

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Part A PPS Discharge (NPE) Item Set

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

Section A	Identification Information
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A0310. Type of Assessment - Continued

Enter Code <input style="width: 40px; height: 20px;" type="text"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

A0410. Unit Certification or Licensure Designation

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

	A. First name: C. Last name:	B. Middle initial: D. Suffix:
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A0600. Social Security and Medicare Numbers

	A. Social Security Number: <div style="text-align: center; margin-top: 10px;"> — — — </div>
	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 style="width: 40px; height: 20px;" type="text"/>	1. Male 2. Female
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A0900. Birth Date

	<div style="text-align: center; margin-top: 10px;"> — — — </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>
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A1000. Race/Ethnicity

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

Section A	Identification Information
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A1100. Language

Enter Code

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

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

B. Preferred language:**A1200. Marital Status**

Enter Code

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

A1300. Optional Resident Items**A. Medical record number:****B. Room number:****C. Name by which resident prefers to be addressed:****D. Lifetime occupation(s)** - put "/" between two occupations:**Most Recent Admission/Entry or Reentry into this Facility****A1600. Entry Date**

— —

Month Day Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

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

Section A	Identification Information
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A1900. Admission Date (Date this episode of care in this facility began)

	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">—</div> <div style="text-align: center;">—</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>
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A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">—</div> <div style="text-align: center;">—</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>
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A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code <div style="border: 1px solid black; height: 20px; width: 50px; margin-top: 5px;"></div>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 08. Deceased 09. Long Term Care Hospital (LTCH) 99. Other
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A2300. Assessment Reference Date

	Observation end date:
	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">—</div> <div style="text-align: center;">—</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div>

A2400. Medicare Stay

Enter Code <div style="border: 1px solid black; height: 20px; width: 50px; margin-top: 5px;"></div>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <p>0. No → Skip to GG0130, Self-Care</p> <p>1. Yes → Continue to A2400B, Start date of most recent Medicare stay</p> <p>B. Start date of most recent Medicare stay:</p> <div style="text-align: center; padding: 10px;"> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">—</div> <div style="text-align: center;">—</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div> </div> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <div style="text-align: center; padding: 10px;"> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">—</div> <div style="text-align: center;">—</div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> Month Day Year </div> </div>
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Section GG**Functional Abilities and Goals - Discharge (End of SNF PPS Stay)****GG0130. Self-Care** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
<input type="text"/>	B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
<input type="text"/>	C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
<input type="text"/>	E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
<input type="text"/>	F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
<input type="text"/>	G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
<input type="text"/>	H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG**Functional Abilities and Goals - Discharge (End of SNF PPS Stay)****GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
[]	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
[]	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
[]	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
[]	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
[]	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
[]	F. Toilet transfer: The ability to get on and off a toilet or commode.
[]	G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
[]	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
[]	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
[]	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Section GG**Functional Abilities and Goals - Discharge (End of SNF PPS Stay)****GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - ContinuedComplete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

- 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. **Resident refused**
- 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- 88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance	
Enter Codes in Boxes ↓	
<input type="text"/>	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
<input type="text"/>	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/>	N. 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
<input type="text"/>	O. 12 steps: The ability to go up and down 12 steps with or without a rail.
<input type="text"/>	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
<input type="text"/>	Q3. Does the resident use a wheelchair and/or scooter? 0. No → Skip to J1800, Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
<input type="text"/>	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
<input type="text"/>	RR3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized
<input type="text"/>	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
<input type="text"/>	SS3. Indicate the type of wheelchair or scooter used. 1. Manual 2. Motorized

Section J		Health Conditions		
J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent				
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent? 0. No → Skip to M0210, Unhealed Pressure Ulcer(s) 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)			
J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent				
Coding: 0. None 1. One 2. Two or more		↓ Enter Codes in Boxes		
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall	
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain	
		<div style="border: 1px solid black; width: 30px; height: 30px; margin: 5px auto;"></div>	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma	

Section M

Skin Conditions

**Report based on highest stage of existing ulcers/injuries at their worst;
do not "reverse" stage**

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code	Does this resident have one or more unhealed pressure ulcers/injuries? 0. No → Skip to N2005, Medication Intervention 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
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M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Enter Number	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number	
Enter Number	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling 1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number	
Enter Number	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device 2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number	
Enter Number	E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar 2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number	
Enter Number	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number	
Enter Number	G. Unstageable - Deep tissue injury: 1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to N2005, Medication Intervention 2. Number of <u>these</u> unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

Section N	Medications
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N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code <div style="border: 1px solid black; width: 40px; height: 40px; margin: 5px 0;"></div>	<p>Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?</p> <p>0. No</p> <p>1. Yes</p> <p>9. NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications</p>
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Section X**Correction Request****Complete Section X only if A0050 = 2 or 3**

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

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

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

	A. First name:
	C. Last name:

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

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

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

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X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

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

X0600 continued on next page

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

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

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

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

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

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

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

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

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

Section X	Correction Request
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X1100. RN Assessment Coordinator Attestation of Completion

	A. Attesting individual's first name:
	B. Attesting individual's last name:
	C. Attesting individual's title:
	D. Signature
	E. Attestation date
	<div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> — Month </div> <div style="text-align: center;"> — Day </div> <div style="text-align: center;"> — Year </div> </div>

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:**

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Month Day Year

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