SHP for Skilled Nursing MDS 1.19.1 to MDS 1.20.1 Crosswalk Guide

Developed by **Strategic Healthcare Programs** • www.SHPdata.com

About this Guide

SHP is pleased to provide skilled nursing facilities with the SHP for Skilled Nursing MDS 1.19.1 to MDS 1.20.1 Crosswalk Guide—a complete side-by-side comparison of versions 1.19.1 and 1.20.1 of the MDS 3.0 Nursing Home Comprehensive (NC). Items that have been changed, added or removed between the two versions are indicated with color coding.

Change Summary

Open Full Change History on CMS.gov

Item #	Name	Change	Notes
A0800	Gender	Item Retired	
A0810	Sex	Item Added	
A1250	Transportation	Item Retired	
A1255	Transportation	Item Added	
O0390	Therapy Services	Item Added	
O0400	Therapies	Subitems Retired	A, B, C, D1, E, F
O0400	Therapies	Subitems Changed	D2
O0420	Distinct Calendar Days of Therapy	Item Retired	

Using this Guide

This guide is an excellent reference for anyone who works with the MDS and will improve accuracy, help reduce coding errors, and potentially reduce the number of returned claims. We recommend printing copies for your staff to aid in the transition to this new MDS and beyond.

Note: When printing from browser, set the scale to "Fit to paper" in the print dialog box for best results.

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A - Identification Information

A0050. Type of Record

Enter Code ☐

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 ☐

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

A0310. Type of Assessment

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 ☐

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 ☐☐

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

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A - Identification Information

A0050. Type of Record

Enter Code ☐

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 ☐

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

A0310. Type of Assessment

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 ☐

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 ☐☐

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

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge - Complete only if A0310F = 10 or 11
1. Planned
2. Unplanned

Enter Code ☐

G1. Is this a SNF Part A Interrupted Stay?
0. No
1. Yes

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: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

B. Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

1. Male
2. Female

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section A - Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

G. Type of discharge - Complete only if A0310F = 10 or 11
1. Planned
2. Unplanned

Enter Code ☐

G1. Is this a SNF Part A Interrupted Stay?
0. No
1. Yes

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: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

B. Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0810. Sex

Enter Code ☐

1. Male
2. Female

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

A1010. Race
What is your race?

↓ **Check all that apply**

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

A1110. Language

A. What is your preferred language?

Enter Code ☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?
0. **No**
1. **Yes**
9. **Unable to determine**

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

A1010. Race
What is your race?

↓ **Check all that apply**

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

A1110. Language

A. *What is your preferred language?*

Enter Code ☐

B. *Do you need or want an interpreter to communicate with a doctor or health care staff?*
0. No
1. Yes
9. Unable to determine

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Resident ______ Identifier ______ Date ______

Section A - Identification Information

A1200. Marital Status

Enter Code [ ]

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

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ **Check all that apply**

- [ ] **A.** Yes, it has kept me from medical appointments or from getting my medications
- [ ] **B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- [ ] **C.** No
- [ ] **X.** Resident unable to respond
- [ ] **Y.** Resident declines to respond

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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:

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01, 03, 04, or 05

Enter Code [ ]

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions

Complete only if A0310A = 01, 03, 04, or 05

↓ **Check all that apply**

- [ ] **A. Serious mental illness**
- [ ] **B. Intellectual Disability**
- [ ] **C. Other related conditions**

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Resident ______ Identifier ______ Date ______

Section A - Identification Information

A1200. Marital Status

Enter Code [ ]

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

A1255. Transportation

Complete only if A0310B = 01 and A2300 minus A1900 is less than 366 days

Enter Code [ ]

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

0. **Yes**
1. **No**
7. **Resident declines to respond**
8. **Resident unable to respond**

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:

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01, 03, 04, or 05

Enter Code [ ]

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditi

Complete only if A0310A = 01, 03, 04, or 05

↓ **Check all that apply**

- [ ] **A. Serious mental illness**
- [ ] **B. Intellectual Disability**
- [ ] **C. Other related conditions**

Transportation item has been derived from the national PRAPARE® social drivers of health assessment tool (2016), which was developed and is owned by the National Association of Community Health Centers (NACHC). This tool was developed in collaboration with the Association of Asian Pacific Community Health Organizations (AAPCHO) and the Oregon Primary Care Association (OPCA). For additional information, please visit www.prapare.org. Used with permission.

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

- ☐ A. **Down syndrome**
- ☐ B. **Autism**
- ☐ C. **Epilepsy**
- ☐ D. **Other organic condition related to ID/DD**

ID/DD Without Organic Condition

- ☐ E. **ID/DD with no organic condition**

No ID/DD

- ☐ Z. **None of the above**

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**

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

- ☐ A. **Down syndrome**
- ☐ B. **Autism**
- ☐ C. **Epilepsy**
- ☐ D. **Other organic condition related to ID/DD**

ID/DD Without Organic Condition

- ☐ E. **ID/DD with no organic condition**

No ID/DD

- ☐ Z. **None of the above**

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**

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
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**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

↓ **Check all that apply**

	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
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**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02–12

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

↓ **Check all that apply**

	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

↓ **Check all that apply**

		Route of Transmission
☐	A.	**Electronic Health Record** (e.g., electronic access to patient portal)
☐	B.	**Health Information Exchange**
☐	C.	**Verbal** (e.g., in-person, telephone, video conferencing)
☐	D.	**Paper-based** (e.g., fax, copies, printouts)
☐	E.	**Other methods** (e.g., texting, email, CDs)

A2200. Previous Assessment Reference Date for Significant Correction
Complete only if A0310A = 05 or 06

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A2400. Medicare Stay
Complete only if A0310G1 = 0

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:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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Resident _____ Identifier _____ Date _____

Section A - Identification Information

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

↓ **Check all that apply**

		Route of Transmission
☐	A.	**Electronic Health Record** (e.g., electronic access to patient portal)
☐	B.	**Health Information Exchange**
☐	C.	**Verbal** (e.g., in-person, telephone, video conferencing)
☐	D.	**Paper-based** (e.g., fax, copies, printouts)
☐	E.	**Other methods** (e.g., texting, email, CDs)

A2200. Previous Assessment Reference Date for Significant Correction
Complete only if A0310A = 05 or 06

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2400. Medicare Stay
Complete only if A0310G1 = 0

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:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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Resident _____ Identifier _____ Date _____

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 B0200, Hearing
1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

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 B0200, Hearing
1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section B - Hearing, Speech, and Vision

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

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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Resident _____ Identifier _____ Date _____

Section B - Hearing, Speech, and Vision

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

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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Resident _____ Identifier _____ Date _____

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 C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

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."*

Enter Code ☐
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)

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

Enter Code ☐
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**

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

Enter Code ☐
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**

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

Enter Code ☐
C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

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.

Enter Code ☐
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

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Resident _____ Identifier _____ Date _____

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 C0700–C1000, Staff Assessment for Mental Status
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

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Resident _____ Identifier _____ Date _____

Section C - Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

☐ **A. Current season**
☐ **B. Location of own room**
☐ **C. Staff names and faces**
☐ **D. That they are in a nursing home/hospital swing bed**
☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

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

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

Enter Codes in Boxes ↓

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ **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)?

☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?
- **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

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Resident _____ Identifier _____ Date _____

Section C - Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700–C1000) be Conducted?

Enter Code ☐

0. No (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. Yes (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200–C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. Memory OK
1. Memory problem

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. Memory OK
1. Memory problem

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

☐ **A. Current season**
☐ **B. Location of own room**
☐ **C. Staff names and faces**
☐ **D. That they are in a nursing home/hospital swing bed**
☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life
0. Independent - decisions consistent/reasonable
1. Modified independence - some difficulty in new situations only
2. Moderately impaired - decisions poor; cues/supervision required
3. Severely impaired - never/rarely made decisions

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Resident _____ Identifier _____ Date _____

Section C - Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

☐ **A. Current season**
☐ **B. Location of own room**
☐ **C. Staff names and faces**
☐ **D. That they are in a nursing home/hospital swing bed**
☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

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

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

Enter Codes in Boxes ↓

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
☐ **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)?
☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?
- **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

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Resident _____ Identifier _____ Date _____

Section C - Cognitive Patterns

Delirium

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

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

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** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	☐	**B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	**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)?
	☐	**D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria? ■ **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

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Resident _____ Identifier _____ Date _____

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 D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
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**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
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. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *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. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

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).

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Resident _____ Identifier _____ Date _____

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 D0500–D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
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. *Little interest or pleasure in doing things*		☐	☐
B. *Feeling down, depressed, or hopeless*		☐	☐
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. *Trouble falling or staying asleep, or sleeping too much*		☐	☐
D. *Feeling tired or having little energy*		☐	☐
E. *Poor appetite or overeating*		☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*		☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		☐	☐
H. *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. *Thoughts that you would be better off dead, or of hurting yourself in some way*		☐	☐

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).

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Resident _____ Identifier _____ Date _____

Section D - Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0150-D0160) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

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

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes↓	
A.	Little interest or pleasure in doing things	☐	☐
B.	Feeling or appearing down, depressed, or hopeless	☐	☐
C.	Trouble falling or staying asleep, or sleeping too much	☐	☐
D.	Feeling tired or having little energy	☐	☐
E.	Poor appetite or overeating	☐	☐
F.	Indicating that they feel bad about self, are a failure, or have let self or family down	☐	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H.	Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual	☐	☐
I.	States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J.	Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 30.

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**

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Resident _____ Identifier _____ Date _____

Section D - Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0150–D0160) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate 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)
	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.	Little interest or pleasure in doing things		☐	☐
B.	Feeling or appearing down, depressed, or hopeless		☐	☐
C.	Trouble falling or staying asleep, or sleeping too much		☐	☐
D.	Feeling tired or having little energy		☐	☐
E.	Poor appetite or overeating		☐	☐
F.	Indicating that they feel bad about self, are a failure, or have let self or family down		☐	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television		☐	☐
H.	Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual		☐	☐
I.	States that life isn't worth living, wishes for death, or attempts to harm self		☐	☐
J.	Being short-tempered, easily annoyed		☐	☐

D0600. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 30.

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**

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Resident _____ Identifier _____ Date _____

Section E - Behavior

E0100. Potential Indicators of Psychosis

↓ Check all that apply

☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)

☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)

☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. Behavior not exhibited
1. Behavior of this type occurred 1 to 3 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

Enter Code ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)

Enter Code ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)

Enter Code ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐ **Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?**
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ A. **Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ B. **Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ C. **Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ A. **Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ B. **Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ C. **Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section E - Behavior

E0100. Potential Indicators of Psychosis

↓ **Check all that apply**

☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)

☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)

☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence and Frequency

Note presence of symptoms and their frequency

Coding:	↓ Enter Codes in Boxes
0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐ **Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?**
0. **No** → Skip to E0800, Rejection of Care - Presence and Frequency
1. **Yes** → Considering all of E0200, Behavioral Symptoms - Presence and Frequency, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ A. **Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ B. **Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ C. **Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ A. **Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ B. **Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ C. **Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

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Section E - Behavior

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

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

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?

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

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

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Resident _____ Identifier _____ Date _____

Section E - Behavior

E0800. Rejection of Care - Presence and Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence and Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

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

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?

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

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

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Resident _____ Identifier _____ Date _____

Section F - Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:

1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes ↓

- ☐ ***A.*** *how important is it to you to* ***choose what clothes to wear?***
- ☐ ***B.*** *how important is it to you to* ***take care of your personal belongings or things?***
- ☐ ***C.*** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
- ☐ ***D.*** *how important is it to you to* ***have snacks available between meals?***
- ☐ ***E.*** *how important is it to you to* ***choose your own bedtime?***
- ☐ ***F.*** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
- ☐ ***G.*** *how important is it to you to* ***be able to use the phone in private?***
- ☐ ***H.*** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:

1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes ↓

- ☐ ***A.*** *how important is it to you to* ***have books, newspapers, and magazines to read?***
- ☐ ***B.*** *how important is it to you to* ***listen to music you like?***
- ☐ ***C.*** *how important is it to you to* ***be around animals such as pets?***
- ☐ ***D.*** *how important is it to you to* ***keep up with the news?***
- ☐ ***E.*** *how important is it to you to* ***do things with groups of people?***
- ☐ ***F.*** *how important is it to you to* ***do your favorite activities?***
- ☐ ***G.*** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
- ☐ ***H.*** *how important is it to you to* ***participate in religious services or practices?***

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items)

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Resident _____ Identifier _____ Date _____

Section F - Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted?

Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:	↓	Enter Codes in Boxes
1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive	☐	***A.*** *how important is it to you to* ***choose what clothes to wear?***
	☐	***B.*** *how important is it to you to* ***take care of your personal belongings or things?***
	☐	***C.*** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
	☐	***D.*** *how important is it to you to* ***have snacks available between meals?***
	☐	***E.*** *how important is it to you to* ***choose your own bedtime?***
	☐	***F.*** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
	☐	***G.*** *how important is it to you to* ***be able to use the phone in private?***
	☐	***H.*** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:	↓	Enter Codes in Boxes
1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive	☐	***A.*** *how important is it to you to* ***have books, newspapers, and magazines to read?***
	☐	***B.*** *how important is it to you to* ***listen to music you like?***
	☐	***C.*** *how important is it to you to* ***be around animals such as pets?***
	☐	***D.*** *how important is it to you to* ***keep up with the news?***
	☐	***E.*** *how important is it to you to* ***do things with groups of people?***
	☐	***F.*** *how important is it to you to* ***do your favorite activities?***
	☐	***G.*** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
	☐	***H.*** *how important is it to you to* ***participate in religious services or practices?***

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items)

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Resident _____ Identifier _____ Date _____

Section F - Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete GG0100, Prior Functioning: Everyday Activities
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply	
☐	A. Choosing clothes to wear
☐	B. Caring for personal belongings
☐	C. Receiving tub bath
☐	D. Receiving shower
☐	E. Receiving bed bath
☐	F. Receiving sponge bath
☐	G. Snacks between meals
☐	H. Staying up past 8:00 p.m.
☐	I. Family or significant other involvement in care discussions
☐	J. Use of phone in private
☐	K. Place to lock personal belongings
☐	L. Reading books, newspapers, or magazines
☐	M. Listening to music
☐	N. Being around animals such as pets
☐	O. Keeping up with the news
☐	P. Doing things with groups of people
☐	Q. Participating in favorite activities
☐	R. Spending time away from the nursing home
☐	S. Spending time outdoors
☐	T. Participating in religious activities or practices
☐	Z. None of the above

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Resident _____ Identifier _____ Date _____

Section F - Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete GG0100, Prior Functioning: Everyday Activities
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400–F0500) was completed

Resident Prefers:

↓ Check all that apply	
☐	A. Choosing clothes to wear
☐	B. Caring for personal belongings
☐	C. Receiving tub bath
☐	D. Receiving shower
☐	E. Receiving bed bath
☐	F. Receiving sponge bath
☐	G. Snacks between meals
☐	H. Staying up past 8:00 p.m.
☐	I. Family or significant other involvement in care discussions
☐	J. Use of phone in private
☐	K. Place to lock personal belongings
☐	L. Reading books, newspapers, or magazines
☐	M. Listening to music
☐	N. Being around animals such as pets
☐	O. Keeping up with the news
☐	P. Doing things with groups of people
☐	Q. Participating in favorite activities
☐	R. Spending time away from the nursing home
☐	S. Spending time outdoors
☐	T. Participating in religious activities or practices
☐	Z. None of the above

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Section GG - Functional Abilities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:
3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Enter Codes in Boxes

- ☐ **A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
- ☐ **B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
- ☐ **C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
- ☐ **D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Check all that apply

- ☐ **A. Manual wheelchair**
- ☐ **B. Motorized wheelchair and/or scooter**
- ☐ **C. Mechanical lift**
- ☐ **D. Walker**
- ☐ **E. Orthotics/Prosthetics**
- ☐ **Z. None of the above**

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Codes in Boxes

- ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)
- ☐ **B. Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices

Check all that were normally used in the last 7 days

- ☐ **A. Cane/crutch**
- ☐ **B. Walker**
- ☐ **C. Wheelchair** (manual or electric)
- ☐ **D. Limb prosthesis**
- ☐ **Z. None of the above** were used

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities

GG0100. Prior Functioning: Everyday Activities
Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:	↓	Enter Codes in Boxes
3. Independent - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.	☐	**A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
2. Needed Some Help - Resident needed partial assistance from another person to complete any activities.	☐	**B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
1. Dependent - A helper completed all the activities for the resident.	☐	**C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
8. Unknown.	☐	**D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.
9. Not Applicable.		

GG0110. Prior Device Use
Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

↓	Check all that apply
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

GG0115. Functional Limitation in Range of Motion
Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:	↓	Enter Codes in Boxes
0. No impairment	☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
1. Impairment on one side		
2. Impairment on both sides	☐	**B. Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices

↓	Check all that were normally used in the last 7 days
☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

SHP for Skilled Nursing MDS 1.19.1 to MDS 1.20.1 Crosswalk Guide

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), 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 themself with no assistance from a helper.
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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**

1. Admission 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.
☐☐	**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Admission

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☐☐	**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.
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Section GG - Functional Abilities - Admission

GG0170. Mobility (Assessment period is the first 3 days of the stay)
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88. **Not attempted due to medical condition or safety concerns**

1. Admission 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.
	FF.	**Tub/shower transfer:** The ability to get in and out of a tub/shower.
	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 admission 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.

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	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.

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Admission

GG0170. Mobility (Assessment period is the first 3 days of the stay)
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1. Admission 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 admission 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 admission 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.
	Q1. Does the resident use a wheelchair and/or scooter? ☐ 0. **No** → Skip to GG0130, Self Care (Discharge) 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.
	RR1. 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.
	SS1. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Admission

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☐☐	**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 ☐	**Q1. Does the resident use a wheelchair and/or scooter?** **0. No** → Skip to GG0130, Self Care - Discharge **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐ Enter Code ☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. **RR1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐ Enter Code ☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **SS1. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

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Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Discharge

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

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.

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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.
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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.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**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.

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

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.*	**If activity was not attempted, code reason:**
06. Independent - Resident completes the activity by themself with no assistance from a helper.	**07. Resident refused**
05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.	**09. Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
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.	**10. Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
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.	**88. Not attempted due to medical condition or safety concerns**
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.	

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.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**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.

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

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.

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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.
	Q3. Does the resident use a wheelchair and/or scooter? ☐ 0. **No** → Skip to H0100, Appliances 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.
	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.
	SS3. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - Discharge

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

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 themself with no assistance from a helper.
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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 H0100, Appliances **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐ Enter Code ☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. **RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐ Enter Code ☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **SS3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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 themself 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**

5. OBRA/Interim 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.
	I.	**Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02–06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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.*	**If activity was not attempted, code reason:**
06. Independent - Resident completes the activity by themself with no assistance from a helper.	**07. Resident refused**
05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.	**09. Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
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.	**10. Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
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.	**88. Not attempted due to medical condition or safety concerns**
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.	

5. OBRA/Interim 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.
	I.	**Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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.

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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**

5. OBRA/Interim 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.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	**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.

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02–06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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.*	**If activity was not attempted, code reason:**
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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.	

5. OBRA/Interim 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.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	**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.

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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.

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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**

5. OBRA/Interim Performance

Enter Codes in Boxes ↓

Q5. Does the resident use a wheelchair and/or scooter?

☐ 0. **No** → Skip to H0100, Appliances
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.

RR5. 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.

SS5. Indicate the type of wheelchair or scooter used.

☐ 1. **Manual**
2. **Motorized**

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section GG - Functional Abilities - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02–06 and A0310B = 99.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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.*	**If activity was not attempted, code reason:**
06. Independent - Resident completes the activity by themself with no assistance from a helper.	**07. Resident refused**
05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.	**09. Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
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.	**10. Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
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.	**88. Not attempted due to medical condition or safety concerns**
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.	

5. OBRA/Interim Performance — **Enter Codes in Boxes**

Enter Code ☐

Q5. Does the resident use a wheelchair and/or scooter?

0. No → Skip to H0100, Appliances
1. Yes → Continue to GG0170R, Wheel 50 feet with two turns

☐☐ Enter Code ☐

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

RR5. Indicate the type of wheelchair or scooter used.

1. Manual
2. Motorized

☐☐ Enter Code ☐

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

SS5. Indicate the type of wheelchair or scooter used.

1. Manual
2. Motorized

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Resident _____ Identifier _____ Date _____

Section H - Bladder and Bowel

H0100. Appliances

↓ **Check all that apply**

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐

B. Response - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

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

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

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

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

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

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Resident _____ Identifier _____ Date _____

Section H - Bladder and Bowel

H0100. Appliances

↓ **Check all that apply**

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐

B. Response - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

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

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

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

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

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

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Resident _____ Identifier _____ Date _____

Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code ☐☐

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medical Complex Conditions**

I0020B. ICD Code

☐☐☐☐☐☐☐☐

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Resident _____ Identifier _____ Date _____

Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medical Complex Conditions**

I0020B. ICD Code

☐☐☐☐☐☐☐☐

Active Diagnoses in the last 7 days

Check all that apply.

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

☐ **I0100. Cancer** (with or without metastasis)

Heart/Circulation

☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)

☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)

☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))

☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**

☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)

☐ **I0700. Hypertension**

☐ **I0800. Orthostatic Hypotension**

☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

☐ **I1100. Cirrhosis**

☐ **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)

☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

☐ **I1400. Benign Prostatic Hyperplasia (BPH)**

☐ **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**

☐ **I1550. Neurogenic Bladder**

☐ **I1650. Obstructive Uropathy**

Active Diagnoses in the last 7 days continued on next page

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Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ **I0100. Cancer** (with or without metastasis)

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

- ☐ **I1100. Cirrhosis**
- ☐ **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ **I1400. Benign Prostatic Hyperplasia (BPH)**
- ☐ **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ **I3800. Osteoporosis**
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I4000. Other Fracture**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

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Resident _____ Identifier _____ Date _____

Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Continued

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ **I3800. Osteoporosis**
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I4000. Other Fracture**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Active Diagnoses in the last 7 days continued on next page

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Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.	_____								
B.	_____								
C.	_____								
D.	_____								
E.	_____								
F.	_____								
G.	_____								
H.	_____								
I.	_____								
J.	_____								

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Resident _____ Identifier _____ Date _____

Section I - Active Diagnoses

Active Diagnoses in the last 7 days - Continued

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.								
B.								
C.								
D.								
E.								
F.								
G.								
H.								
I.								
J.								

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
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 J1100, Shortness of Breath
1. **Yes** → Continue to J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐ Ask resident: ***"How much of the time have you experienced pain or hurting** over the last 5 days?"*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
9. **Unable to answer**

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**

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

J0100. Pain Management
Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. No
1. Yes

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. No
1. Yes

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. No
1. Yes

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
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 J1100, Shortness of Breath (dyspnea)
1. Yes → Continue to J0410, Pain Frequency
9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐ Ask resident: ***"How much of the time have you experienced pain or hurting** over the last 5 days?"*
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
9. Unable to answer

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

Pain Assessment Interview continued on next page

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

Pain Assessment Interview - Continued

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**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. Numeric Rating Scale (00-10)
Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00 -10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. Verbal Descriptor Scale
Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain.

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

☐ **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)

☐ **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)

☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)

☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)

☐ **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

Pain Assessment Interview - Continued

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**

J0600. Pain Intensity
Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. Numeric Rating Scale (00–10)
Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00–10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. Verbal Descriptor Scale
Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

☐ **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)

☐ **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)

☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)

☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)

☐ **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1300. Current Tobacco Use

Enter Code ☐

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

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

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

J1550. Problem Conditions

↓ **Check all that apply**

- ☐ **A. Fever**
- ☐ **B. Vomiting**
- ☐ **C. Dehydrated**
- ☐ **D. Internal bleeding**
- ☐ **Z. None of the above**

J1700. Fall History on Admission/Entry or Reentry

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2-6 months** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

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 J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1300. Current Tobacco Use

Enter Code ☐

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

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

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

J1550. Problem Conditions

↓ **Check all that apply**

- ☐ **A. Fever**
- ☐ **B. Vomiting**
- ☐ **C. Dehydrated**
- ☐ **D. Internal bleeding**
- ☐ **Z. None of the above**

J1700. Fall History on Admission/Entry or Reentry

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2–6 months** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?

0. **No**
1. **Yes**
9. **Unable to determine**

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 J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

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 ↓

☐ **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)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐ Did the resident have major surgery during the **100 days prior to admission?**
0. **No**
1. **Yes**
8. **Unknown**

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code ☐ Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
0. **No**
1. **Yes**
8. **Unknown**

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

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)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

J2000. Prior Surgery
Complete only if A0310B = 01

Enter Code ☐ Did the resident have major surgery during the **100 days prior to admission?**
0. **No**
1. **Yes**
8. **Unknown**

J2100. Recent Surgery Requiring Active SNF Care
Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code ☐ Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
0. **No**
1. **Yes**
8. **Unknown**

Surgical Procedures

Complete only if J2100 = 1

↓	Check all that apply
	Major Joint Replacement
☐	**J2300. Knee Replacement** - partial or total
☐	**J2310. Hip Replacement** - partial or total
☐	**J2320. Ankle Replacement** - partial or total
☐	**J2330. Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400. Involving the spinal cord or major spinal nerves**
☐	**J2410. Involving fusion of spinal bones**
☐	**J2420. Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**

Surgical Procedures continued on next page

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Section J - Health Conditions

Surgical Procedures - Complete only if J2100 = 1

↓ **Check all that apply**

Major Joint Replacement

- ☐ **J2300. Knee Replacement** - partial or total
- ☐ **J2310. Hip Replacement** - partial or total
- ☐ **J2320. Ankle Replacement** - partial or total
- ☐ **J2330. Shoulder Replacement** - partial or total

Spinal Surgery

- ☐ **J2400. Involving the spinal cord or major spinal nerves**
- ☐ **J2410. Involving fusion of spinal bones**
- ☐ **J2420. Involving lamina, discs, or facets**
- ☐ **J2499. Other major spinal surgery**

Other Orthopedic Surgery

- ☐ **J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
- ☐ **J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
- ☐ **J2520. Repair but not replace joints**
- ☐ **J2530. Repair other bones** (such as hand, foot, jaw)
- ☐ **J2599. Other major orthopedic surgery**

Neurological Surgery

- ☐ **J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
- ☐ **J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
- ☐ **J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
- ☐ **J2699. Other major neurological surgery**

Cardiopulmonary Surgery

- ☐ **J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
- ☐ **J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
- ☐ **J2799. Other major cardiopulmonary surgery**

Genitourinary Surgery

- ☐ **J2800. Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
- ☐ **J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
- ☐ **J2899. Other major genitourinary surgery**

Other Major Surgery

- ☐ **J2900. Involving tendons, ligaments, or muscles**
- ☐ **J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
- ☐ **J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
- ☐ **J2930. Involving the breast**
- ☐ **J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
- ☐ **J5000. Other major surgery not listed above**

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Resident _____ Identifier _____ Date _____

Section J - Health Conditions

Surgical Procedures - Continued

Complete only if J2100 = 1

↓	Check all that apply
	Other Orthopedic Surgery
☐	**J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520. Repair but not replace joints**
☐	**J2530. Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800. Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐	**J2899. Other major genitourinary surgery**
	Other Major Surgery
☐	**J2900. Involving tendons, ligaments, or muscles**
☐	**J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐	**J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐	**J2930. Involving the breast**
☐	**J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐	**J5000. Other major surgery not listed above**

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Section K - Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

Inches ☐☐ **A. Height** (in inches). Record most recent height measure since the most recent admission/entry or reentry

Pounds ☐☐☐ **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐ **Loss of 5% or more in the last month or loss of 10% or more in last 6 months**

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0310. Weight Gain

Enter Code ☐ **Gain of 5% or more in the last month or gain of 10% or more in last 6 months**

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

K0520. Nutritional Approaches
Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***
   Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
	↓ Check all that apply ↓			
A. Parenteral/IV feeding	☐	☐	☐	☐
B. Feeding tube (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	[redacted]	☐	☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. None of the above	☐	☐	☐	☐

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Resident _____ Identifier _____ Date _____

Section K - Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight
While measuring, if the number is X.1–X.4 round down; X.5 or greater round up

Inches ☐☐ **A. Height** (in inches)
Record most recent height measure since the most recent admission/entry or reentry

Pounds ☐☐☐ **B. Weight** (in pounds)
Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐ **Loss of 5% or more in the last month or loss of 10% or more in last 6 months**

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0310. Weight Gain

Enter Code ☐ **Gain of 5% or more in the last month or gain of 10% or more in last 6 months**

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

K0520. Nutritional Approaches
Check all of the following nutritional approaches that apply

1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B	Performed ***while NOT a resident*** of this facility and within the ***last 7 days*** Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.	Performed ***while a resident*** of this facility and within the ***last 7 days***	Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	Check all that apply	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
A.	**Parenteral/IV feeding**	☐	☐	☐	☐
B.	**Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C.	**Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D.	**Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z.	**None of the above**	☐	☐	☐	☐

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Resident _____ Identifier _____ Date _____

Section K - Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	☐	☐

Section L - Oral/Dental Status

L0200. Dental

↓	Check all that apply
☐	**A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	**B. No natural teeth or tooth fragment(s)** (edentulous)
☐	**C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	**D. Obvious or likely cavity or broken natural teeth**
☐	**E. Inflamed or bleeding gums or loose natural teeth**
☐	**F. Mouth or facial pain, discomfort or difficulty with chewing**
☐	**G. Unable to examine**
☐	**Z. None of the above were present**

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Resident _____ Identifier _____ Date _____

Section K - Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route
Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

	2. While a Resident	3. During Entire 7 Days
	Performed ***while a resident*** of this facility and within the ***last 7 days***	Performed during the entire ***last 7 days***
	Enter Codes	**2.** While a Resident / **3.** During Entire 7 Days
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26–50% 3. 51% or more		☐ ☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more		☐ ☐

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Section K - Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	☐	☐

Section L - Oral/Dental Status

L0200. Dental

↓	Check all that apply
☐	**A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	**B. No natural teeth or tooth fragment(s)** (edentulous)
☐	**C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	**D. Obvious or likely cavity or broken natural teeth**
☐	**E. Inflamed or bleeding gums or loose natural teeth**
☐	**F. Mouth or facial pain, discomfort or difficulty with chewing**
☐	**G. Unable to examine**
☐	**Z. None of the above were present**

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Resident _____ Identifier _____ Date _____

Section L - Oral/Dental Status

L0200. Dental

↓	Check all that apply
☐	**A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	**B. No natural teeth or tooth fragment(s)** (edentulous)
☐	**C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	**D. Obvious or likely cavity or broken natural teeth**
☐	**E. Inflamed or bleeding gums or loose natural teeth**
☐	**F. Mouth or facial pain, discomfort or difficulty with chewing**
☐	**G. Unable to examine**
☐	**Z. None of the above were present**

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Section M - Skin Conditions

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

M0100. Determination of Pressure Ulcer/Injury Risk

↓ **Check all that apply**

- ☐ **A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers/Injuries

Enter Code ☐

Is this resident at risk of developing pressure ulcers/injuries?

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

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this resident have one or more unhealed pressure ulcers/injuries?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
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

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐ **1. Number of Stage 1 pressure injuries**

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 <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

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 <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

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 <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

M0300 continued on next page

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Resident _____ Identifier _____ Date _____

Section M - Skin Conditions

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

M0100. Determination of Pressure Ulcer/Injury Risk

↓ **Check all that apply**

- ☐ **A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers/Injuries

Enter Code ☐

Is this resident at risk of developing pressure ulcers/injuries?

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

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

Does this resident have one or more unhealed pressure ulcers/injuries?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
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

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐ **1. Number of Stage 1 pressure injuries**

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 <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

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 <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

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 <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

M0300 continued on next page

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Resident _____ Identifier _____ Date _____

Section M - Skin Conditions

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

Enter Number ☐ **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 <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 ☐ **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 <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 ☐ **G. Unstageable - Deep tissue injury:**

Enter Number ☐ **1. Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Enter Number ☐ **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

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ **Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

☐ **A. Infection of the foot** (e.g., cellulitis, purulent drainage)

☐ **B. Diabetic foot ulcer(s)**

☐ **C. Other open lesion(s) on the foot**

Other Problems

☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)

☐ **E. Surgical wound(s)**

☐ **F. Burn(s)** (second or third degree)

☐ **G. Skin tear(s)**

☐ **H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)

None of the Above

☐ **Z. None of the above** were present

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Resident _____ Identifier _____ Date _____

Section M - Skin Conditions

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

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 <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

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 <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

G. Unstageable - Deep tissue injury:

Enter Number ☐ **1. Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Enter Number ☐ **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

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ **Enter the total number of venous and arterial ulcers present**

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Resident _____ Identifier _____ Date _____

Section M - Skin Conditions

M1200. Skin and Ulcer/Injury Treatments

↓ **Check all that apply**

- ☐ **A. Pressure reducing device for chair**
- ☐ **B. Pressure reducing device for bed**
- ☐ **C. Turning/repositioning program**
- ☐ **D. Nutrition or hydration intervention** to manage skin problems
- ☐ **E. Pressure ulcer/injury care**
- ☐ **F. Surgical wound care**
- ☐ **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
- ☐ **H. Applications of ointments/medications** other than to feet
- ☐ **I. Application of dressings to feet** (with or without topical medications)
- ☐ **Z. None of the above** were provided

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Resident _____ Identifier _____ Date _____

Section M - Skin Conditions

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

- ☐ **A. Infection of the foot** (e.g., cellulitis, purulent drainage)
- ☐ **B. Diabetic foot ulcer(s)**
- ☐ **C. Other open lesion(s) on the foot**

Other Problems

- ☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- ☐ **E. Surgical wound(s)**
- ☐ **F. Burn(s)** (second or third degree)
- ☐ **G. Skin tear(s)**
- ☐ **H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)

None of the Above

- ☐ **Z. None of the above** were present

M1200. Skin and Ulcer/Injury Treatments

↓ **Check all that apply**

- ☐ **A. Pressure reducing device for chair**
- ☐ **B. Pressure reducing device for bed**
- ☐ **C. Turning/repositioning program**
- ☐ **D. Nutrition or hydration intervention** to manage skin problems
- ☐ **E. Pressure ulcer/injury care**
- ☐ **F. Surgical wound care**
- ☐ **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
- ☐ **H. Applications of ointments/medications** other than to feet
- ☐ **I. Application of dressings to feet** (with or without topical medications)
- ☐ **Z. None of the above** were provided

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Section N - Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication

N0350. Insulin

Enter Days ☐ **A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ **B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   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
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

		1. Is taking	2. Indication noted
		↓ Check all that apply ↓	
A.	**Antipsychotic**	☐	☐
B.	**Antianxiety**	☐	☐
C.	**Antidepressant**	☐	☐
D.	**Hypnotic**	☐	☐
E.	**Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F.	**Antibiotic**	☐	☐
G.	**Diuretic**	☐	☐
H.	**Opioid**	☐	☐
I.	**Antiplatelet**	☐	☐
J.	**Hypoglycemic** (including insulin)	☐	☐
K.	**Anticonvulsant**	☐	☐
Z.	**None of the above**	☐	

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Resident _____ Identifier _____ Date _____

Section N - Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication

N0350. Insulin

Enter Days ☐ **A. Insulin injections**
Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ **B. Orders for insulin**
Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days

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**	☐	☐
B.	**Antianxiety**	☐	☐
C.	**Antidepressant**	☐	☐
D.	**Hypnotic**	☐	☐
E.	**Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F.	**Antibiotic**	☐	☐
G.	**Diuretic**	☐	☐
H.	**Opioid**	☐	☐
I.	**Antiplatelet**	☐	☐
J.	**Hypoglycemic** (including insulin)	☐	☐
K.	**Anticonvulsant**	☐	☐
Z.	**None of the above**	☐	

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Section N - Medications

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip N0450B, N0450C, N0450D, and N0450E
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip N0450E, Date physician documented GDR as clinically contraindicated
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2003. Medication Follow-up - Complete only if N2001 = 1

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

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

N2005. Medication Intervention - Complete only if A0310H = 1

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. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

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Resident _____ Identifier _____ Date _____

Section N - Medications

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip N0450B, N0450C, N0450D, and N0450E
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip N0450E, Date physician documented GDR as clinically contraindicated
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

N2001. Drug Regimen Review

Complete only if A0310B = 01

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **N/A** - Resident is not taking any medications

N2003. Medication Follow-up

Complete only if N2001 = 1

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

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

N2005. Medication Intervention

Complete only if A0310H = 1

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

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Section O - Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

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

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B

b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***

c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐	[redacted]	☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐
Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐	[redacted]	☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐	[redacted]	☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐	[redacted]	☐
G3. CPAP	☐		☐
Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐	[redacted]	☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐

O0110 continued on next page

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

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

a. On Admission	b. While a Resident	c. At Discharge
Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B	Performed ***while a resident*** of this facility and within the ***last 14 days***	Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

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

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Section O - Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs - Continued

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

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***
c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓ Check all that apply	↓	↓
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐	■	☐
J3. Peritoneal dialysis	☐	■	☐
K1. Hospice care	■	☐	■
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	■	☐	■
O1. IV Access	☐	☐	☐
O2. Peripheral	☐	■	☐
O3. Midline	☐	■	☐
O4. Central (e.g., PICC, tunneled, port)	☐	■	☐
None of the Above			
Z1. None of the above	☐	☐	☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?
0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. **Date influenza vaccine received** → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Enter Code ☐

C. **If influenza vaccine not received, state reason:**
1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. **Is the resident's Pneumococcal vaccination up to date?**
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0350, Resident's COVID-19 vaccination is up to date

Enter Code ☐

B. **If Pneumococcal vaccine not received, state reason:**
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

O0350. 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

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0250. Influenza Vaccine

Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?
0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. **Date influenza vaccine received** → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Enter Code ☐

C. **If influenza vaccine not received, state reason:**
1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. **Is the resident's Pneumococcal vaccination up to date?**
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0350, Resident's COVID-19 vaccination is up to date

Enter Code ☐

B. **If Pneumococcal vaccine not received, state reason:**
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

O0350. 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

O0390. Therapy Services

Indicate therapies administered for at least 15 minutes a day on one or more days in the last 7 days

↓ Check all that apply	
☐	A. Speech-Language Pathology and Audiology Services
☐	B. Occupational Therapy
☐	C. Physical Therapy
☐	D. Respiratory Therapy
☐	E. Psychological Therapy
☐	Z. None of the above

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0400. 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** in the last 7 days

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** in the last 7 days

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** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

Enter Number of Minutes ☐☐☐☐

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐-☐☐-☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐-☐☐-☐☐☐☐
Month Day Year

B. Occupational Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

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** in the last 7 days

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** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

Enter Number of Minutes ☐☐☐☐

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐-☐☐-☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐-☐☐-☐☐☐☐
Month Day Year

O0400 continued on next page

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies

Complete only if O0390D is checked

D. Respiratory Therapy

Enter Number of Days ☐

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0425. Part A Therapies

Complete only if A0310H = 1

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)

O0425 continued on next page

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0400. 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** in the last 7 days

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** in the last 7 days

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** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

Enter Number of Minutes ☐☐☐☐

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐-☐☐-☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐-☐☐-☐☐☐☐
Month Day Year

D. Respiratory Therapy

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400E, Psychological Therapy

Enter Number of Days ☐

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0400F, Recreational Therapy

Enter Number of Days ☐

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
If zero, → skip to O0420, Distinct Calendar Days of Therapy

Enter Number of Days ☐

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0420. Distinct Calendar Days of 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 in the past 7 days.

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies
Complete only if O0390D is checked

D. Respiratory Therapy

Enter Number of Days ☐

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0425. Part A Therapies
Complete only if A0310H = 1

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)

O0425 continued on next page

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Complete only if A0310H = 1

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)

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 O0430, 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)

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0425. 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 O0430, 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)

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

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)

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed for **at least 15 minutes** a day in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

	Technique
↓	**Number of Days**
☐	**A. Range of motion (passive)**
☐	**B. Range of motion (active)**
☐	**C. Splint or brace assistance**
	Training and Skill Practice In:
↓	**Number of Days**
☐	**D. Bed mobility**
☐	**E. Transfer**
☐	**F. Walking**
☐	**G. Dressing and/or grooming**
☐	**H. Eating and/or swallowing**
☐	**I. Amputation/prostheses care**
☐	**J. Communication**

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

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)

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	**Training and Skill Practice In:**
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

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Resident _____ Identifier _____ Date _____

Section O - Special Treatments, Procedures, and Programs

O0425. 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 O0430, 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)

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

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)

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed for **at least 15 minutes** a day in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

↓	Technique
	Number of Days
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
	Training and Skill Practice In:
↓	**Number of Days**
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

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Resident _____ Identifier _____ Date _____

Section P - Restraints and Alarms

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:

0. **Not used**
1. **Used less than daily**
2. **Used daily**

Enter Codes in Boxes

↓

Used in Bed

- ☐ A. Bed rail
- ☐ B. Trunk restraint
- ☐ C. Limb restraint
- ☐ D. Other

Used in Chair or Out of Bed

- ☐ E. Trunk restraint
- ☐ F. Limb restraint
- ☐ G. Chair prevents rising
- ☐ H. Other

P0200. Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected

Coding:

0. **Not used**
1. **Used less than daily**
2. **Used daily**

Enter Codes in Boxes

↓

- ☐ A. Bed alarm
- ☐ B. Chair alarm
- ☐ C. Floor mat alarm
- ☐ D. Motion sensor alarm
- ☐ E. Wander/elopement alarm
- ☐ F. Other alarm

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Resident _____ Identifier _____ Date _____

Section P - Restraints and Alarms

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:	↓ Enter Codes in Boxes
0. Not used 1. Used less than daily 2. Used daily	**Used in Bed**
	☐ A. Bed rail
	☐ B. Trunk restraint
	☐ C. Limb restraint
	☐ D. Other
	Used in Chair or Out of Bed
	☐ E. Trunk restraint
	☐ F. Limb restraint
	☐ G. Chair prevents rising
	☐ H. Other

P0200. Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected

Coding:	↓ Enter Codes in Boxes
0. Not used 1. Used less than daily 2. Used daily	☐ A. Bed alarm
	☐ B. Chair alarm
	☐ C. Floor mat alarm
	☐ D. Motion sensor alarm
	☐ E. Wander/elopement alarm
	☐ F. Other alarm

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Resident _____ Identifier _____ Date _____

Section Q - Participation in Assessment and Goal Setting

Q0110. Participation in Assessment and Goal Setting

Identify all active participants in the assessment process

↓	Check all that apply
☐	A. Resident
☐	B. Family
☐	C. Significant other
☐	D. Legal guardian
☐	E. Other legally authorized representative
☐	Z. None of the above

Q0310. Resident's Overall Goal

Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal for discharge established during the assessment process

1. Discharge to the community
2. Remain in this facility
3. Discharge to another facility/institution
9. Unknown or uncertain

Enter Code ☐

B. Indicate information source for Q0310A

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?

0. No
1. Yes → Skip to Q0610, Referral

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment?

0. No
1. Yes → Skip to Q0610, Referral

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

0. No
1. Yes
9. Unknown or uncertain

Enter Code ☐

C. Indicate information source for Q0500B

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

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Resident _____ Identifier _____ Date _____

Section Q - Participation in Assessment and Goal Setting

Q0110. Participation in Assessment and Goal Setting

Identify all active participants in the assessment process

↓	Check all that apply
☐	A. Resident
☐	B. Family
☐	C. Significant other
☐	D. Legal guardian
☐	E. Other legally authorized representative
☐	Z. None of the above

Q0310. Resident's Overall Goal

Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal for discharge established during the assessment process

1. Discharge to the community
2. Remain in this facility
3. Discharge to another facility/institution
9. Unknown or uncertain

Enter Code ☐

B. Indicate information source for Q0310A

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?

0. No
1. Yes → Skip to Q0610, Referral

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment?

0. No
1. Yes → Skip to Q0610, Referral

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"*Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?*"**

0. No
1. Yes
9. Unknown or uncertain

Enter Code ☐

C. Indicate information source for Q0500B

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

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Resident _____ Identifier _____ Date _____

Section Q - Participation in Assessment and Goal Setting

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B

Enter Code ☐

A. Does resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone)

0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment
1. **Yes**
8. **Information not available**

Enter Code ☐

C. Indicate information source for Q0550A

1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

Q0610. Referral

Enter Code ☐

A. Has a referral been made to the Local Contact Agency (LCA)?

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

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0

Enter Code ☐

Indicate reason why referral to LCA was not made

1. **LCA unknown**
2. **Referral previously made**
3. **Referral not wanted**
4. **Discharge date 3 or fewer months away**
5. **Discharge date more than 3 months away**

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Resident _____ Identifier _____ Date _____

Section Q - Participation in Assessment and Goal Setting

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B

Enter Code ☐

A. Does resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone)

0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment
1. Yes
8. Information not available

Enter Code ☐

C. Indicate information source for Q0550A

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Q0610. Referral

Enter Code ☐

A. Has a referral been made to the Local Contact Agency (LCA)?

0. No
1. Yes

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0

Enter Code ☐

Indicate reason why referral to LCA was not made

1. LCA unknown
2. Referral previously made
3. Referral not wanted
4. Discharge date 3 or fewer months away
5. Discharge date more than 3 months away

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Resident _____ Identifier _____ Date _____

Section V - Care Area Assessment (CAA) Summary

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01 - 06 or A0310B = 01

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)

Month - Day - Year

Enter Score

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score

E. Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 value from prior assessment)

Enter Score

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assesment)

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Resident _____ Identifier _____ Date _____

Section V - Care Area Assessment (CAA) Summary

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01–06 or A0310B = 01

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior 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. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)

Month - Day - Year

Enter Score

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score

E. Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 value from prior assessment)

Enter Score

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

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Resident _____ Identifier _____ Date _____

Section V - Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

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Resident _____ Identifier _____ Date _____

Section V - Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area — Check all that apply	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA Documentation
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date ☐☐ - ☐☐ - ☐☐☐☐ (Month - Day - Year)

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Resident _____ Identifier _____ Date _____

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 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**

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Resident _____ Identifier _____ Date _____

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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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)

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

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

☐☐☐ - ☐☐ - ☐☐☐☐

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Resident _____ Identifier _____ Date _____

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 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**

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Resident _____ Identifier _____ Date _____

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
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

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

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Resident _____ Identifier _____ Date _____

Section X - Correction Request

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

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Resident _____ Identifier _____ Date _____

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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Resident _____ Identifier _____ Date _____

Section X - Correction Request

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

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Resident _____ Identifier _____ Date _____

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

← v1.19.1 • OLD

Resident _____ Identifier _____ Date _____

Section Z - Assessment Administration

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code:

B. Version code:

Z0200. State Medicaid Billing (if required by the state)

A. Case Mix group:

B. Version code:

Z0250. Alternate State Medicaid Billing (if required by the state)

A. Case Mix group:

B. Version code:

Z0300. Insurance Billing

A. Billing code:

B. Billing version:

NEW • v1.20.1 →

Resident _____ Identifier _____ Date _____

Section Z - Assessment Administration

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code:

B. Version code:

Z0200. State Medicaid Billing (if required by the state)

A. Case Mix group:

B. Version code:

Z0250. Alternate State Medicaid Billing (if required by the state)

A. Case Mix group:

B. Version code:

Z0300. Insurance Billing

A. Billing code:

B. Billing version:

Resident _____ Identifier _____ Date _____

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:

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Resident _____ Identifier _____ Date _____

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:

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

Back to Change Summary