

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

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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

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Type of provider

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

A0310. Type of Assessment

Enter Code

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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

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B. PPS Assessment

- PPS Scheduled Assessment for a Medicare Part A Stay**
01. **5-day** scheduled assessment
- PPS Unscheduled Assessment for a Medicare Part A Stay**
08. **IPA** - Interim Payment Assessment
- Not PPS Assessment**
99. **None of the above**

Enter Code

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E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?

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

Enter Code

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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**

A0310 continued on next page

Section A - Identification Information

A0310. Type of Assessment - Continued

Enter Code

G. Type of discharge

1. Planned
2. Unplanned

Enter Code

H. Is this a SNF Part A PPS Discharge Assessment?

0. No
1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code

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:

| | | | | | | | | | | | | | | | | | |
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B. Middle initial:

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C. Last name:

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D. Suffix:

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A0600. Social Security and Medicare Numbers

A. Social Security Number:

| | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
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B. Medicare Number:

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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A0700. Medicaid Number

Enter "+" if pending, "N" if not a Medicaid recipient

| | | | | | | | | | | | | | | | | | |
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A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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Month

Day

Year

Section A - Identification Information

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓

Check all that apply

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. No, not of Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> | B. Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> | C. Yes, Puerto Rican |
| <input type="checkbox"/> | D. Yes, Cuban |
| <input type="checkbox"/> | E. Yes, another Hispanic, Latino/a, or Spanish origin |
| <input type="checkbox"/> | X. Resident unable to respond |
| <input type="checkbox"/> | Y. Resident declines to respond |

A1010. Race

What is your race?

↓

Check all that apply

- | | |
|--------------------------|--|
| <input type="checkbox"/> | A. White |
| <input type="checkbox"/> | B. Black or African American |
| <input type="checkbox"/> | C. American Indian or Alaska Native |
| <input type="checkbox"/> | D. Asian Indian |
| <input type="checkbox"/> | E. Chinese |
| <input type="checkbox"/> | F. Filipino |
| <input type="checkbox"/> | G. Japanese |
| <input type="checkbox"/> | H. Korean |
| <input type="checkbox"/> | I. Vietnamese |
| <input type="checkbox"/> | J. Other Asian |
| <input type="checkbox"/> | K. Native Hawaiian |
| <input type="checkbox"/> | L. Guamanian or Chamorro |
| <input type="checkbox"/> | M. Samoan |
| <input type="checkbox"/> | N. Other Pacific Islander |
| <input type="checkbox"/> | X. Resident unable to respond |
| <input type="checkbox"/> | Y. Resident declines to respond |
| <input type="checkbox"/> | Z. None of the above |

A1200. Marital Status

Enter Code

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

Section A - Identification Information

A1300. Optional Resident Items

A. Medical record number:

[illegible]

B. Room number:

[illegible]

C. Name by which resident prefers to be addressed:

[illegible]

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

[illegible]

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

The diagram illustrates the components of a date. It consists of three main parts: a box for the Month, a box for the Day, and a box for the Year. Each box is divided into two equal halves. The Month box is followed by a minus sign, the Day box is followed by a minus sign, and the Year box is followed by a plus sign. The labels 'Month', 'Day', and 'Year' are centered below their respective boxes.

A1700. Type of Entry

Enter Code

1. Admission
2. Reentry

A1805. Entered From

Enter Code

| | |
|--|--|
| | |
|--|--|

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

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

- -
 Month Day Year

A2300. Assessment Reference Date

Observation end date:

- -
 Month Day Year

Section A - Identification Information

A2400. Medicare Stay

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?**0. No** → Skip to B0100, Comatose**1. Yes** → Continue to A2400B, Start date of most recent Medicare stay**B. Start date of most recent Medicare stay:**

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

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

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

Look back period for all items is 7 days unless another time frame is indicated**Section B - Hearing, Speech, and Vision****B0100. Comatose**

Enter Code

Persistent vegetative state/no discernible consciousness

- 0. **No** → Continue to B1300, Health Literacy
- 1. **Yes** → Skip to GG0130, Self-Care

B1300. Health Literacy

Enter Code

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

- 0. **Never**
- 1. **Rarely**
- 2. **Sometimes**
- 3. **Often**
- 4. **Always**
- 7. **Resident declines to respond**
- 8. **Resident unable to respond**

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Section C - Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200–C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C1310, Signs and Symptoms of Delirium (from CAM®)
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed.** Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: *"Please tell me what year it is right now."*

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2–5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask resident: *"What month are we in right now?"*

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask resident: *"What day of the week is today?"*

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (*something to wear; a color; a piece of furniture*) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** (*"something to wear"*)
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** (*"a color"*)
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** (*"a piece of furniture"*)
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200–C0400 and fill in total score (00–15)
Enter 99 if the resident was unable to complete the interview



Section C - Cognitive Patterns

Delirium

C1310. Signs and Symptoms of Delirium (from CAM®)

Enter Code

☐**A. Acute Onset Mental Status Change**

Is there evidence of an acute change in mental status from the resident's baseline?

0. No
1. Yes

| Coding: | ↓ | Enter Codes in Boxes |
|---|--------------------------|--|
| 0. Behavior not present | <input type="checkbox"/> | B. Inattention - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? |
| 1. Behavior continuously present, does not fluctuate | <input type="checkbox"/> | C. Disorganized Thinking - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? |
| 2. Behavior present, fluctuates (comes and goes, changes in severity) | <input type="checkbox"/> | D. Altered Level of Consciousness - Did the resident have altered level of consciousness, as indicated by any of the following criteria? <ul style="list-style-type: none"> ▪ vigilant - startled easily to any sound or touch ▪ lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ stuporous - very difficult to arouse and keep aroused for the interview ▪ comatose - could not be aroused |

Section D - Mood

D0100. Should Resident Mood Interview be Conducted?

Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete D0700, Social Isolation

1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9[©])

D0150. Resident Mood Interview (PHQ-2 to 9[©])

Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: "About **how often** have you been bothered by this?"

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

| 1. Symptom Presence | 2. Symptom Frequency |
|--|--|
| 0. No (enter 0 in column 2) | 0. Never or 1 day |
| 1. Yes (enter 0–3 in column 2) | 1. 2–6 days (several days) |
| 9. No response (leave column 2 blank) | 2. 7–11 days (half or more of the days) |
| | 3. 12–14 days (nearly every day) |

| | Enter Scores in Boxes | 1. Symptom Presence | 2. Symptom Frequency |
|--|-----------------------|----------------------|----------------------|
| A. <i>Little interest or pleasure in doing things</i> | | <input type="text"/> | <input type="text"/> |
| B. <i>Feeling down, depressed, or hopeless</i> | | <input type="text"/> | <input type="text"/> |
| If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue. | | | |
| C. <i>Trouble falling or staying asleep, or sleeping too much</i> | | <input type="text"/> | <input type="text"/> |
| D. <i>Feeling tired or having little energy</i> | | <input type="text"/> | <input type="text"/> |
| E. <i>Poor appetite or overeating</i> | | <input type="text"/> | <input type="text"/> |
| F. <i>Feeling bad about yourself - or that you are a failure or have let yourself or your family down</i> | | <input type="text"/> | <input type="text"/> |
| G. <i>Trouble concentrating on things, such as reading the newspaper or watching television</i> | | <input type="text"/> | <input type="text"/> |
| H. <i>Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</i> | | <input type="text"/> | <input type="text"/> |
| I. <i>Thoughts that you would be better off dead, or of hurting yourself in some way</i> | | <input type="text"/> | <input type="text"/> |

D0160. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.

Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).



Section D - Mood

D0700. Social Isolation

Enter Code

How often do you feel lonely or isolated from those around you?

- 0. Never
- 1. Rarely
- 2. Sometimes
- 3. Often
- 4. Always
- 7. Resident declines to respond
- 8. Resident unable to respond

Section GG - Functional Abilities - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the Stay)

Complete when A2400C minus A2400B is greater than 2.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the 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 themselves 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. 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.

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.

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.

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.

F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.

G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.

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 - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the Stay)

Complete when A2400C minus A2400B is greater than 2.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the 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 themselves 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 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 - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the Stay)

Complete when A2400C minus A2400B is greater than 2.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the 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 themselves 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

- 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.

- 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

- 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

- O. 12 steps:** The ability to go up and down 12 steps with or without a rail.

- 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.

Enter Code

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

- R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Enter Code

RR3. Indicate the type of wheelchair or scooter used.

- 1. Manual**
- 2. Motorized**

- S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

Enter Code

SS3. Indicate the type of wheelchair or scooter used.

- 1. Manual**
- 2. Motorized**

Section J - Health Conditions

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents.

Enter Code

☐

- 0. **No** (resident is rarely/never understood) → 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 J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code

☐

Ask resident: ***“Have you had pain or hurting at any time in the last 5 days?”***

- 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 J0510, Pain Effect on Sleep
- 9. **Unable to answer** → Skip to J1800, Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J0510. Pain Effect on Sleep

Enter Code

☐

Ask resident: ***“Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?”***

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code

☐

Ask resident: ***“Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?”***

- 0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code

☐

Ask resident: ***“Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?”***

- 1. **Rarely or not at all**
- 2. **Occasionally**
- 3. **Frequently**
- 4. **Almost constantly**
- 8. **Unable to answer**

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

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 K0520, Nutritional Approaches**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:**

↓

Enter Codes in Boxes**0. None****1. One****2. Two or more****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**B. Injury (except major)** - as described in the CMS LTCF RAI User's Manual**C. Major injury** - as described in the CMS LTCF RAI User's Manual

Section K - Swallowing/Nutritional Status

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

4. At Discharge

Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

| Check all that apply | | 4. At Discharge |
|--|--|--------------------------|
| A. Parenteral/IV feeding | | <input type="checkbox"/> |
| B. Feeding tube (e.g., nasogastric or abdominal (PEG)) | | <input type="checkbox"/> |
| C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids) | | <input type="checkbox"/> |
| D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol) | | <input type="checkbox"/> |
| Z. None of the above | | <input type="checkbox"/> |

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 N0415, High-Risk Drug Classes: Use and Indication
 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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

Enter Number

☐

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number

☐

2. **Number of these 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

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

Enter Number

☐

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number

☐

2. **Number of these 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

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

Enter Number

☐

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device

Enter Number

☐

2. **Number of these 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

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

Enter Number

☐

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

Enter Number

☐

2. **Number of these 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

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number

☐

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

Enter Number

☐

2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page

Section M - Skin Conditions

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

G. Unstageable - Deep tissue injury:

| | |
|--------------------------------------|--|
| Enter Number <input type="text"/> | 1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication |
| Enter Number <input type="text"/> | 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

N0415. High-Risk Drug Classes: Use and Indication

| 1. Is taking | 2. Indication noted | |
|---|---|--------------------------|
| Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days | If Column 1 is checked, check if there is an indication noted for all medications in the drug class | |
| Check all that apply | 1. Is taking | 2. Indication noted |
| A. Antipsychotic | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Antianxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Antidepressant | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Hypnotic | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Antibiotic | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Diuretic | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Opioid | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Antiplatelet | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Hypoglycemic (including insulin) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Anticonvulsant | <input type="checkbox"/> | <input type="checkbox"/> |
| Z. None of the above | <input type="checkbox"/> | |

N2005. Medication Intervention

Enter Code

☐

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?

0. No

1. Yes

9. N/A - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Section O - Special Treatments, Procedures, and Programs

00110. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed

c. At Discharge

Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

| | Check all that apply | c. At Discharge |
|--|----------------------|--------------------------|
| Cancer Treatments | | |
| A1. Chemotherapy | | <input type="checkbox"/> |
| A2. IV | | <input type="checkbox"/> |
| A3. Oral | | <input type="checkbox"/> |
| A10. Other | | <input type="checkbox"/> |
| B1. Radiation | | <input type="checkbox"/> |
| Respiratory Treatments | | |
| C1. Oxygen therapy | | <input type="checkbox"/> |
| C2. Continuous | | <input type="checkbox"/> |
| C3. Intermittent | | <input type="checkbox"/> |
| C4. High-concentration | | <input type="checkbox"/> |
| D1. Suctioning | | <input type="checkbox"/> |
| D2. Scheduled | | <input type="checkbox"/> |
| D3. As needed | | <input type="checkbox"/> |
| E1. Tracheostomy care | | <input type="checkbox"/> |
| F1. Invasive Mechanical Ventilator (ventilator or respirator) | | <input type="checkbox"/> |
| G1. Non-invasive Mechanical Ventilator | | <input type="checkbox"/> |
| G2. BiPAP | | <input type="checkbox"/> |
| G3. CPAP | | <input type="checkbox"/> |
| Other | | |
| H1. IV Medications | | <input type="checkbox"/> |
| H2. Vasoactive medications | | <input type="checkbox"/> |
| H3. Antibiotics | | <input type="checkbox"/> |
| H4. Anticoagulant | | <input type="checkbox"/> |
| H10. Other | | <input type="checkbox"/> |
| I1. Transfusions | | <input type="checkbox"/> |
| J1. Dialysis | | <input type="checkbox"/> |
| J2. Hemodialysis | | <input type="checkbox"/> |
| J3. Peritoneal dialysis | | <input type="checkbox"/> |
| K1. Hospice care | | |
| M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | |
| O1. IV Access | | <input type="checkbox"/> |
| O2. Peripheral | | <input type="checkbox"/> |
| O3. Midline | | <input type="checkbox"/> |
| O4. Central (e.g., PICC, tunneled, port) | | <input type="checkbox"/> |
| None of the Above | | |
| Z1. None of the above | | <input type="checkbox"/> |

Section O - Special Treatments, Procedures, and Programs

00350. Resident's COVID-19 vaccination is up to date

Enter Code

☐

0. No, resident is not up to date
1. Yes, resident is up to date

00425. Part A Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

Enter Number of Minutes

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy

Enter Number of Minutes

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

00425 continued on next page

00425. Part A Therapies - Continued**C. Physical Therapy**

Enter Number of Minutes

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to 00430, Distinct Calendar Days of Part A Therapy

Enter Number of Minutes

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

| | | |
|--|--|--|
| | | |
|--|--|--|

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

00430. Distinct Calendar Days of Part A Therapy

Enter Number of Days

| | | |
|--|--|--|
| | | |
|--|--|--|

Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for **at least 15 minutes** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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:

[illegible]

C. Last name:

[illegible]

X0310. Sex (A0810 on existing record to be modified/inactivated)

Enter Code

1. Male
2. Female

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

The diagram illustrates the subtraction of time units from a date. It consists of three rectangular boxes arranged horizontally, separated by minus signs. The first box is divided into two equal vertical sections and is labeled "Month" below it. The second box is also divided into two equal vertical sections and is labeled "Day" below it. The third box is divided into three equal vertical sections and is labeled "Year" below it.

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

$$\boxed{} \boxed{} \boxed{} - \boxed{} \boxed{} - \boxed{} \boxed{} \boxed{} \boxed{}$$

Section X - Correction Request

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 Assessment for a Medicare Part A Stay

- 01. 5-day scheduled assessment

PPS Unscheduled Assessment for a Medicare Part A Stay

- 08. IPA - Interim Payment Assessment

Not PPS Assessment

- 99. None of the above

Enter Code

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

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

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

Section X - Correction Request

Correction Attestation Section

Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number

| | |
|--|--|
| | |
|--|--|

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification

Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓

Check all that apply

☐

A. Transcription error

☐

B. Data entry error

☐

C. Software product error

☐

D. Item coding error

☐

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

☐

A. Event did not occur

☐

Z. Other error requiring inactivation

If "Other" checked, please specify: _____

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

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:

| | | | | | | | | | |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | | Day | | | Year | | | |

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