

# MINIMUM DATA SET (MDS) - Version 3.0

## RESIDENT ASSESSMENT AND CARE SCREENING

### *Nursing Home and Swing Bed Tracking (NT/ST) Item Set*

Section A	Identification Information
<b>A0050. Type of Record</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	1. <b>Add new record</b> → Continue to A0100, Facility Provider Numbers 2. <b>Modify existing record</b> → Continue to A0100, Facility Provider Numbers 3. <b>Inactivate existing record</b> → Skip to X0150, Type of Provider
<b>A0100. Facility Provider Numbers</b>	
	<b>A. National Provider Identifier (NPI):</b>  <b>B. CMS Certification Number (CCN):</b>  <b>C. State Provider Number:</b>
<b>A0200. Type of Provider</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>Type of provider</b> 1. <b>Nursing home (SNF/NF)</b> 2. <b>Swing Bed</b>
<b>A0310. Type of Assessment</b>	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. <b>None of the above</b>
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>B. PPS Assessment</b> <u><b>PPS Scheduled Assessments for a Medicare Part A Stay</b></u> 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment <u><b>PPS Unscheduled Assessments for a Medicare Part A Stay</b></u> 07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment) <u><b>Not PPS Assessment</b></u> 99. <b>None of the above</b>
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. <b>No</b> 1. <b>Start of therapy</b> assessment 2. <b>End of therapy</b> assessment 3. <b>Both Start and End of therapy</b> assessment 4. <b>Change of therapy</b> assessment
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if A0200 = 2 0. <b>No</b> 1. <b>Yes</b>
<b>A0310 continued on next page</b>	

<b>Section A</b>	<b>Identification Information</b>
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**A0310. Type of Assessment - Continued**

Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>E. Is this assessment the first assessment</b> (OBRA, Scheduled PPS, or Discharge) <b>since the most recent admission/entry or reentry?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	<b>G. Type of discharge</b> - Complete only if A0310F = 10 or 11 1. <b>Planned</b> 2. <b>Unplanned</b>

**A0410. Unit Certification or Licensure Designation**

Enter Code <input style="width: 40px; height: 20px;" type="text"/>	1. <b>Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State</b> 2. <b>Unit is neither Medicare nor Medicaid certified but MDS data is required by the State</b> 3. <b>Unit is Medicare and/or Medicaid certified</b>
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**A0500. Legal Name of Resident**

	<b>A. First name:</b> _____ <b>B. Middle initial:</b> _____  <b>C. Last name:</b> _____ <b>D. Suffix:</b> _____
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**A0600. Social Security and Medicare Numbers**

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

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**A0800. Gender**

Enter Code <input style="width: 40px; height: 20px;" type="text"/>	1. <b>Male</b> 2. <b>Female</b>
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**A0900. Birth Date**

	_____ - _____ - _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
--	--

**A1000. Race/Ethnicity**

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

**Section A Identification Information****A1200. Marital Status**

Enter Code <input type="text"/>	<ol style="list-style-type: none"><li>1. <b>Never married</b></li><li>2. <b>Married</b></li><li>3. <b>Widowed</b></li><li>4. <b>Separated</b></li><li>5. <b>Divorced</b></li></ol>
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**A1300. Optional Resident Items**

	<p><b>A. Medical record number:</b></p>  <p><b>B. Room number:</b></p>  <p><b>C. Name by which resident prefers to be addressed:</b></p>  <p><b>D. Lifetime occupation(s)</b> - put "/" between two occupations:</p>
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**Most Recent Admission/Entry or Reentry into this Facility****A1600. Entry Date**

	— —
	Month Day Year

**A1700. Type of Entry**

Enter Code <input type="text"/>	<ol style="list-style-type: none"><li>1. <b>Admission</b></li><li>2. <b>Reentry</b></li></ol>
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**A1800. Entered From**

Enter Code <input type="text"/>	<ol style="list-style-type: none"><li>01. <b>Community</b> (private home/apt., board/care, assisted living, group home)</li><li>02. <b>Another nursing home or swing bed</b></li><li>03. <b>Acute hospital</b></li><li>04. <b>Psychiatric hospital</b></li><li>05. <b>Inpatient rehabilitation facility</b></li><li>06. <b>ID/DD facility</b></li><li>07. <b>Hospice</b></li><li>09. <b>Long Term Care Hospital</b> (LTCH)</li><li>99. <b>Other</b></li></ol>
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**A1900. Admission Date (Date this episode of care in this facility began)**

	— —
	Month Day Year

<b>Section A</b>		<b>Identification Information</b>	
<b>A2000. Discharge Date</b>			
Complete only if A0310F = 10, 11, or 12			
	<div>—</div> <div>Month</div>	<div>—</div> <div>Day</div>	<div>—</div> <div>Year</div>
<b>A2100. Discharge Status</b>			
Complete only if A0310F = 10, 11, or 12			
<div>Enter Code</div> <div></div>	<div>01. <b>Community</b> (private home/apt., board/care, assisted living, group home)</div> <div>02. <b>Another nursing home or swing bed</b></div> <div>03. <b>Acute hospital</b></div> <div>04. <b>Psychiatric hospital</b></div> <div>05. <b>Inpatient rehabilitation facility</b></div> <div>06. <b>ID/DD facility</b></div> <div>07. <b>Hospice</b></div> <div>08. <b>Deceased</b></div> <div>09. <b>Long Term Care Hospital</b> (LTCH)</div> <div>99. <b>Other</b></div>		
<b>A2400. Medicare Stay</b>			
<div>Enter Code</div> <div></div>	<div><b>A. Has the resident had a Medicare-covered stay since the most recent entry?</b></div> <div>0. <b>No</b> → Skip to Section X, Correction Request</div> <div>1. <b>Yes</b> → Continue to A2400B, Start date of most recent Medicare stay</div> <div><b>B. Start date of most recent Medicare stay:</b></div> <div> <div>—</div> <div>Month</div> </div> <div> <div>—</div> <div>Day</div> </div> <div> <div>—</div> <div>Year</div> </div> <div><b>C. End date of most recent Medicare stay</b> - Enter dashes if stay is ongoing:</div> <div> <div>—</div> <div>Month</div> </div> <div> <div>—</div> <div>Day</div> </div> <div> <div>—</div> <div>Year</div> </div>		

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

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

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

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

	<b>A. First name:</b>
	<b>C. Last name:</b>

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

Enter Code <input type="text"/>	1. <b>Male</b> 2. <b>Female</b>
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**X0400. Birth Date** (A0900 on existing record to be modified/inactivated)

	<div style="display: flex; justify-content: space-around; align-items: center;"> <div>—</div> <div>—</div> </div> <div style="display: flex; justify-content: space-around; align-items: center;"> <div>Month</div> <div>Day</div> <div>Year</div> </div>
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**X0500. Social Security Number** (A0600A on existing record to be modified/inactivated)

	<div style="display: flex; justify-content: space-around; align-items: center;"> <div>—</div> <div>—</div> </div>
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**X0600. Type of Assessment** (A0310 on existing record to be modified/inactivated)

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

**X0600 continued on next page**

<b>Section X</b>	<b>Correction Request</b>
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**X0600. Type of Assessment - Continued**

Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if X0150 = 2 0. <b>No</b> 1. <b>Yes</b>
Enter Code <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>F. Entry/discharge reporting</b> 01. <b>Entry</b> tracking record 10. <b>Discharge</b> assessment- <b>return not anticipated</b> 11. <b>Discharge</b> assessment- <b>return anticipated</b> 12. <b>Death in facility</b> tracking record 99. <b>None of the above</b>

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

	<b>A. Assessment Reference Date</b> (A2300 on existing record to be modified/inactivated - Complete only if X0600F = 99 <div style="text-align: center; margin-top: 10px;">             —                      —              Month                  Day                      Year           </div>
	<b>B. Discharge Date</b> (A2000 on existing record to be modified/inactivated - Complete only if X0600F = 10, 11, or 12 <div style="text-align: center; margin-top: 10px;">             —                      —              Month                  Day                      Year           </div>
	<b>C. Entry Date</b> (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01 <div style="text-align: center; margin-top: 10px;">             —                      —              Month                  Day                      Year           </div>

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

Enter Number <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div>	<b>Enter the number of correction requests to modify/inactivate the existing record, including the present one</b>
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**X0900. Reasons for Modification** - Complete only if Type of Record is to modify a record in error (A0050 = 2)

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

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

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

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

<b>Section Z</b>	<b>Assessment Administration</b>		
<b>Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting</b>			
<p>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.</p>			
	<b>Signature</b>	<b>Title</b>	<b>Date Section Completed</b>
A.			
B.			
C.			

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