>
<b>Quality Improvement and Evaluation System</b>	<b>QIES</b>	The umbrella system that encompasses the MDS and Swing Bed (SB)-MDS system, other systems for survey and certification, and home health providers.
<b>Quality Improvement Organization</b>	<b>QIO</b>	A program administered by CMS that is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of fifty-three QIOs (formerly known as Peer Review Organizations or PRO) responsible for each U.S. State, territory, and the District of Columbia. Their mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries.
<b>Quality Indicator</b>	<b>QI</b>	Developed as part of the CMS funded Multi-State Nursing Facility Case Mix and Quality Demonstration (NHCMQ) by the University of Wisconsin. The QIs represent common conditions and important aspects of care. QI reports reflect a measure of the prevalence or incidence of conditions based on MDS assessment data.
<b>Quality Measure</b>	<b>QM</b>	Information derived from MDS data that is available to the public as part of the Nursing Facility Quality Initiative. The Quality Measures are designed to provide consumers with additional information for them to make informed decisions about the quality of care in nursing facilities.
<b>Read</b>		To read or listen to script, Braille, or audio recorded written material.
<b>Readmission</b>		Day 1 of Medicare Part A coverage after readmission following a discharge.
<b>Record Type</b>		A code submitted in the MDS and tracking form records used to identify certain combinations of reasons for assessment.

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Term	Abbreviation	Definition
<b>Recreational Therapists</b>		Professionals, who hold a national certification in therapeutic recreation and the credential of Certified Therapeutic Recreation Specialist. Recreational therapy includes, but is not limited to, providing treatment services and recreation activities to individuals using a variety of techniques, including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings. Recreation therapists treat and help maintain the physical, mental, and emotional well-being of their clients by seeking to reduce depression, stress, and anxiety; recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively. Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment.
<b>Recreational Therapy</b>		Services that are provided or directly supervised by a qualified recreational therapist, also referred to as a “therapeutic recreation specialist.”
<b>Reentry</b>		When a resident returns to a facility following a temporary discharge (return anticipated), a reentry is reported to either the MDS or SB-MDS system.
<b>Registered Nurse Assessment Coordinator</b>	<b>RNAC</b>	An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, who is responsible for coordinating and certifying completion of the resident assessment.
<b>Religion</b>		<p>Participate in religious services: any means of taking part in religious services or practices, including listening to services on the radio or television, attending services in the facility or in the community, or participating in private prayer or religious study</p> <p>Religious practices: rituals associated with various religious traditions or faiths, such as performing washing rituals in preparation for prayer, following kosher dietary laws, honoring holidays and religious festivals, and participating in communion or confession.</p> <p>Religious services: formal gatherings or informal prayer meetings attended in person or by listening to the radio or television.</p>

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Term	Abbreviation	Definition
<b>Resident Assessment</b>		A comprehensive, standardized evaluation of each resident's physical, mental, psychosocial, and functional status conducted within 14 days of admission to a nursing facility, promptly after a significant change in a resident's status, and on an annual basis.
<b>Resident Assessment Instrument</b>	<b>RAI</b>	The designation for the complete resident assessment process mandated by CMS, including the comprehensive MDS, Care Area Assessment (CAA), and care planning decisions. The RAI helps facility staff gather definitive information on a resident's strengths and needs that must be addressed in an individualized care plan.
<b>Resident Assessment Instrument (RAI) Coordinator</b>		A resource person, usually with a State agency, who can provide information regarding specific State RAI requirements and assistance in MDS or SB-MDS completion.
<b>Resident Assessment Validation and Entry System</b>	<b>RAVEN</b>	Data entry software supplied by CMS for nursing facilities to use to enter MDS assessment data.
<b>Resident Assessment Validation and Entry System for Swing-Beds</b>	<b>RAVEN-SB</b>	Data entry software supplied by CMS for swing-bed hospitals to use to enter MDS assessment data.
<b>Resource Use</b>		The measure of the number of minutes of care used to develop the classification system. Direct and indirect time is obtained from RNs, licensed practical nurses (LPNs), nursing assistants, physical, occupational and speech therapists, social workers, and activity staff. An index score is created based on the amount of staff time, weighted by staff salary and benefits.
<b>Resource Utilization Group, Version IV</b>	<b>RUG-IV</b>	A category-based classification system in which nursing facility residents classify into one of 66 or 57 or 47 RUG-IV groups. Residents in each group utilize similar quantities and patterns of resource. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0. Medicare uses the 66-group classification.

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Term	Abbreviation	Definition
<b>Respiratory Nurse</b>		A nurse who received specific training on the administration of respiratory treatments and procedures when permitted by the state Nurse Practice Act. This training may have been provided at a hospital or nursing facility as part of work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.
<b>Respiratory Therapy</b>		Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. Does not include hand-held medication dispensers.
<b>Respite</b>		Short-term, temporary care provided to residents to allow family members to take a break from the daily routine of care giving.
<b>Scheduled Pain Medication Regimen</b>		Pain medication order that defines dose and specific time interval for pain medication administration. For example, "once a day," "every 12 hours."
<b>Significant Change in Status Assessment</b>	<b>SCSA</b>	A comprehensive assessment required when there is a decline or improvement in a resident's status that (1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, (2) impacts more than one area of the patient's health status, and (3) requires interdisciplinary review and/or revision of the care plan.
<b>Significant Correction Assessment</b>		A comprehensive assessment that is required when a major error has been identified in a previous assessment and has not been corrected in a subsequent assessment.
<b>Significant Other</b>		A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, legal guardian, primary community caregiver or close friend. Significant other does not, however, include staff at the nursing home.

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<b>Term</b>	<b>Abbreviation</b>	<b>Definition</b>
<b>Skilled Nursing Facility</b>	<b>SNF</b>	A facility that primarily provides skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons.
<b>Sleep Hygiene</b>		Practices, habits, and environmental factors that promote and/or improve sleep patterns.
<b>Slough Tissue</b>		Necrotic/avascular tissue in the process of separating from the viable portions of the body and is usually light colored, soft, moist, and stringy (at times). Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
<b>Snack</b>		Food available between meals, including between dinner and breakfast.
<b>Social Security Number</b>		A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.
<b>Speech</b>		A verbal expression of articulate words.
<b>Speech-Language Pathology, Audiology</b>		Services that are provided by a licensed speech-language pathologist and/or audiologist. Rehabilitative treatment addresses physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing (dysphagia). Communication includes speech, language (both receptive and expressive) and non-verbal communication such as facial expression and gesture. Swallowing problems managed under speech therapy are problems in the oral, laryngeal, and/or pharyngeal stages of swallowing. Depending on the nature and severity of the disorder, common treatments may range from physical strengthening exercises, instructive or repetitive practice and drilling, to the use of audio-visual aids and introduction of strategies to facilitate functional communication. Speech therapy may also include sign language and the use of picture symbols. Speech-language pathologist is defined in regulation 42 CFR 484.4.

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Term	Abbreviation	Definition
<b>Stage 1 Pressure Ulcer</b>		An observable, pressure-related alteration of intact skin, whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.
<b>Stage 2 Pressure Ulcer</b>		Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
<b>Stage 3 Pressure Ulcer</b>		Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
<b>Stage 4 Pressure Ulcer</b>		Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers.
<b>Start of Therapy OMRA</b>		An optional assessment completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group, which may only be completed if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. The Start of Therapy OMRA must have an ARD (item A2300) set on day 5-7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest data). The Start of Therapy OMRA will establish a RUG-IV classification and Medicare payment, which begins on the day therapy started.
<b>State Operations Manual</b>	<b>SOM</b>	A manual provided by CMS that contains guidelines for the survey process.
<b>State Provider Number</b>		Medicaid Provider Number established by a state.

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Term	Abbreviation	Definition
<b>Submission Requirement</b>	<b>SUB_REQ</b>	A field in the MDS electronic record that identifies the authority for data collection. CMS has authority to collect assessments for all residents (regardless of their payer source) who reside in Medicare- and/or Medicaid-certified units. States may or may not have regulatory authority to collect assessments for residents in non-certified units.
<b>Suprapubic Catheter</b>		An indwelling catheter that is placed by an urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.
<b>Surgical Wounds</b>		Surgical wounds are any healing and non-healing, open or closed surgical incisions, skin grafts, or drainage sites on any part of the body.
<b>Surgical Wound Care</b>		Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.
<b>Suspected Deep Tissue Injury</b>		Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.
<b>Swing Bed</b>		A rural hospital with fewer than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.
<b>Swing-Bed MDS</b>	<b>SB-MDS</b>	MDS assessments completed by swing bed hospitals for Medicare Prospective Payment.
<b>System of Records</b>	<b>SOR</b>	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
<b>Temporal Orientation</b>		In general, the ability to place oneself in correct time. For BIMS, it is the ability to indicate correct date in current surroundings.

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Term	Abbreviation	Definition
<b>Target Date</b>		A term used in CMS system-generated reports. This date is the Assessment Reference Date for an assessment, date of discharge for a discharge, and date of reentry for a reentry.
<b>Therapeutic Diet</b>		A diet ordered to manage problematic health conditions. Therapeutic refers to the nutritional content of the food. Examples include calorie-specific, low-salt, low-fat, lactose-free, and no added sugar diets, as well as those requiring supplements during meals.
<b>Tobacco Use</b>		Includes tobacco used in any form.
<b>Total Severity Score</b>		A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.
<b>Transfer</b>		When a resident leaves a nursing facility either temporarily or permanently, and goes to another health care setting.
<b>Triggers</b>		Specific MDS item responses that indicate the presence of clinical factors that should be considered by the interdisciplinary team when making care planning decisions.
<b>Turning/ Repositioning Program</b>		Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."
<b>Ulcer</b>		Mouth sore, blister, or eroded area of tissue on any oral surface.
<b>Ulcer Care</b>		Includes any intervention for treating skin problems coded in M0300. Examples include use of topical dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.
<b>Unsteady</b>		Residents may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

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Term	Abbreviation	Definition
<b>Urinary Incontinence</b>		Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or prompted toileting.
<b>Urostomy</b>		A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible (e.g., after extensive surgery or in case of obstruction).
<b>Utilization Guidelines</b>		Comprehensive information for evaluating factors that may cause, contribute to, or exacerbate a triggered condition.
<b>Validation Report</b>		See FVR or Final Validation Report.
<b>V Codes</b>		A supplementary classification of ICD codes used to describe the circumstances that influence a resident's health status and identify the reasons for medical visits resulting from circumstances other than a disease or injury.
<b>Venous Ulcers</b>		Ulcers caused by peripheral venous disease and most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle or on the lower calf area of the leg.
<b>Vocal Complaints of Pain</b>		"That hurts," "ouch," "stop," etc.
<b>Vomiting</b>		Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).
<b>White</b>		Persons who have origins in any of the original peoples of Europe, the Middle East, or North Africa.



## Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
CAA	Care Area Assessment
CAH	Critical Access Hospital
CAT	Care Area Trigger
CBSA	Core-Based Statistical Area
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPT	(Physicians) Current Procedural Terminology
CR	Change Request
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
ESRD	End Stage Renal Disease
FI	Fiscal Intermediary
FMR	Focused Medial Review
FR	Final Rule
FY	Fiscal Year

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<b>Acronym</b>	<b>Definition</b>
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCFA Pub. 10	Hospital Manual
HCFA Pub. 12	Skilled Nursing Facility Manual
HCFA Pub. 7	State Operations Manual
HCFA Pub.13-3	Medicare Intermediary Manual, Claims Process, Part 3
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance PPS (Rate Codes)
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
IFC	Interim Final Rule with Comment
IOM	Internet-Only Manual
LOA	Leave of Absence
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review (File)
MIM	Medicare Intermediary Manual
MPAF	Medicare Prospective Payment System Assessment Form
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
NCS	National Supplier Clearinghouse
NDM	National Data Mover
NECMA	New England Country Metropolitan Area
NSC	National Supplier Clearinghouse
OBRA	Omnibus Budget Reconciliation Act of 1987
OMB	Office of Management and Budget
OMRA	Other Medicare-required Assessment
OT	Occupational Therapy/Therapist
PCE	Personal Care Expenditures
PIM	Program Integrity Manual
PM	Program Memorandum
POS	Point of Service
PPI	Producer Price Index

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<b>Acronym</b>	<b>Definition</b>
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PT	Physical Therapy/Therapist
PTA	Physical Therapist Assistant
Pub.100-1	Medicare General Information, Eligibility, and Entitlement IOM
Pub.100-2	Medicare Benefit IOM
Pub.100-4	Medicare Claims Processing IOM
Pub.100-7	Medicare State Operation IOM
Pub.100-8	Medicare Program Integrity IOM
Pub.100-12	State Medicaid IOM
QIO	Quality Improvement Organization
RAI	Resident Assessment Instrument
RUG	Resource Utilization Group
SB-MDS	Swing Bed Minimum Data Set
SB-PPS	Swing Bed Prospective Payment System
SCSA	Significant Change in Status Assessment
SNF	Skilled Nursing Facility
SNF PPS	Skilled Nursing Facility Prospective Payment System
SLP (or ST)	Speech Language Pathology Services
STM	Staff Time Measure

## APPENDIX B: STATE AGENCY AND CMS REGIONAL OFFICE RAI/MDS CONTACTS

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## **APPENDIX C: CARE AREA ASSESSMENT (CAA) RESOURCES**

Appendix C will be added to the manual in 12/2009 with the availability of Chapter 4 (CAAs).

## Appendix D: Interviewing to Increase Resident Voice in MDS Assessments

All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives. There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information (e.g., mood, preferences, pain). Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident regarding these specific topic areas; however, resident interview/inquiry should become part of a supportive care environment that helps residents fulfill their choices over aspects of their lives.

In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident's cognitive status. The majority of residents, even those with moderate to severe cognitive impairment, are able to answer some simple questions about these topics.

Even simple scripted interviews like those in MDS 3.0 involve a dynamic, collaborative process. There are some basic approaches that can make interviews simpler and more effective.

- **Introduce yourself** to the resident.
- **Be sure the resident can hear what you are saying.**
  - Do not mumble or rush. Articulate words clearly.
  - Ask the resident if he or she uses or owns a hearing aid or other communication device.
  - Help him or her get the aid or device in place before starting the interview.
  - The assessor may need to offer an assistive device (headphones).
- **Ask whether the resident would like an interpreter (language or signing)** if the resident does not appear to be fluent in English or continues to have difficulty understanding. Interpreters are people who translate oral or written language from one language to another. If an interpreter is used during resident interviews, he or she should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the interviewee's responses. The resident should determine meaning based solely on his or her interpretation of what is being translated.
- **Find a quiet, private area where you are not likely to be interrupted or overheard.** This is important for several reasons:
  - Background noise should be minimized.
  - Some items are personal, and the resident will be more comfortable answering in private. The interviewer is in a better position to respond to issues that arise.
  - Decrease available distractions.
- **Sit where the resident can see you clearly and you can see his or her expressions.**
  - Have your face well lighted.
  - Minimize glare.
  - Ask the resident where you should sit so that he or she can see you best. Some residents have decreased central vision or limited ability to turn their heads.
- **Establish rapport and respect.**
  - The steps you have already taken to ensure comfort go a long way toward establishing rapport and demonstrating respect.

- You can also engage the resident in general conversation to help establish rapport.
- If the resident asks a particular question or makes a request, try to address the request or question before proceeding with the interview.
- **Explain the purpose of the questions to the resident.**
  - Start by introducing the topic and explain that you are going to ask a series of questions.
  - You can tell the resident that these questions are designed to be asked of everyone to make sure that nothing is missed.
  - Highlight what you will ask.
  - End by explaining that their answers will help the care team develop a care plan that is appropriate for the resident.
  - Suggested explanations and introductions are included in specific item instructions.
- **Say and show the item responses.**
  - It is helpful to many older adults to both hear and read the response options.
  - As you verbally review the response options, show the resident the items written in large, clear print on a piece of paper or card.
  - Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.
- **Ask the questions** as they appear in the questionnaire.
  - Use a nonjudgmental approach to questioning.
  - Don't be afraid of what the resident might say; you are there to hear it.
  - Actively listen; these questions can provide insights beyond the direct answer.
- **Break the question apart if necessary.** If the resident has difficulty understanding, requests clarification, or seems hesitant, you can employ unfolding or disentangling techniques. (Do not, however, use these techniques for the memory test).
  1. **Unfolding** refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present. This approach walks the resident through the steps needed to think through the question.

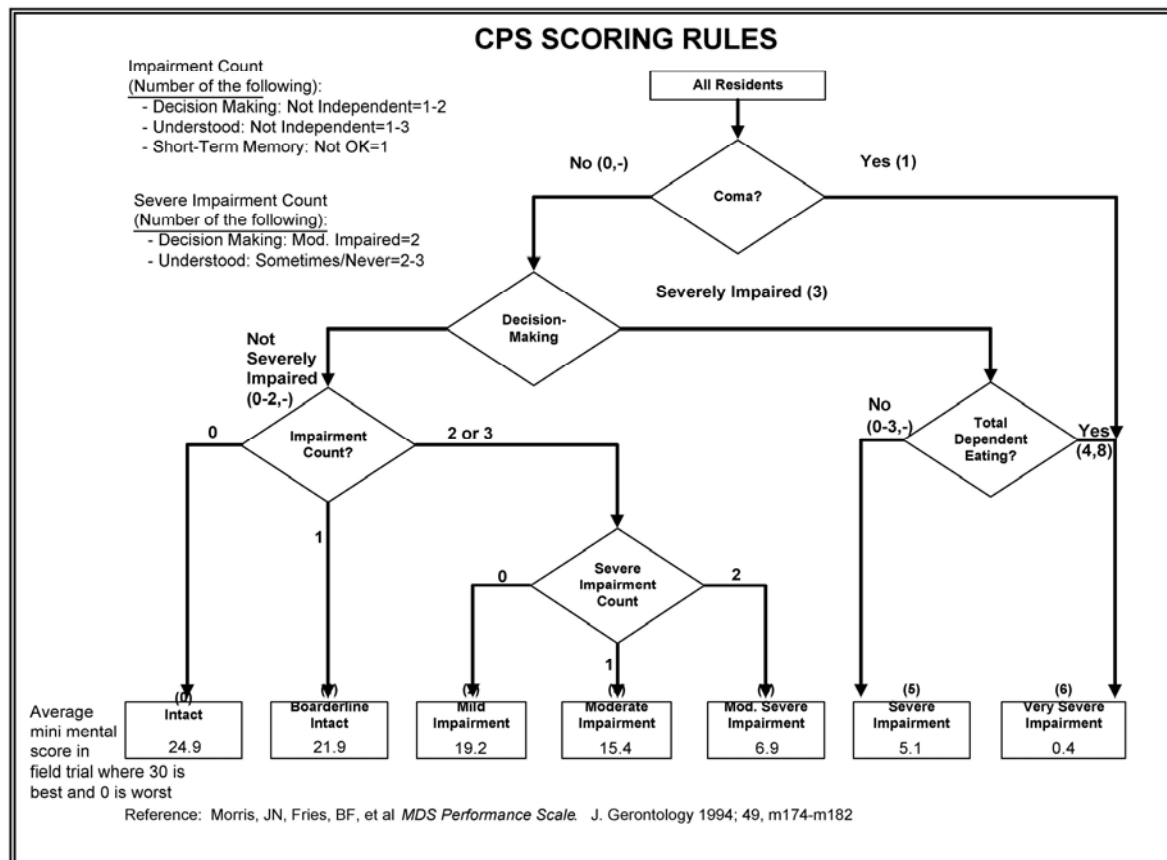
**Example:** Read the item (or part of the item) to the resident, then say, "Do you have this at all?" If yes, then, "Do you have it every day?" If no, then, "Did you have it at least half the days in the past 2 weeks?"
  2. **Disentangling** refers to separating items with several parts into manageable pieces. The type of items that lend themselves to this approach are those that include a list and phrases such as "and" or "or." The resident is given a chance to respond to each piece separately. If a resident responds positively to more than one component of a complex item, obtain a frequency rating for each positive response and score that item using the frequency of the component that occurred most often.

**Example:** An item asks about "Poor appetite or overeating." Disentangle this item by asking, "Poor appetite?"; pause for a response and then ask, "Or overeating?" If neither part is rated positively by the resident, mark no. If either or both are rated positively, then mark yes.

- **Clarify using echoing.** If the resident appears to understand but is having difficulty selecting an answer, try clarifying their response by first echoing what they told you and then repeating the related response options.
  - **Echoing** means simply restating part of the resident's response. This is often extremely helpful during clinical interviews. If the resident provides a related response but does not use the provided response scale or fails to directly answer the question, then help clarify the best response by repeating the resident's own comment and then asking the related response options again. This interview approach frequently helps the resident clarify which response option he or she prefers.
- **Repeat the response options** as needed. Some residents might need to have response choices repeated for each item on a given list.
- **Move on to another question** if the resident is unable to answer.
  - Even if the interview item cannot be completed the time spent is not wasted. The observation of resident behaviors and attention during the interview attempt provide important insights into delirium, cognition, mood, etc.
- **Break up the interview if the resident becomes tired or needs to leave for rehabilitation, etc.**
  - Try to complete the current item set and then offer to come back at another time to complete the remaining interview sections.
  - It is particularly important to complete the performance-based cognitive items in one sitting.
- **Do not try to talk a resident out of an answer.** If the resident expresses strong emotions, be nonjudgmental, and listen.
- **Record the resident's response**, not what you believe they should have said.
- **If the resident becomes deeply sorrowful or agitated**, sympathetically respond to his or her feelings.
  - Allowing emotional expression—even when it is uncomfortable for you as the interviewer—recognizes its validity and provides cathartic support to residents.
  - If the resident remains agitated or overly emotional and does not want to continue, respond to their need. This is more important than finishing the interview at that moment. You can complete this and other sections at a later point in time.
- **Resident preferences may be influenced by many factors in a resident's physical, psychological and environmental state, and can be challenging to truly discern.**
  - Residents should be encouraged to articulate their desires and not be strictly limited by their physical limitations and perceived environmental restrictions.
  - When a resident is unable to communicate information about his or her preferences, a family member, close friend, or other representative must be used to complete preference questions. In this case, it is important to emphasize that this person should try to answer based on what the resident would prefer. The resident's preferences while in the nursing home and the resident's current responses when the particular item is offered or provided should form the basis for these responses.



## APPENDIX E: COGNITIVE PERFORMANCE SCALE (CPS) SCORING RULES



NOTE: Values are denoted as (0-2,-); the dash signifies missing data.

The CPS scale is used in the RUG-IV classification system to measure a resident's cognitive performance. The RUG-IV Classification system uses the CPS scale to identify residents who demonstrate moderate to severe cognitive impairment as a basis for classification in the Impaired Cognition RUG-IV groups.

## APPENDIX F: MDS 3.0 DRAFT MATRIX

**Matrix Version (09/16/09) Based on MDS 3.0 v30**  
**Data Specifications Version: RUG-IV version 1.00**  
**MDS 3.0 Item "DRAFT" Matrix**

<b>Record Type Codes Used:</b>	<b>Application Codes Used:</b>
T = Tracking Record	RG = RUG-IV Case Mix Classification
C = Comprehensive Assessment (Admission, Annual, Significant Change, Significant Correction of Prior Full)	QI = Quality Indicators
	CT = Care Area Triggers (CATs)
Q = OBRA Quarterly (Significant Correction of Prior Quarterly)	QM = Quality Measures
	PQ = Potential Quality Items
P = PPS MPAF	
D = Discharge	
O = OMRA	
S = OMRA SOT stand-alone	
W = PPS Swingbed	

Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
A0100A	National Provider Identifier	x	x	x	x	x	x	x	x		x		x
A0100B	CMS certification number	x	x	x	x	x	x	x	x		x		x
A0100C	State provider number	x	x	x	x	x	x	x	x		x		
A0200	Type of provider	x	x	x	x	x	x	x	x	x	x		x
A0310A	Federal OBRA Reason for Assessment/Tracking	x	x	x	x	x	x	x	x	x	x	x	x
A0310B	PPS Assessment	x	x	x	x	x	x	x	x	x	x		x
A0310C	PPS Other Medicare-required Assessment (OMRA)	x	x	x	x	x	x	x	x				
A0310D	Swing bed clinical change assessment	x	x	x	x	x	x	x	x		x		x
A0310E	First assessment since most recent admission	x	x	x	x	x	x	x	x				
A0310F	Entry/discharge reporting	x	x	x	x	x	x	x	x				
A0410	Submission requirement	x	x	x	x	x	x	x	x				
A0500A	First name	x	x	x	x	x	x	x	x				
A0500B	Middle initial	x	x	x	x	x	x	x	x				
A0500C	Last name	x	x	x	x	x	x	x	x				
A0500D	Suffix	x	x	x	x	x	x	x	x				
A0600A	Social security number	x	x	x	x	x	x	x	x				
A0600B	Medicare number	x	x	x	x	x	x	x	x				
A0700	Medicaid number	x	x	x	x	x	x	x	x				
A0800	Gender	x	x	x	x	x	x	x	x		x		
A0900	Birth date	x	x	x	x	x	x	x	x		x		
A1000A	American Indian or Alaska Native	x	x	x	x	x	x	x	x				
A1000B	Asian	x	x	x	x	x	x	x	x				
A1000C	Black or African American	x	x	x	x	x	x	x	x				
A1000D	Hispanic or Latino	x	x	x	x	x	x	x	x				
A1000E	Native Hawaiian or Other Pacific Islander	x	x	x	x	x	x	x	x				
A1000F	White	x	x	x	x	x	x	x	x				
A1100A	Need/want interpreter		x										
A1100B	Preferred language		x										
A1200	Marital status	x	x	x	x	x	x	x	x				
A1300A	Medical record number	x	x	x	x	x	x	x	x				

(continued)

Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
A1300B	Room number	x	x	x	x	x	x	x	x				
A1300C	Name that resident prefers	x	x	x	x	x	x	x	x				
A1300D	Lifetime occupation(s)	x											
A1500	Preadmission Screening and Resident Review (PASSR)		x										
A1550A	Down syndrome		x										
A1550B	Autism		x										
A1550C	Epilepsy		x										
A1550D	Other organic condition related to MR/DD		x										
A1550E	MR/DD with no organic condition		x										
A1550Z	None of the above—MR/DD status		x										
A1600	Entry date	x	x	x	x	x	x	x	x		x		x
A1700	Type of entry	x											
A1800	Entered from	x	x	x	x	x	x	x	x		x		x
A2000	Discharge date	x	x	x	x	x	x	x	x		x		x
A2100	Discharge status	x	x	x	x	x	x	x	x		x		x
A2200	Previous ARD for significant correction		x	x	x	x							
A2300	Assessment reference date		x	x	x	x	x	x	x		x		x
A2400A	Medicare stay since most recent entry	x	x	x	x	x	x	x	x				
A2400B	Start date of most recent Medicare stay	x	x	x	x	x	x	x	x				
A2400C	End date of most recent Medicare stay	x	x	x	x	x	x	x	x				
B0100	Comatose		x	x	x	x	x		x	x	x		x
B0200	Hearing		x	x	x	x			x			x	x
B0300	Hearing aid		x	x	x	x			x				x
B0600	Speech clarity		x	x	x	x			x				x
B0700	Makes self understood		x	x	x	x	x		x	x		x	x
B0800	Ability to understand others		x	x	x	x			x			x	x
B1000	Vision		x	x	x	x			x			x	x
B1200	Corrective lenses		x	x	x	x			x				x
C0100	Should BIMS be conducted?		x	x	x	x	x		x				
C0200	Repetition of three words		x	x	x	x	x		x	x		x	x

(continued)

		Item Required on Record Type									Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM	
C0300A	Able to report correct year		X	X	X	X	X		X	X		X	X	
C0300B	Able to report correct month		X	X	X	X	X		X	X		X	X	
C0300C	Able to report correct day of week		X	X	X	X	X		X	X		X	X	
C0400A	Able to recall "sock"		X	X	X	X	X		X	X		X	X	
C0400B	Able to recall "blue"		X	X	X	X	X		X	X		X	X	
C0400C	Able to recall "bed"		X	X	X	X	X		X	X		X	X	
C0500	Summary Score—BIMS		X	X	X	X	X		X					
C0600	Should staff assessment for mental status be conducted?		X	X	X	X	X		X					
C0700	Short-term memory OK		X	X	X	X	X		X	X		X	X	
C0800	Long-term memory OK		X	X	X	X			X			X	X	
C0900A	Current season		X	X	X	X			X				X	
C0900B	Location of own room		X	X	X	X			X				X	
C0900C	Staff names and faces		X	X	X	X			X				X	
C0900D	That he/she is in a nursing home		X	X	X	X			X				X	
C0900Z	None of the above were recalled		X	X	X	X								
C1000	Cognitive skills for daily decision making		X	X	X	X	X		X	X		X	X	
C1300A	Inattention		X	X	X	X			X			X	X	
C1300B	Disorganized thinking		X	X	X	X			X			X	X	
C1300C	Altered level of consciousness		X	X	X	X			X			X	X	
C1300D	Psychomotor retardation		X	X	X	X			X			X	X	
C1600	Acute onset mental status change		X	X	X	X			X			X	X	
D0100	Should resident mood interview be conducted?		X	X	X	X	X		X			X		
D0200A1	Little interest/pleasure in doing things—presence		X	X	X	X	X		X			X		
D0200A2	Little interest/pleasure in doing things—frequency		X	X	X	X	X		X	X	X	X	X	
D0200B1	Feeling down, depressed, or hopeless—presence		X	X	X	X	X		X					
D0200B2	Feeling down, depressed, or hopeless—frequency		X	X	X	X	X		X	X	X	X	X	
D0200C1	Trouble falling/staying asleep, sleeping too much—presence		X	X	X	X	X		X					
D0200C2	Trouble falling/staying asleep, sleeping too much—frequency		X	X	X	X	X		X	X	X	X	X	
D0200D1	Feeling tired or having little energy—presence		X	X	X	X	X		X					
D0200D2	Feeling tired or having little energy—frequency		X	X	X	X	X		X	X	X	X	X	

(continued)

		Item Required on Record Type									Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM	
D0200E1	Poor appetite or overeating—presence		X	X	X	X	X		X					
D0200E2	Poor appetite or overeating—frequency		X	X	X	X	X		X	X	X	X	X	
D0200F1	Feeling bad about yourself—presence		X	X	X	X	X		X					
D0200F2	Feeling bad about yourself—frequency		X	X	X	X	X		X	X	X	X	X	
D0200G1	Trouble concentrating on things—presence		X	X	X	X	X		X					
D0200G2	Trouble concentrating on things—frequency		X	X	X	X	X		X	X	X	X	X	
D0200H1	Moving/speaking slowly or being fidgety/restless—presence		X	X	X	X	X		X					
D0200H2	Moving/speaking slowly or being fidgety/restless—frequency		X	X	X	X	X		X	X	X	X	X	
D0200I1	Thoughts you would be better off dead—presence		X	X	X	X	X		X			X		
D0200I2	Thoughts you would be better off dead—frequency		X	X	X	X	X		X	X	X	X	X	
D0300	Total Severity Score—PHQ-9		X	X	X	X	X		X					
D0350	Safety Notification—PHQ-9		X	X	X	X	X		X					
D0500A1	Little interest/pleasure in doing things—presence		X	X	X	X	X		X			X		
D0500A2	Little interest/pleasure in doing things—frequency		X	X	X	X	X		X	X	X	X	X	
D0500B1	Feeling down, depressed, or hopeless—presence		X	X	X	X	X		X					
D0500B2	Feeling down, depressed, or hopeless—frequency		X	X	X	X	X		X	X	X	X	X	
D0500C1	Trouble falling/staying asleep, sleeping too much—presence		X	X	X	X	X		X					
D0500C2	Trouble falling/staying asleep, sleeping too much—frequency		X	X	X	X	X		X	X	X	X	X	
D0500D1	Feeling tired or having little energy—presence		X	X	X	X	X		X					
D0500D2	Feeling tired or having little energy—frequency		X	X	X	X	X		X	X	X	X	X	
D0500E1	Poor appetite or overeating—presence		X	X	X	X	X		X					
D0500E2	Poor appetite or overeating—frequency		X	X	X	X	X		X	X	X	X	X	
D0500F1	Indicating that s/he feels bad about self—presence		X	X	X	X	X		X					
D0500F2	Indicating that s/he feels bad about self—frequency		X	X	X	X	X		X	X	X	X	X	
D0500G1	Trouble concentrating on things—presence		X	X	X	X	X		X					
D0500G2	Trouble concentrating on things—frequency		X	X	X	X	X		X	X	X	X	X	
D0500H1	Moving/speaking slowly or being fidgety/restless—presence		X	X	X	X	X		X					
D0500H2	Moving/speaking slowly or being fidgety/restless—frequency		X	X	X	X	X		X	X	X	X	X	
D0500I1	States that life isn't worth living—presence		X	X	X	X	X		X			X		
D0500I2	States that life isn't worth living—frequency		X	X	X	X	X		X	X	X	X	X	

(continued)



Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
D0500J1	Being short-tempered, easily annoyed—presence		x	x	x	x	x		x				
D0500J2	Being short-tempered, easily annoyed—frequency		x	x	x	x	x		x	x		x	x
D0600	Total Severity Score—PHQ-9-OV		x	x	x	x	x		x				
D0650	Safety Notification—PHQ-9-OV		x	x	x	x	x		x				
E0100A	Hallucinations		x	x	x		x		x	x			
E0100B	Delusions		x	x	x		x		x	x			
E0100Z	None of the above—psychosis		x	x	x		x						
E0200A	Physical behavioral symptoms directed toward others		x	x	x		x		x	x		x	
E0200B	Verbal behavioral symptoms directed toward others		x	x	x		x		x	x		x	
E0200C	Other behavioral symptoms not directed toward others		x	x	x		x		x	x			
E0300	Overall presence of behavioral symptoms		x	x	x						x	x	
E0500A	Put resident at significant risk for physical illness/injury		x										
E0500B	Significantly interfere with resident's care		x										
E0500C	Significantly interfere with resident's participation in activities		x										
E0600A	Put others at significant risk for physical injury		x										
E0600B	Significantly intrude on the privacy or activity of others		x										
E0600C	Significantly disrupt care or living environment		x										
E0800	Rejection of care—presence & frequency		x	x	x		x		x	x	x	x	
E0900	Wandering—presence & frequency		x	x	x		x		x	x	x	x	
E1000A	Wandering resident at significant risk to dangerous place		x										
E1000B	Wandering significantly intrude on privacy/activities others		x										
E1100	Change in behavior or other symptoms		x									x	
F0300	Should interview for preferences be conducted?		x										
F0400A	Choose what clothes to wear		x										
F0400B	Take care of your personal belongings or things		x										
F0400C	Choose between tub bath, shower, bed bath, or sponge bath		x										
F0400D	Have snacks available between meals		x										
F0400E	Choose your own bedtime		x										
F0400F	Have family/close friend involved in discussions about care		x										
F0400G	Be able to use the phone in private		x										

(continued)

Item	Description	Item Required on Record Type									Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM	
F0400H	Have a place to lock your things to keep them safe		x											
F0500A	Have books, newspapers, and magazines to read		x									x		
F0500B	Listen to music you like		x									x		
F0500C	Be around animals such as pets		x									x		
F0500D	Keep up with the news		x									x		
F0500E	Do things with groups of people		x									x		
F0500F	Do your favorite activities		x									x		
F0500G	Go outside to get fresh air when weather is good		x									x		
F0500H	Participate in religious services or practices		x									x		
F0600	Daily and activity preferences primary respondent		x									x		
F0700	Should staff assessment of preferences be conducted?		x											
F0800A	Choosing clothes to wear		x											
F0800B	Caring for personal belongings		x											
F0800C	Receiving tub bath		x											
F0800D	Receiving shower		x											
F0800E	Receiving bed bath		x											
F0800F	Receiving sponge bath		x											
F0800G	Snacks between meals		x											
F0800H	Staying up past 8:00 p.m.		x											
F0800I	Family or significant other involvement in care discussions		x											
F0800J	Use of phone in private		x											
F0800K	Place to lock personal belongings		x											
F0800L	Reading books, newspapers, or magazines		x									x		
F0800M	Listening to music		x									x		
F0800N	Being around animals such as pets		x									x		
F0800O	Keeping up with the news		x									x		
F0800P	Doing things with groups of people		x									x		
F0800Q	Participating in favorite activities		x									x		
F0800R	Spending time away from the nursing home		x									x		
F0800S	Spending time outdoors		x									x		

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
F0800T	Participating in religious activities or practices		X										X		
F0800Z	None of the above—staff assessment of preferences		X												
G0110A1	Bed mobility—self-performance		X	X	X	X	X	X	X	X	X	X	X		
G0110A2	Bed mobility—support		X	X	X	X	X	X	X	X	X		X		
G0110B1	Transfer—self-performance		X	X	X	X	X	X	X	X	X	X	X		
G0110B2	Transfer—support		X	X	X	X	X	X	X	X	X		X		
G0110C1	Walk in room—self-performance		X	X	X	X			X		X	X	X		
G0110C2	Walk in room—support		X	X	X	X			X		X		X		
G0110D1	Walk in corridor—self-performance		X	X	X	X			X		X	X	X		
G0110D2	Walk in corridor—support		X	X	X	X			X		X		X		
G0110E1	Locomotion on unit—self-performance		X	X	X	X			X		X	X	X		
G0110E2	Locomotion on unit—support		X	X	X	X			X		X		X		
G0110F1	Locomotion off unit—self-performance		X	X	X	X			X		X	X	X		
G0110F2	Locomotion off unit—support		X	X	X	X			X		X		X		
G0110G1	Dressing—self-performance		X	X	X	X			X		X	X	X		
G0110G2	Dressing—support		X	X	X	X			X		X		X		
G0110H1	Eating—self-performance		X	X	X	X	X	X	X	X	X	X	X		
G0110H2	Eating—support		X	X	X	X	X	X	X	X	X		X		
G0110I1	Toilet use—self-performance		X	X	X	X	X	X	X	X	X	X	X		
G0110I2	Toilet use—support		X	X	X	X	X	X	X	X	X		X		
G0110J1	Personal hygiene—self-performance		X	X	X	X			X		X	X	X		
G0110J2	Personal hygiene—support		X	X	X	X			X		X		X		
G0120A	Bathing—self-performance		X	X	X	X			X		X	X	X		
G0120B	Bathing—support provided		X	X	X	X			X		X	X	X		
G0300A	Balance—moving from seated to standing position		X	X	X	X			X		X	X	X		
G0300B	Balance—walking		X	X	X	X			X		X	X	X		
G0300C	Balance—turning around while walking		X	X	X	X			X		X	X	X		
G0300D	Balance—moving on and off toilet		X	X	X	X			X		X	X	X		
G0300E	Balance—surface-to-surface transfer		X	X	X	X			X		X	X	X		
G0400A	Range of motion—upper extremity		X	X	X	X			X		X		X		

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
G0400B	Range of motion—lower extremity		X	X	X	X			X		X		X		
G0600A	Cane/crutch		X	X	X	X			X		X		X		
G0600B	Walker		X	X	X	X			X		X		X		
G0600C	Wheelchair (manual or electric)		X	X	X	X			X		X		X		
G0600D	Limb prosthesis		X	X	X	X			X		X		X		
G0600Z	None of the above—mobility devices		X	X	X	X									
G0900A	Resident believes capable of increased independence		X	X	X							X			
G0900B	Direct care staff believe capable of increased independence		X	X	X							X			
H0100A	Indwelling catheter		X	X	X	X			X			X	X		
H0100B	External catheter		X	X	X	X			X			X	X		
H0100C	Ostomy		X	X	X	X			X				X		
H0100D	Intermittent catheterization		X	X	X	X			X			X	X		
H0100Z	None of the above—appliances		X	X	X	X									
H0200A	Has a trial of toileting program been attempted		X												
H0200B	Response to trial toilet program		X												
H0200C	Current toileting program or trial		X	X	X		X	X	X	X					
H0300	Urinary continence		X	X	X	X			X		X	X	X		
H0400	Bowel continence		X	X	X	X			X		X	X	X		
H0500	Bowel toileting program		X	X	X		X	X	X	X					
H0600	Bowel patterns		X									X			
I0100	Cancer		X												
I0200	Anemia		X												
I0300	Atrial fibrillation and other dysrhythmias		X												
I0400	Coronary artery disease		X												
I0500	Deep venous thrombosis/pulmonary embolus/PTE		X												
I0600	Heart failure		X												
I0700	Hypertension		X												
I0800	Orthostatic hypotension		X												
I0900	Peripheral vascular/arterial disease		X												
I1100	Cirrhosis		X												

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
I1200	Gastroesophageal reflux disease/ulcer		x												
I1300	Ulcerative colitis/Crohn's disease/inflammatory bowel disease		x												
I1400	Benign prostatic hyperplasia		x												
I1500	Renal insufficiency or failure/end-stage renal disease		x												
I1550	Neurogenic bladder		x	x	x	x			x				x		
I1650	Obstructive uropathy		x	x	x	x			x				x		
I1700	Multidrug-resistant organism		x	x	x							x			
I2000	Pneumonia		x	x	x	x	x		x	x		x	x		
I2100	Septicemia		x	x	x	x	x		x	x		x	x		
I2200	Tuberculosis		x	x	x	x			x			x	x		
I2300	Urinary tract infection (last 30 days)		x	x	x	x			x		x	x	x		
I2400	Viral hepatitis		x	x	x							x			
I2500	Wound infection		x	x	x	x			x			x	x		
I2900	Diabetes mellitus		x	x	x	x	x		x	x			x		
I3100	Hyponatremia		x												
I3200	Hyperkalemia		x												
I3300	Hyperlipidemia		x												
I3400	Thyroid disorder		x												
I3700	Arthritis		x												
I3800	Osteoporosis		x												
I3900	Hip fracture		x	x	x	x			x		x		x		
I4000	Other fracture		x	x	x	x			x		x		x		
I4200	Alzheimer's disease		x	x	x							x			
I4300	Aphasia		x	x	x										
I4400	Cerebral palsy		x	x	x		x		x	x					
I4500	Cerebrovascular accident/transient ischemic attack/stroke		x	x	x	x			x				x		
I4800	Dementia		x	x	x	x			x			x	x		
I4900	Hemiplegia/hemiparesis		x	x	x	x	x		x	x			x		
I5000	Paraplegia		x	x	x	x			x				x		
I5100	Quadriplegia		x	x	x	x	x		x	x			x		

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Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
I5200	Multiple sclerosis		X	X	X	X	X		X	X			X		
I5250	Huntington's disease		X	X	X	X			X				X		
I5300	Parkinson's disease		X	X	X	X	X		X	X			X		
I5350	Tourette's syndrome		X												
I5400	Seizure disorder or epilepsy		X												
I5500	Traumatic brain injury		X	X	X	X			X				X		
I5600	Malnutrition		X												
I5700	Anxiety disorder		X	X	X	X			X		X		X		
I5800	Depression (other than bipolar)		X	X	X	X			X		X		X		
I5900	Manic depression (bipolar disease)		X	X	X	X			X		X		X		
I5950	Psychotic disorder (other than schizophrenia)		X	X	X	X			X		X		X		
I6000	Schizophrenia		X	X	X	X			X		X		X		
I6100	Post-traumatic stress disorder		X	X	X										
I6200	Asthma/COPD/chronic lung disease		X	X	X	X	X		X	X	X		X		
I6300	Respiratory failure		X	X	X		X		X	X					
I6500	Cataracts, glaucoma, or macular degeneration		X									X			
I7900	None of the above—active diagnoses		X												
I8000A	Additional active diagnoses		X	X	X										
I8000B	Additional active diagnoses		X	X	X										
I8000C	Additional active diagnoses		X	X	X										
I8000D	Additional active diagnoses		X	X	X										
I8000E	Additional active diagnoses		X	X	X										
I8000F	Additional active diagnoses		X	X	X										
I8000G	Additional active diagnoses		X	X	X										
I8000H	Additional active diagnoses		X	X	X										
I8000I	Additional active diagnoses		X	X	X										
I8000J	Additional active diagnoses		X	X	X										
J0100A	Been on a scheduled pain medication regimen		X	X	X	X			X		X		X		
J0100B	Received PRN pain medications		X	X	X	X			X		X		X		
J0100C	Received non-medication intervention for pain		X	X	X	X			X		X		X		

(continued)

Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
J0200	Should pain assessment interview be conducted?		X	X	X	X			X				
J0300	Pain presence		X	X	X	X			X		X		X
J0400	Pain frequency		X	X	X	X			X		X	X	X
J0500A	Has pain made it hard for you to sleep at night		X	X	X	X			X		X	X	X
J0500B	Have you limited your day-to-day activities because of pain		X	X	X	X			X		X	X	X
J0600A	Pain intensity—numeric rating scale		X	X	X	X			X		X	X	X
J0600B	Pain intensity—verbal descriptor scale		X	X	X	X			X		X	X	X
J0700	Should staff assessment for pain be conducted?		X	X	X	X			X				
J0800A	Non-verbal sounds		X	X	X	X			X		X	X	X
J0800B	Vocal complaints of pain		X	X	X	X			X		X	X	X
J0800C	Facial expressions		X	X	X	X			X		X	X	X
J0800D	Protective body movements or postures		X	X	X	X			X		X	X	X
J0800Z	None of these signs observed or documented—pain		X	X	X	X			X				
J0850	Frequency of indicator of pain or possible pain		X	X	X	X			X		X		X
J1100A	Shortness of breath, trouble breathing with exertion		X	X	X	X			X		X		X
J1100B	Shortness of breath, troubled breathing when sitting at rest		X	X	X	X			X		X		X
J1100C	Shortness of breath, trouble breathing when lying flat		X	X	X	X	X		X	X	X		X
J1100Z	None of the above—shortness of breath		X	X	X	X							
J1300	Current tobacco use		X										
J1400	Prognosis		X	X	X	X			X		X		X
J1550A	Fever		X	X	X		X		X	X		X	
J1550B	Vomiting		X	X	X		X		X	X		X	
J1550C	Dehydrated		X	X	X				-	-		X	
J1550D	Internal bleeding		X	X	X							X	
J1550Z	None of the above—problem conditions		X	X	X								
J1700A	Resident fall one or more last month prior to admission		X	X	X	X			X		X	X	X
J1700B	Resident fall one or more last 2-6 months prior to admission		X	X	X	X			X		X	X	X
J1700C	Resident fracture related to fall 6 months prior to admission		X	X	X	X			X		X		X
J1800	Any falls since admission or prior assessment		X	X	X	X			X		X	X	X
J1900A	Number of falls—no injury		X	X	X	X			X		X		X

(continued)



Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
J1900B	Number of falls—injury (except major)		X	X	X	X			X		X		X		
J1900C	Number of falls—major injury		X	X	X	X			X		X		X		
K0100A	Loss of liquids/solids from mouth when eating or drinking		X	X	X										
K0100B	Holding food in mouth/cheeks, residual food in mouth after meals		X	X	X										
K0100C	Coughing/choking during meals, when swallowing medications		X	X	X										
K0100D	Complaints of difficulty or pain with swallowing		X	X	X										
K0100Z	None of the above—swallow disorder		X	X	X										
K0200A	Height		X	X	X	X			X		X		X		
K0200B	Weight		X	X	X	X			X		X		X		
K0300	Weight loss		X	X	X	X	X		X	X	X	X	X		
K0500A	Parenteral/IV feeding		X	X	X		X		X	X		X			
K0500B	Feeding tube		X	X	X		X		X	X		X			
K0500C	Mechanically altered diet		X	X	X							X			
K0500D	Therapeutic diet		X									X			
K0500Z	None of the above—nutritional approaches		X												
K0700A	Total calories (%) through parenteral or tube feedings		X	X	X		X		X	X					
K0700B	Average fluid intake per day by IV or tube feeding		X	X	X		X		X	X					
L0200A	Broken or loosely fitting full or partial denture		X	X	X							X			
L0200B	No natural teeth or tooth fragment(s)		X									X			
L0200C	Abnormal mouth tissue		X									X			
L0200D	Obvious or likely cavity or broken natural teeth		X									X			
L0200E	Inflamed or bleeding gums or loose natural teeth		X									X			
L0200F	Mouth or facial pain, discomfort or difficulty with chewing		X	X	X							X			
L0200G	Unable to examine		X												
L0200Z	None of the above were present—dental		X												
M0100A	Resident stage 1 or greater/scar/non-removable dressing/device		X	X	X	X			X		X		X		
M0100B	Formal assessment instrument/tool		X	X	X	X			X		X		X		
M0100C	Clinical assessment		X	X	X	X			X		X		X		
M0100Z	None of the above—pressure ulcer risk		X	X	X	X									
M0150	Risk of pressure ulcers		X	X	X	X			X		X	X	X		

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
M0210	Unhealed pressure ulcer(s)		X	X	X	X			X		X		X		
M0300A	Number of Stage 1 pressure ulcers		X	X	X	X			X		X	X	X		
M0300B1	Number of Stage 2 pressure ulcers		X	X	X	X	X		X	X	X	X	X		
M0300B2	Number of Stage 2 that were present admission/reentry		X	X	X	X			X		X		X		
M0300B3	Date of oldest Stage 2 pressure ulcer		X	X	X	X			X		X		X		
M0300C1	Number of Stage 3 pressure ulcers		X	X	X	X	X		X	X	X	X	X		
M0300C2	Number of Stage 3 that were present admission/reentry		X	X	X	X			X		X		X		
M0300D1	Number of Stage 4 pressure ulcers		X	X	X	X	X		X	X	X	X	X		
M0300D2	Number of Stage 4 that were present admission/reentry		X	X	X	X			X		X		X		
M0300E1	Number of unstageable pressure ulcers, non-removable dressing		X	X	X	X			X		X	X	X		
M0300E2	Number of unstageable present admission/reentry, dressing		X	X	X	X			X		X		X		
M0300F1	Number of unstageable pressure ulcers, slough/eschar		X	X	X	X	X		X	X	X		X		
M0300F2	Number of unstageable present admission/reentry, slough/eschar		X	X	X	X			X		X		X		
M0300G1	Number of unstageable pressure ulcers, suspected deep tissue injury		X	X	X	X			X		X		X		
M0300G2	Number of unstageable present admission/reentry, sdti		X	X	X	X			X		X		X		
M0610A	Pressure ulcer length		X	X	X	X			X		X		X		
M0610B	Pressure ulcer width		X	X	X	X			X		X		X		
M0610C	Pressure ulcer depth		X	X	X	X			X		X		X		
M0700	Most severe tissue type for any pressure ulcer		X	X	X	X			X		X		X		
M0800A	Worsening in pressure ulcer status—# of Stage 2		X	X	X	X			X		X	X	X		
M0800B	Worsening in pressure ulcer status—# of Stage 3		X	X	X	X			X		X	X	X		
M0800C	Worsening in pressure ulcer status—# of Stage 4		X	X	X	X			X		X	X	X		
M0900A	Healed pressure ulcers present on the prior assessment		X	X	X	X			X						
M0900B	Healed pressure ulcers—# of Stage 2		X	X	X	X			X		X		X		
M0900C	Healed pressure ulcers—# of Stage 3		X	X	X	X			X		X		X		
M0900D	Healed pressure ulcers—# of Stage 4		X	X	X	X			X		X		X		
M1030	Total number of venous/arterial ulcers		X	X	X	X	X		X	X	X		X		
M1040A	Infection of foot		X	X	X	X	X		X	X	X		X		
M1040B	Diabetic foot ulcer(s)		X	X	X	X	X		X	X	X		X		
M1040C	Other open lesion(s) of foot		X	X	X	X	X		X	X	X	X	X		

(continued)

		Item Required on Record Type									Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM	
M1040D	Open lesion(s) other than ulcers, rashes, cuts		X	X	X	X	X		X	X	X		X	
M1040E	Surgical wound(s)		X	X	X	X	X		X	X	X		X	
M1040F	Burn(s) (second or third degree)		X	X	X	X	X		X	X	X		X	
M1040Z	None of the above—other ulcers, wounds and skin problems		X	X	X	X	X							
M1200A	Pressure reducing device for chair		X	X	X	X	X		X	X	X		X	
M1200B	Pressure reducing device for bed		X	X	X	X	X		X	X	X		X	
M1200C	Turning/repositioning program		X	X	X	X	X		X	X	X		X	
M1200D	Nutrition or hydration intervention		X	X	X	X	X		X	X	X		X	
M1200E	Ulcer care		X	X	X	X	X		X	X	X		X	
M1200F	Surgical wound care		X	X	X	X	X		X	X	X		X	
M1200G	Application of nonsurgical dressings other than feet		X	X	X	X	X		X	X	X		X	
M1200H	Applications of ointments/medications other than feet		X	X	X	X	X		X	X	X		X	
M1200I	Application of dressings to feet		X	X	X	X	X		X	X	X		X	
M1200Z	None of the above—skin and ulcer treatments		X	X	X	X	X							
N0300	Injections—number of days		X	X	X									
N0350A	Insulin injections—number of days		X	X	X		X		X	X				
N0350B	Orders for insulin—number of days		X	X	X		X		X	X				
N0400A	Antipsychotic		X	X	X	X			X		X	X	X	
N0400B	Antianxiety		X	X	X	X			X		X	X	X	
N0400C	Antidepressants		X	X	X	X			X		X	X	X	
N0400D	Hypnotic		X	X	X	X			X		X	X	X	
N0400E	Anticoagulant		X											
N0400F	Antibiotic		X											
N0400G	Diuretic		X											
N0400Z	None of the above were received—medications		X											
O0100A1	Chemotherapy—not resident		X	X	X									
O0100A2	Chemotherapy—resident		X	X	X		X		X	X				
O0100B1	Radiation—not resident		X	X	X									
O0100B2	Radiation—resident		X	X	X		X		X	X				
O0100C1	Oxygen therapy—not resident		X	X	X									

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
O0100C2	Oxygen therapy—resident		X	X	X		X		X	X					
O0100D1	Suctioning—not resident		X	X	X										
O0100D2	Suctioning—resident		X	X	X										
O0100E1	Tracheostomy care—not resident		X	X	X										
O0100E2	Tracheostomy care—resident		X	X	X		X	X	X	X					
O0100F1	Ventilator or respirator—not resident		X	X	X										
O0100F2	Ventilator or respirator—resident		X	X	X		X	X	X	X					
O0100G1	BiPAP/CPAP machine—not resident		X												
O0100G2	BiPAP/CPAP machine—not resident		X												
O0100H1	IV medications—not resident		X	X	X										
O0100H2	IV medications—resident		X	X	X		X		X	X					
O0100I1	Transfusions—not resident		X	X	X										
O0100I2	Transfusions—resident		X	X	X		X		X	X					
O0100J1	Dialysis—not resident		X	X	X										
O0100J2	Dialysis—resident		X	X	X		X		X	X					
O0100K1	Hospice care—not resident		X												
O0100K2	Hospice care—resident		X	X	X	X			X				X		
O0100L2	Respite care—resident		X												
O0100M1	Isolation/quarantine for active infectious disease—not resident		X												
O0100M2	Isolation/quarantine for active infectious disease—resident		X	X	X		X	X	X	X					
O0100Z1	None of the above—special treatments—not resident		X												
O0100Z2	None of the above—special treatments—resident		X												
O0250A	Influenza vaccine received		X	X	X	X			X		X		X		
O0250B	Date vaccine received		X	X	X	X			X		X		X		
O0250C	Influenza vaccine not received, state reason		X	X	X	X			X		X		X		
O0300A	Pneumococcal vaccination up to date		X	X	X	X			X		X		X		
O0300B	Pneumococcal vaccine not received, state reason		X	X	X	X			X		X		X		
O0400A1	Speech-language pathology/audiology services individual minutes		X	X	X		X	X	X	X					
O0400A2	Speech-language pathology/audiology services concurrent minutes		X	X	X		X	X	X	X					
O0400A3	Speech-language pathology/audiology services group minutes		X	X	X		X	X	X	X					

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
O0400A4	Speech-language pathology/audiology services days		x	x	x		x	x	x	x					
O0400A5	Speech-language pathology/audiology services therapy start date		x	x	x		x	x	x	x					
O0400A6	Speech-language pathology/audiology services therapy end date		x	x	x		x	x	x	x					
O0400B1	Occupational therapy individual minutes		x	x	x		x	x	x	x					
O0400B2	Occupational therapy concurrent minutes		x	x	x		x	x	x	x					
O0400B3	Occupational therapy group minutes		x	x	x		x	x	x	x					
O0400B4	Occupational therapy days		x	x	x		x	x	x	x					
O0400B5	Occupational therapy start date		x	x	x		x	x	x	x					
O0400B6	Occupational therapy end date		x	x	x		x	x	x	x					
O0400C1	Physical therapy individual minutes		x	x	x		x	x	x	x					
O0400C2	Physical therapy concurrent minutes		x	x	x		x	x	x	x					
O0400C3	Physical therapy group minutes		x	x	x		x	x	x	x					
O0400C4	Physical therapy days		x	x	x		x	x	x	x					
O0400C5	Physical therapy start date		x	x	x		x	x	x	x					
O0400C6	Physical therapy end date		x	x	x		x	x	x	x					
O0400D1	Respiratory therapy minutes		x												
O0400D2	Respiratory therapy days		x	x	x		x		x	x					
O0400E1	Psychological therapy minutes		x												
O0400E2	Psychological therapy days		x	x	x										
O0400F1	Recreational therapy minutes		x												
O0400F2	Recreational therapy days		x												
O0500A	Restorative nursing program—ROM passive		x	x	x		x	x	x	x					
O0500B	Restorative nursing program—ROM active		x	x	x		x	x	x	x					
O0500C	Restorative nursing program—splint or brace		x	x	x		x	x	x	x					
O0500D	Restorative nursing program—bed mobility		x	x	x		x	x	x	x					
O0500E	Restorative nursing program—transfer		x	x	x		x	x	x	x					
O0500F	Restorative nursing program—walking		x	x	x		x	x	x	x					
O0500G	Restorative nursing program—dressing and/or grooming		x	x	x		x	x	x	x					
O0500H	Restorative nursing program—eating and/or swallowing		x	x	x		x	x	x	x					
O0500I	Restorative nursing program—amputation/prostheses		x	x	x		x	x	x	x					

(continued)

Item	Description	Item Required on Record Type									Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM	
O0500J	Restorative nursing program—communication		X	X	X		X	X	X	X				
O0600	Physician examinations		X	X	X									
O0700	Physician orders		X	X	X									
P0100A	Bed rail		X	X	X	X			X		X	X	X	
P0100B	Trunk restraint—bed		X	X	X	X			X		X	X	X	
P0100C	Limb restraint—bed		X	X	X	X			X		X	X	X	
P0100D	Other restraint—bed		X	X	X	X			X		X	X	X	
P0100E	Trunk restraint—chair or out of bed		X	X	X	X			X		X	X	X	
P0100F	Limb restraint—chair or out of bed		X	X	X	X			X		X	X	X	
P0100G	Chair prevents rising		X	X	X	X			X		X	X	X	
P0100H	Other restraint—chair or out of bed		X	X	X	X			X		X	X	X	
Q0100A	Resident participated in assessment		X	X	X	X								
Q0100B	Family or significant other participated in assessment		X	X	X	X								
Q0100C	Guardian/legally authorized representative participated		X	X	X	X								
Q0300A	Resident's overall goal established during assessment process		X	X	X									
Q0300B	Resident's information source		X	X	X									
Q0400A	Active discharge plan in place		X	X	X									
Q0400B	Determination made to return to community		X	X	X							X		
Q0500A	Resident asked about returning to community		X	X	X									
Q0500B	Ask resident—do you want to talk to someone		X	X	X							X		
Q0600	Referral made to local contact agency		X	X	X							X		
V0100A	CAA—Prior OBRA Assessment		X											
V0100B	CAA—Prior PPS Assessment		X											
V0100C	CAA—Prior ARD		X											
V0100D	CAA—Prior BIMS Summary Score		X									X		
V0100E	CAA—Prior PHQ-9 Total Severity Score		X									X		
V0100F	CAA—Prior PHQ-9-OV Total Severity Score		X									X		
V0200A01A	Delirium—Care Area triggered		X									X		
V0200A01B	Delirium—addressed in care plan		X									X		
V0200A02A	Cognitive loss/dementia—Care Area triggered		X									X		

(continued)

Item	Description	Item Required on Record Type										Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM		
V0200A02B	Cognitive loss/dementia—addressed in care plan		x										x		
V0200A03A	Visual function—Care Area triggered		x										x		
V0200A03B	Visual function—addressed in care plan		x										x		
V0200A04A	Communication—Care Area triggered		x										x		
V0200A04B	Communication—addressed in care plan		x										x		
V0200A05A	ADL functional/rehabilitation potential—Care Area triggered		x										x		
V0200A05B	ADL functional/rehabilitation potential—addressed in care plan		x										x		
V0200A06A	Urinary incontinence/indwelling catheter—Care Area triggered		x										x		
V0200A06B	Urinary incontinence/indwelling catheter—addressed in care plan		x										x		
V0200A07A	Psychosocial well-being—Care Area triggered		x										x		
V0200A07B	Psychosocial well-being—addressed in care plan		x										x		
V0200A08A	Mood state—Care Area triggered		x										x		
V0200A08B	Mood state—addressed in care plan		x										x		
V0200A09A	Behavioral symptoms—Care Area triggered		x										x		
V0200A09B	Behavioral symptoms—addressed in care plan		x										x		
V0200A10A	Activities—Care Area triggered		x										x		
V0200A10B	Activities—addressed in care plan		x										x		
V0200A11A	Falls—Care Area triggered		x										x		
V0200A11B	Falls—addressed in care plan		x										x		
V0200A12A	Nutritional status—Care Area triggered		x										x		
V0200A12B	Nutritional status—addressed in care plan		x										x		
V0200A13A	Feeding tube—Care Area triggered		x										x		
V0200A13B	Feeding tube—addressed in care plan		x										x		
V0200A14A	Dehydration/fluid maintenance—Care Area triggered		x										x		
V0200A14B	Dehydration/fluid maintenance—addressed in care plan		x										x		
V0200A15A	Dental care—Care Area triggered		x										x		
V0200A15B	Dental care—addressed in care plan		x										x		
V0200A16A	Pressure ulcer—Care Area triggered		x										x		
V0200A16B	Pressure ulcer—addressed in care plan		x										x		
V0200A17A	Psychotropic drug use—Care Area triggered		x										x		

(continued)

Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
V0200A17B	Psychotropic drug use—addressed in care plan		x										x
V0200A18A	Physical restraints—Care Area triggered		x										x
V0200A18B	Physical restraints—addressed in care plan		x										x
V0200A19A	Pain—Care Area triggered		x										x
V0200A19B	Pain—addressed in care plan		x										x
V0200A20A	Return to community referral—Care Area triggered		x										x
V0200A20B	Return to community referral—addressed in care plan		x										x
V0200B1	CAA Process—RN coordinator signature		x										
V0200B2	CAA—RN coordinator date signed		x										
V0200C1	Care plan—person completing signature		x										
V0200C2	Care plan—person completing date signed		x										
X0100	Correction—type of transaction	x	x	x	x	x	x	x	x				
X0200A	Correction—resident first name	x	x	x	x	x	x	x	x				
X0200B	Correction—resident middle initial	x	x	x	x	x	x	x	x				
X0200C	Correction—resident last name	x	x	x	x	x	x	x	x				
X0200D	Correction—resident suffix	x	x	x	x	x	x	x	x				
X0300	Correction—gender	x	x	x	x	x	x	x	x				
X0400	Correction—birth date	x	x	x	x	x	x	x	x				
X0500	Correction—social security number	x	x	x	x	x	x	x	x				
X0600A	Correction—Federal OBRA Reason for Assessment/Tracking	x	x	x	x	x	x	x	x				
X0600B	Correction—PPS assessment	x	x	x	x	x	x	x	x				
X0600C	Correction—PPS Other Medicare-required Assessment (OMRA)	x	x	x	x	x	x	x	x				
X0600D	Correction—swing bed clinical change assessment	x	x	x	x	x	x	x	x				
X0600F	Correction—Entry/discharge reporting	x	x	x	x	x	x	x	x				
X0700A	Correction—assessment reference date	x	x	x	x	x	x	x	x				
X0700B	Correction—discharge date	x	x	x	x	x	x	x	x				
X0700C	Correction—entry date	x	x	x	x	x	x	x	x				
X0800	Correction number	x	x	x	x	x	x	x	x				
X0900A	Reasons for modification—transcription error	x	x	x	x	x	x	x	x				
X0900B	Reasons for modification—data entry error	x	x	x	x	x	x	x	x				

(continued)



Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
X0900C	Reasons for modification—software product error	x	x	x	x	x	x	x	x				
X0900D	Reasons for modification—item coding error	x	x	x	x	x	x	x	x				
X0900Z	Reasons for modification—other error requiring modification	x	x	x	x	x	x	x	x				
X1050A	Reasons for inactivation—event did not occur	x	x	x	x	x	x	x	x				
X1050Z	Reasons for inactivation—other error requiring inactivation	x	x	x	x	x	x	x	x				
X1100A	Correction—completion—attesting individual's first name	x	x	x	x	x	x	x	x				
X1100B	Correction—completion—attesting individual's last name	x	x	x	x	x	x	x	x				
X1100C	Correction—completion—attesting individual's title	x	x	x	x	x	x	x	x				
X1100D	Correction—completion—attesting individual's signature	x	x	x	x	x	x	x	x				
X1100E	Correction—completion—attestation date	x	x	x	x	x	x	x	x				
Z0100A	Medicare Part A HIPPS code		x	x	x		x	x	x				
Z0100B	Medicare RUG version code		x	x	x		x	x	x				
Z0100C	Medicare Short Stay Assessment		x	x	x		x	x	x				
Z0150A	Medicare Non-Therapy Part A HIPPS code		x	x	x		x	x	x				
Z0150B	Medicare RUG version code		x	x	x		x	x	x				
Z0200A	State Medicaid RUG Case Mix group		x	x	x								
Z0200B	State Medicaid RUG version code		x	x	x								
Z0250A	Alternate State Medicaid RUG Case Mix group		x	x	x								
Z0250B	Alternate State Medicaid RUG version code		x	x	x								
Z0300A	Insurance billing RUG Case Mix group		x	x	x								
Z0300B	Insurance billing RUG version code		x	x	x								
Z0400A	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400B	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400C	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400D	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400E	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400F	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400G	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400H	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400I	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				

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Item	Description	Item Required on Record Type								Item Included in Application			
		T	C	Q	P	D	O	S	W	RG	QI	CT	QM
Z0400J	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400K	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0400L	Attestation signature, title, sections, date completed		x	x	x	x	x	x	x				
Z0500A	RN assessment coordinator signature—assessment completion	x	x	x	x	x	x	x	x				
Z0500B	RN assessment coordinator date signed—assessment completion	x	x	x	x	x	x	x	x				

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