EXHIBIT 260

MDS KEY FIELD CORRECTION FORM

Facility State ID Number (FAC-ID) _____

Facility Medicare Provider Number _____

Facility Name _____ Resident Last Name _____

Resident First Name _____ Resident Middle Initial _____

Resident Social Security Number _____

Resident Date of Birth _____

Assessment Reference Dates (MDS Item A3a) _____

1.	Key Field	_____	Old Value	_____	New Value	_____
2.	Key Field	_____	Old Value	_____	New Value	_____
3.	Key Field	_____	Old Value	_____	New Value	_____
4.	Key Field	_____	Old Value	_____	New Value	_____
5.	Key Field	_____	Old Value	_____	New Value	_____
6.	Key Field	_____	Old Value	_____	New Value	_____
7.	Key Field	_____	Old Value	_____	New Value	_____
8.	Key Field	_____	Old Value	_____	New Value	_____
9.	Key Field	_____	Old Value	_____	New Value	_____
10.	Key Field	_____	Old Value	_____	New Value	_____
Requested by: _____					Date: _____	
Facilities must have a method of ensuring that subsequent assessments include the corrected information. This request may only be use for Key Item Corrections.						