

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
A0050. Type of Record	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	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	
	A. National Provider Identifier (NPI): B. CMS Certification Number (CCN): C. State Provider Number:
A0200. Type of Provider	
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed
A0310. Type of Assessment	
Enter Code <input style="width: 40px; height: 20px;" 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 style="width: 40px; height: 20px;" type="text"/>	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 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. None of the above
Enter Code <input style="width: 40px; height: 20px;" 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
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2 0. No 1. Yes
Enter Code <input style="width: 40px; height: 20px;" type="text"/>	E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes
A0310 continued on next page	

Section A	Identification Information
------------------	-----------------------------------

A0310. Type of Assessment - Continued

Enter Code <input style="width: 100%;" 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: 100%;" type="text"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code <input style="width: 100%;" 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: 100%;" 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
---	--

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

--	--

A0800. Gender

Enter Code <input style="width: 100%;" type="text"/>	1. Male 2. Female
---	------------------------------------

A0900. Birth Date

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

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
------------------	-----------------------------------

A1200. Marital Status

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<ol style="list-style-type: none"> 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
---	--

A1300. Optional Resident Items

	<p>A. Medical record number:</p> <p>B. Room number:</p> <p>C. Name by which resident prefers to be addressed:</p> <p>D. Lifetime occupation(s) - put "/" between two occupations:</p>
--	--

Most Recent Admission/Entry or Reentry into this Facility**A1600. Entry Date**

	<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; margin-top: 5px;"> Month Day Year </div>
--	--

A1700. Type of Entry

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<ol style="list-style-type: none"> 1. Admission 2. Reentry
---	--

A1800. Entered From

Enter Code <div style="border: 1px solid black; width: 30px; height: 20px; margin: 5px auto;"></div>	<ol style="list-style-type: none"> 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
---	---

A1900. Admission Date (Date this episode of care in this facility began)

	<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; margin-top: 5px;"> Month Day Year </div>
--	--

Section A	Identification Information
------------------	-----------------------------------

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. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital (LTCH)**
99. **Other**

A2400. Medicare Stay

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to Section X, Correction Request
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

—	—	
Month	Day	Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

—	—	
Month	Day	Year

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 **Type of provider**

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

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

1. **Male**
2. **Female**

X0400. Birth Date (A0900 on existing record to be modified/inactivated)

— — —
Month Day Year

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

— — — — —

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

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. **None of the above**

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

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. **None of the above**

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
4. **Change of therapy** assessment

X0600 continued on next page

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			
	<div> <div>—</div> <div>Month</div> </div>	<div> <div>—</div> <div>Day</div> </div>	<div> <div></div> <div>Year</div> </div>

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

Legal Notice Regarding MDS 3.0 - Copyright 2011 United States of America and interRAI. This work may be freely used and distributed solely within the United States. Portions of the MDS 3.0 are under separate copyright protections; Pfizer Inc. holds the copyright for the PHQ-9; Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Both Pfizer Inc. and the Hospital Elder Life Program, LLC have granted permission to use these instruments in association with the MDS 3.0.