

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed OMRA-Start of Therapy (NS/SS) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider

1. Nursing home (SNF/NF)
2. Swing Bed

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction to prior comprehensive** assessment
06. **Significant correction to prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
- Not PPS Assessment**
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2

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

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**

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

Enter Code

F. Entry/discharge reporting

01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Section A Identification Information

A0410. Submission Requirement

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

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

A0600. Social Security and Medicare Numbers

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

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

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A0800. Gender

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

	— — — — —
	Month Day Year

A1000. Race/Ethnicity

↓ Check all that apply

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

A1200. Marital Status

Enter Code <input type="checkbox"/>	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
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Section A Identification Information

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

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

A1600. Entry Date (date of this admission/reentry into the facility)

Month Day Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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

A2300. Assessment Reference Date

Observation end date:

Month Day Year

Section A Identification Information

A2400. Medicare Stay

Enter Code <input type="text"/>	A. Has the resident had a Medicare-covered stay since the most recent entry?
	0. No → Skip to G0110, Activities of Daily Living (ADL) Assistance
	1. Yes → Continue to A2400B, Start date of most recent Medicare stay
	B. Start date of most recent Medicare stay:
	<div> <div>—</div> <div>—</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>
	C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
	<div> <div>—</div> <div>—</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

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

Instructions for Rule of 3

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

If none of the above are met, code supervision.

1. ADL Self-Performance

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

Coding:

Activity Occurred 3 or More Times

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

Activity Occurred 2 or Fewer Times

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

2. ADL Support Provided

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

Coding:

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

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	<input type="text"/>	<input type="text"/>
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)	<input type="text"/>	<input type="text"/>
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	<input type="text"/>	<input type="text"/>
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	<input type="text"/>	<input type="text"/>

Section H Bladder and Bowel

H0200. Urinary Toileting Program

Enter Code <input type="checkbox"/>	C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. No 1. Yes
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H0500. Bowel Toileting Program

Enter Code <input type="checkbox"/>	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes
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Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. While NOT a Resident Performed while NOT a resident of this facility and within the last 14 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank	1. While NOT a Resident	2. While a Resident
2. While a Resident Performed while a resident of this facility and within the last 14 days	↓ Check all that apply ↓	
Respiratory Treatments		
E. Tracheostomy care		<input type="checkbox"/>
F. Ventilator or respirator		<input type="checkbox"/>
Other		
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		<input type="checkbox"/>

O0400. Therapies

Enter Number of Minutes <input type="text"/> Enter Number of Minutes <input type="text"/> Enter Number of Minutes <input type="text"/> Enter Number of Days <input type="text"/>	A. Speech-Language Pathology and Audiology Services	
	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days	
	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days	
	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days	
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy	
	4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days	6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing
	5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started	
	_____ Month Day Year	_____ Month Day Year

O0400 continued on next page

Section O

Special Treatments, Procedures, and Programs

00400. Therapies - Continued

<div>Enter Number of Minutes</div> <div></div> <div>Enter Number of Minutes</div> <div></div> <div>Enter Number of Minutes</div> <div></div> <div>Enter Number of Days</div> <div></div>	B. Occupational Therapy
	<div>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</div> <div>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</div> <div>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</div> <div>If the sum of individual, concurrent, and group minutes is zero, → skip to 00400C, Physical Therapy</div> <div>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</div> <div>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</div> <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</div> <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div>
	C. Physical Therapy
	<div>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</div> <div>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</div> <div>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</div> <div>If the sum of individual, concurrent, and group minutes is zero, → skip to 00500, Restorative Nursing Programs</div> <div>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</div> <div>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</div> <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</div> <div> <div>—</div> <div>—</div> <div>—</div> <div>Month</div> <div>Day</div> <div>Year</div> </div>

Section O Special Treatments, Procedures, and Programs

O0500. Restorative Nursing Programs

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

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

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

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

Section X**Correction Request****X0100. Type of Record**

Enter Code <input type="text"/>	1. Add new record → Skip to Z0100, Medicare Part A Billing 2. Modify existing record → Continue to X0150, Type of Provider 3. Inactivate existing record → Continue to X0150, Type of Provider
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Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

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

<input type="text"/>	A. First name: C. Last name:
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X0300. Gender on existing record to be modified/inactivated

Enter Code <input type="text"/>	1. Male 2. Female
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X0400. Birth Date on existing record to be modified/inactivated

<input type="text"/>	— — Month Day Year
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X0500. Social Security Number on existing record to be modified/inactivated

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

Enter Code <input type="text"/>	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. Not OBRA required assessment
Enter Code <input type="text"/>	B. PPS Assessment <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. Not PPS assessment
Enter Code <input type="text"/>	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment

X0600 continued on next page

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

Enter Code <input type="text"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="text"/>	F. Entry/discharge reporting 01. Entry record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility record 99. Not entry/discharge record

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

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

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

Enter Number <input type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
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X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

↓ Check all that apply	
<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	Z. Other error requiring modification If "Other" checked, please specify: _____

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

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

Section X

Correction Request

X1100. RN Assessment Coordinator Attestation of Completion			
	A. Attesting individual's first name:		
	B. Attesting individual's last name:		
	C. Attesting individual's title:		
	D. Signature		
	E. Attestation date		
	Month	Day	Year

Section Z

Assessment Administration

Z0100. Medicare Part A Billing

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

Z0150. Medicare Part A Non-Therapy Billing

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

Z0300. Insurance Billing

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

Section Z Assessment Administration

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

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

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

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

— —
Month Day Year

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