

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

Section A	Identification Information
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A0050. Type of Record

Enter Code <input style="width: 100%;" type="text"/>	<ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider
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A0100. Facility Provider Numbers

	<p>A. National Provider Identifier (NPI):</p> <p>B. CMS Certification Number (CCN):</p> <p>C. State Provider Number:</p>
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A0200. Type of Provider

Enter Code <input style="width: 100%;" type="text"/>	<p>Type of provider</p> <ol style="list-style-type: none"> 1. Nursing home (SNF/NF) 2. Swing Bed 	
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A0310. Type of Assessment

Enter Code <input style="width: 100%;" type="text"/>	<p>A. Federal OBRA Reason for Assessment</p> <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above 	
Enter Code <input style="width: 100%;" type="text"/>	<p>B. PPS Assessment</p> <p>PPS Scheduled Assessments for a Medicare Part A Stay</p> <ol style="list-style-type: none"> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment <p>PPS Unscheduled Assessments for a Medicare Part A Stay</p> <ol style="list-style-type: none"> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <p>Not PPS Assessment</p> <ol style="list-style-type: none"> 99. None of the above 	
Enter Code <input style="width: 100%;" type="text"/>	<p>C. PPS Other Medicare Required Assessment - OMRA</p> <ol style="list-style-type: none"> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment 	
Enter Code <input style="width: 100%;" type="text"/>	<p>D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2</p> <ol style="list-style-type: none"> 0. No 1. Yes 	

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code <input type="checkbox"/>	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned

A0410. Unit Certification or Licensure Designation

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State Unit is neither Medicare nor Medicaid certified but MDS data is required by the State Unit is Medicare and/or Medicaid certified
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A0500. Legal Name of Resident

	A. First name:		B. Middle initial:
	C. Last name:		D. Suffix:

A0600. Social Security and Medicare Numbers

	A. Social Security Number: — —
	B. Medicare number (or comparable railroad insurance number):

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

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A0800. Gender

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> Male Female
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A0900. Birth Date

	— — Month Day Year
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A1000. Race/Ethnicity

↓ Check all that apply

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

Section A**Identification Information****A1100. Language**

Enter Code

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

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

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

Enter Code

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

A1300. Optional Resident Items**A. Medical record number:****B. Room number:****C. Name by which resident prefers to be addressed:****D. Lifetime occupation(s) - put "/" between two occupations:****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 ("mental retardation" in federal regulation) 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 ("mental retardation" in federal regulation)****C. Other related conditions**

Section A	Identification Information
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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
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
<input type="checkbox"/>	E. ID/DD with no organic condition
	No ID/DD
<input type="checkbox"/>	Z. None of the above

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

	— — Month Day Year
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A1700. Type of Entry

Enter Code	1. Admission 2. Reentry	
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A1800. Entered From

Enter Code	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other
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A1900. Admission Date (Date this episode of care in this facility began)

	— — Month Day Year
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A2000. Discharge Date
 Complete only if A0310F = 10, 11, or 12

	— — Month Day Year
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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 <input style="width: 100%;" type="text"/>	Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance	
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B0200. Hearing

Enter Code <input style="width: 100%;" type="text"/>	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	
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B0300. Hearing Aid

Enter Code <input style="width: 100%;" type="text"/>	Hearing aid or other hearing appliance used in completing B0200, Hearing 0. No 1. Yes	
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B0600. Speech Clarity

Enter Code <input style="width: 100%;" type="text"/>	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	
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B0700. Makes Self Understood

Enter Code <input style="width: 100%;" type="text"/>	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	
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B0800. Ability To Understand Others

Enter Code <input style="width: 100%;" type="text"/>	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	
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B1000. Vision

Enter Code <input style="width: 100%;" type="text"/>	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	
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B1200. Corrective Lenses

Enter Code <input style="width: 100%;" type="text"/>	Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision 0. No 1. Yes	
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Section C**Cognitive Patterns****C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**

Attempt to conduct interview with all residents

Enter Code

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

RUG III RUG IV

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**

RUG III RUG IV

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**

RUG III RUG IV

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**

RUG III RUG IV

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**

RUG III RUG IV

Enter Code

B. Able to recall "blue"

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

RUG III RUG IV

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**

RUG III RUG IV

C0500. 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

CATs RUG III RUG IV



Section C Cognitive Patterns

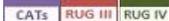
C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code	0. No (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium 1. Yes (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK
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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	
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C0800. Long-term Memory OK

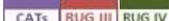
Enter Code	Seems or appears to recall long past 0. Memory OK 1. Memory problem	
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C0900. Memory/Recall Ability

↓ 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 he or she is in a nursing home**
- 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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Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)*

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

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	
	<input type="checkbox"/>	A. Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)? 
	<input type="checkbox"/>	B. 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)? 
	<input type="checkbox"/>	C. Altered level of consciousness - Did the resident have altered level of consciousness (e.g., 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)? 
	<input type="checkbox"/>	D. Psychomotor retardation - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly? 

C1600. 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	
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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 D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-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		1. Symptom Presence	2. Symptom Frequency
	0. No (enter 0 in column 2)	1. Yes (enter 0-3 in column 2)	0. Never or 1 day	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 ↓	
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D0300. 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 items).



D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?

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



Section D | **Mood**

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

Do not conduct if Resident Mood Interview (D0200-D0300) 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	1. Symptom Presence	2. Symptom Frequency
	0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2)	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)	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CATs	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
B. Feeling or appearing down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
I. States that life isn't worth living, wishes for death, or attempts to harm self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CATs	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
J. Being short-tempered, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV

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. CATs RUG III RUG IV

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code Was responsible staff or provider informed that there is a potential for resident self harm?
 0. No
 1. Yes

Section E	Behavior
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E0100. Potential Indicators of Psychosis

↓ Check all that apply

- | | | | |
|--------------------------|---|--|--|
| <input type="checkbox"/> | A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) | | |
| <input type="checkbox"/> | B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) | | |
| <input type="checkbox"/> | Z. None of the above | | |

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

<p>Coding:</p> <p>0. Behavior not exhibited</p> <p>1. Behavior of this type occurred 1 to 3 days</p> <p>2. Behavior of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p>	↓	Enter Codes in Boxes	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%;"><input type="checkbox"/></td> <td style="width:85%;">A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td>B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>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)</td> <td></td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/>	A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)				<input type="checkbox"/>	B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)				<input type="checkbox"/>	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)			
<input type="checkbox"/>	A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)																	
<input type="checkbox"/>	B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)																	
<input type="checkbox"/>	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 <input type="checkbox"/>	<p>Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?</p> <p>0. No → Skip to E0800, Rejection of Care</p> <p>1. Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below</p>	
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E0500. Impact on Resident

Enter Code <input type="checkbox"/>	<p>Did any of the identified symptom(s):</p> <p>A. Put the resident at significant risk for physical illness or injury?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input type="checkbox"/>	<p>B. Significantly interfere with the resident's care?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input type="checkbox"/>	<p>C. Significantly interfere with the resident's participation in activities or social interactions?</p> <p>0. No</p> <p>1. Yes</p>

E0600. Impact on Others

Enter Code <input type="checkbox"/>	<p>Did any of the identified symptom(s):</p> <p>A. Put others at significant risk for physical injury?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input type="checkbox"/>	<p>B. Significantly intrude on the privacy or activity of others?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input type="checkbox"/>	<p>C. Significantly disrupt care or living environment?</p> <p>0. No</p> <p>1. Yes</p>

E0800. Rejection of Care - Presence & Frequency

Enter Code <input type="checkbox"/>	<p>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.</p> <p>0. Behavior not exhibited</p> <p>1. Behavior of this type occurred 1 to 3 days</p> <p>2. Behavior of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p>			
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Section E	Behavior
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E0900. Wandering - Presence & Frequency

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p>Has the resident wandered?</p> <p>0. Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms</p> <p>1. Behavior of this type occurred 1 to 3 days</p> <p>2. Behavior of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p>	<div style="display: flex; justify-content: space-between; font-size: 8px;"> CATs RUG III RUG IV </div>
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E1000. Wandering - Impact

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p>A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?</p> <p>0. No</p> <p>1. Yes</p>
Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p>B. Does the wandering significantly intrude on the privacy or activities of others?</p> <p>0. No</p> <p>1. Yes</p>

E1100. Change in Behavior or Other Symptoms
Consider all of the symptoms assessed in items E0100 through E1000

Enter Code <input style="width: 100%; height: 20px;" type="text"/>	<p>How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?</p> <p>0. Same</p> <p>1. Improved</p> <p>2. Worse</p> <p>3. N/A because no prior MDS assessment</p>	<div style="display: flex; justify-content: flex-end; font-size: 8px;"> CATs </div>
---	--	---

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 <u>and</u> 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
	<input type="checkbox"/> A. how important is it to you to choose what clothes to wear?
	<input type="checkbox"/> B. how important is it to you to take care of your personal belongings or things?
	<input type="checkbox"/> C. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?
	<input type="checkbox"/> D. how important is it to you to have snacks available between meals?
	<input type="checkbox"/> E. how important is it to you to choose your own bedtime?
	<input type="checkbox"/> F. how important is it to you to have your family or a close friend involved in discussions about your care?
	<input type="checkbox"/> G. how important is it to you to be able to use the phone in private?
	<input type="checkbox"/> 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
	<input type="checkbox"/> A. how important is it to you to have books, newspapers, and magazines to read? CATs
	<input type="checkbox"/> B. how important is it to you to listen to music you like? CATs
	<input type="checkbox"/> C. how important is it to you to be around animals such as pets? CATs
	<input type="checkbox"/> D. how important is it to you to keep up with the news? CATs
	<input type="checkbox"/> E. how important is it to you to do things with groups of people? CATs
	<input type="checkbox"/> F. how important is it to you to do your favorite activities? CATs
	<input type="checkbox"/> G. how important is it to you to go outside to get fresh air when the weather is good? CATs
	<input type="checkbox"/> H. how important is it to you to participate in religious services or practices? CATs

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")
------------	---

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 G0110, Activities of Daily Living (ADL) Assistance
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

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

Section G**Functional Status****G0110. Activities of Daily Living (ADL) Assistance**

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
 - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
 - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.**1. ADL Self-Performance**Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time**Coding:****Activity Occurred 3 or More Times**

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support ProvidedCode for **most support provided** over all shifts; code regardless of resident's self-performance classification**Coding:**

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture**B. Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)**C. Walk in room** - how resident walks between locations in his/her room**D. Walk in corridor** - how resident walks in corridor on unit**E. Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair**F. Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair**G. Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses**H. Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)**I. Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag**J. Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	
CATs <input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
CATs <input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
CATs <input type="checkbox"/>	
CATs <input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
CATs <input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
CATs <input type="checkbox"/>	

Section G**Functional Status****G0120. Bathing**

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code <input type="text"/>	A. Self-performance 0. Independent - no help provided 1. Supervision - oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period	<input type="text"/> CATs
Enter Code <input type="text"/>	B. Support provided (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided , above)	

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding: 0. Steady at all times 1. Not steady, but able to stabilize without staff assistance 2. Not steady, only able to stabilize with staff assistance 8. Activity did not occur	↓ Enter Codes in Boxes		
	<input type="text"/>	A. Moving from seated to standing position	<input type="text"/> CATs
	<input type="text"/>	B. Walking (with assistive device if used)	<input type="text"/> CATs
	<input type="text"/>	C. Turning around and facing the opposite direction while walking	<input type="text"/> CATs
	<input type="text"/>	D. Moving on and off toilet	<input type="text"/> CATs
	<input type="text"/>	E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)	<input type="text"/> CATs

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides	↓ Enter Codes in Boxes		
	<input type="text"/>	A. Upper extremity (shoulder, elbow, wrist, hand)	
	<input type="text"/>	B. Lower extremity (hip, knee, ankle, foot)	

G0600. Mobility Devices

↓ Check all that were normally used

- | | |
|--------------------------|---|
| <input type="checkbox"/> | A. Cane/crutch |
| <input type="checkbox"/> | B. Walker |
| <input type="checkbox"/> | C. Wheelchair (manual or electric) |
| <input type="checkbox"/> | D. Limb prosthesis |
| <input type="checkbox"/> | Z. None of the above were used |

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code <input type="text"/>	A. Resident believes he or she is capable of increased independence in at least some ADLs 0. No 1. Yes 9. Unable to determine	<input type="text"/> CATs
Enter Code <input type="text"/>	B. Direct care staff believe resident is capable of increased independence in at least some ADLs 0. No 1. Yes	<input type="text"/> CATs

Section H**Bladder and Bowel****H0100. Appliances**

↓ Check all that apply

- | | | |
|--------------------------|--|------|
| <input type="checkbox"/> | A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) | CATs |
| <input type="checkbox"/> | B. External catheter | CATs |
| <input type="checkbox"/> | C. Ostomy (including urostomy, ileostomy, and colostomy) | |
| <input type="checkbox"/> | D. Intermittent catheterization | CATs |
| <input type="checkbox"/> | Z. None of the above | |

H0200. Urinary Toileting Program

- | | | |
|--|--|----------------|
| Enter Code
<input type="checkbox"/> | 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
<input type="checkbox"/> | 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
<input type="checkbox"/> | 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 | RUG III RUG IV |

H0300. Urinary Continence

- | | | |
|--|--|------|
| Enter Code
<input type="checkbox"/> | 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 | CATs |
|--|--|------|

H0400. Bowel Continence

- | | | |
|--|--|------|
| Enter Code
<input type="checkbox"/> | 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 | CATs |
|--|--|------|

H0500. Bowel Toileting Program

- | | | |
|--|--|----------------|
| Enter Code
<input type="checkbox"/> | Is a toileting program currently being used to manage the resident's bowel continence?
0. No
1. Yes | RUG III RUG IV |
|--|--|----------------|

H0600. Bowel Patterns

- | | | |
|--|---|------|
| Enter Code
<input type="checkbox"/> | Constipation present?
0. No
1. Yes | CATs |
|--|---|------|

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		
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)	
Heart/Circulation		
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)	
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)	
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))	
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)	
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)	
<input type="checkbox"/>	I0700. Hypertension	
<input type="checkbox"/>	I0800. Orthostatic Hypotension	
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)	
Gastrointestinal		
<input type="checkbox"/>	I1100. Cirrhosis	
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)	
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease	
Genitourinary		
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)	
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)	
<input type="checkbox"/>	I1550. Neurogenic Bladder	
<input type="checkbox"/>	I1650. Obstructive Uropathy	
Infections		
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)	CATs
<input type="checkbox"/>	I2000. Pneumonia	CATs RUG III RUG IV
<input type="checkbox"/>	I2100. Septicemia	CATs RUG III RUG IV
<input type="checkbox"/>	I2200. Tuberculosis	CATs
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)	CATs
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)	CATs
<input type="checkbox"/>	I2500. Wound Infection (other than foot)	CATs
Metabolic		
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)	RUG III RUG IV
<input type="checkbox"/>	I3100. Hyponatremia	
<input type="checkbox"/>	I3200. Hyperkalemia	
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)	
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)	
Musculoskeletal		
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))	
<input type="checkbox"/>	I3800. Osteoporosis	
<input type="checkbox"/>	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)	
<input type="checkbox"/>	I4000. Other Fracture	
Neurological		
<input type="checkbox"/>	I4200. Alzheimer's Disease	CATs
<input type="checkbox"/>	I4300. Aphasia	RUG III
<input type="checkbox"/>	I4400. Cerebral Palsy	RUG III RUG IV
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke	
<input type="checkbox"/>	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)	CATs

Neurological Diagnoses continued on next page

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. Manic Depression** (bipolar disease)
- 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. _____

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 <input type="checkbox"/>	A. Received scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Received PRN pain medications OR was offered and declined? 0. No 1. Yes
Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	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 <input type="checkbox"/>	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 J0400, Pain Frequency 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain
--	--

J0400. Pain Frequency

Enter Code <input type="checkbox"/>	Ask resident: " How much of the time have you experienced pain or hurting over the last 5 days? " 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer	
--	---	---

J0500. Pain Effect on Function

Enter Code <input type="checkbox"/>	A. Ask resident: " Over the past 5 days, has pain made it hard for you to sleep at night? " 0. No 1. Yes 9. Unable to answer	
Enter Code <input type="checkbox"/>	B. Ask resident: " Over the past 5 days, have you limited your day-to-day activities because of pain? " 0. No 1. Yes 9. Unable to answer	

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

Enter Rating <input type="checkbox"/>	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 <input type="checkbox"/>	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	



Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

- Enter Code
- 0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
 - 1. **Yes** (J0400 = 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) CATs
- B. Vocal complaints of pain** (e.g., that hurts, ouch, stop) CATs
- C. Facial expressions** (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw) CATs
- 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) CATs
- 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**

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** RUG IV
- Z. None of the above**

J1300. Current Tobacco Use

- Enter Code
- Tobacco use**
- 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** CATs RUG III RUG IV
- B. Vomiting** CATs RUG III RUG IV
- C. Dehydrated** CATs RUG III
- D. Internal bleeding** CATs RUG III
- Z. None of the above**

Section J**Health Conditions****J1700. Fall History on Admission/Entry or Reentry**

Complete only if A0310A = 01 or A0310E = 1

Enter Code <input type="text"/>	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 <input type="text"/>	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 <input type="text"/>	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 <input type="text"/>	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 K0100, Swallowing Disorder 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)	
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J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

↓ Enter Codes in Boxes

Coding: 0. None 1. One 2. Two or more	<input type="text"/> <input type="text"/> <input type="text"/>	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
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Section K	Swallowing/Nutritional Status
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K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ Check all that apply	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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

<input style="width: 100%; height: 20px;" type="text"/> inches	A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry CATs
<input style="width: 100%; height: 20px;" type="text"/> 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.) CATs

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	CATs RUG III RUG IV
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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	CATs
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K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last 7 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the last 7 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed <i>while a resident</i> of this facility and within the last 7 days	1. While NOT a Resident	2. While a Resident
↓ Check all that apply ↓		
A. Parenteral/IV feeding	CATs RUG III <input type="checkbox"/> RUG IV	CATs RUG III <input type="checkbox"/> RUG IV
B. Feeding tube - nasogastric or abdominal (PEG)	CATs RUG III <input type="checkbox"/> RUG IV	CATs RUG III <input type="checkbox"/> RUG IV
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	CATs <input type="checkbox"/>	CATs <input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	CATs <input type="checkbox"/>	CATs <input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Section K	Swallowing/Nutritional Status
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K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B			
<p>1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the last 7 days. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank</p> <p>2. While a Resident Performed <i>while a resident</i> of this facility and within the last 7 days</p> <p>3. During Entire 7 Days Performed during the entire last 7 days</p>	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
↓ Enter Codes ↓			
<p>A. Proportion of total calories the resident received through parenteral or tube feeding</p> <p>1. 25% or less 2. 26-50% 3. 51% or more</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV
<p>B. Average fluid intake per day by IV or tube feeding</p> <p>1. 500 cc/day or less 2. 501 cc/day or more</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> RUG III <input type="checkbox"/> RUG IV

Section L	Oral/Dental Status
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L0200. Dental		
↓ Check all that apply		
<input type="checkbox"/>	A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)	<input type="checkbox"/> CATs
<input type="checkbox"/>	B. No natural teeth or tooth fragment(s) (edentulous)	<input type="checkbox"/> CATs
<input type="checkbox"/>	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)	<input type="checkbox"/> CATs
<input type="checkbox"/>	D. Obvious or likely cavity or broken natural teeth	<input type="checkbox"/> CATs
<input type="checkbox"/>	E. Inflamed or bleeding gums or loose natural teeth	<input type="checkbox"/> CATs
<input type="checkbox"/>	F. Mouth or facial pain, discomfort or difficulty with chewing	<input type="checkbox"/> CATs
<input type="checkbox"/>	G. Unable to examine	<input type="checkbox"/> CATs
<input type="checkbox"/>	Z. None of the above were present	<input type="checkbox"/> CATs

Section M

Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ Check all that apply

- A. Resident has a stage 1 or greater, 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

Enter Code	Is this resident at risk of developing pressure ulcers?	
<input type="checkbox"/>	0. No	
<input type="checkbox"/>	1. Yes	

M0210. Unhealed Pressure Ulcer(s)

Enter Code	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
<input type="checkbox"/>	0. No → Skip to M0900, Healed Pressure Ulcers
<input type="checkbox"/>	1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number	A. Number of Stage 1 pressure ulcers	
	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	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	
	2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry	
	3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="text-align: center;"> - - Month Day Year </div>	
Enter Number	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling	
Enter Number	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4	
	2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry	
Enter Number	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling	
Enter Number	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing	
	2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry	

M0300 continued on next page

Section M | Skin Conditions

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

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar CATs</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>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 CATs RUG III RUG IV</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution</p> <p>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar CATs</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
 Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

<input type="text"/> . <input type="text"/> cm	A. Pressure ulcer length: Longest length from head to toe
<input type="text"/> . <input type="text"/> cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> . <input type="text"/> cm	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code <input type="text"/>	<p>Select the best description of the most severe type of tissue present in any pressure ulcer bed</p> <p>1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</p> <p>2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance</p> <p>3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</p> <p>4. Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</p> <p>9. None of the Above</p>
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M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry
 Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number <input type="text"/>	A. Stage 2 CATs
Enter Number <input type="text"/>	B. Stage 3 CATs
Enter Number <input type="text"/>	C. Stage 4 CATs

Section M	Skin Conditions
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M0900. Healed Pressure Ulcers
 Complete only if A0310E = 0

Enter Code <input style="width:30px; height:20px;" type="text"/>	A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Enter Number <input style="width:30px; height:20px;" type="text"/>	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input style="width:30px; height:20px;" type="text"/>	B. Stage 2
Enter Number <input style="width:30px; height:20px;" type="text"/>	C. Stage 3
Enter Number <input style="width:30px; height:20px;" type="text"/>	D. Stage 4

M1030. Number of Venous and Arterial Ulcers

Enter Number <input style="width:30px; height:20px;" type="text"/>	Enter the total number of venous and arterial ulcers present	<input style="width:30px; height:15px; border: 1px solid black;" type="text"/> <input style="width:30px; height:15px; border: 1px solid black;" type="text"/>
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M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply

Foot Problems		
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> CATs <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	B. Diabetic foot ulcer(s)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	C. Other open lesion(s) on the foot	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
Other Problems		
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	E. Surgical wound(s)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	F. Burn(s) (second or third degree)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	G. Skin tear(s)	
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> CATs
None of the Above		
<input type="checkbox"/>	Z. None of the above were present	

M1200. Skin and Ulcer Treatments

↓ Check all that apply

<input type="checkbox"/>	A. Pressure reducing device for chair	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	B. Pressure reducing device for bed	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	C. Turning/repositioning program	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	E. Pressure ulcer care	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	F. Surgical wound care	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)	<input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG III <input style="width:20px; height:15px; border: 1px solid black;" type="text"/> RUG IV
<input type="checkbox"/>	Z. None of the above were provided	

Section N	Medications
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N0300. Injections

Enter Days <input style="width: 100%;" type="text"/>	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 N0410, Medications Received RUG III
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N0350. Insulin

Enter Days <input style="width: 100%;" type="text"/>	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 RUG IV
Enter Days <input style="width: 100%;" type="text"/>	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 RUG IV

N0410. Medications Received

Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days

Enter Days <input style="width: 100%;" type="text"/>	A. Antipsychotic CATs
Enter Days <input style="width: 100%;" type="text"/>	B. Antianxiety CATs
Enter Days <input style="width: 100%;" type="text"/>	C. Antidepressant CATs
Enter Days <input style="width: 100%;" type="text"/>	D. Hypnotic CATs
Enter Days <input style="width: 100%;" type="text"/>	E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
Enter Days <input style="width: 100%;" type="text"/>	F. Antibiotic
Enter Days <input style="width: 100%;" type="text"/>	G. Diuretic

Section O Special Treatments, Procedures, and Programs

00100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

<p>1. While NOT a Resident Performed while NOT a resident of this facility and within the last 14 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank</p> <p>2. While a Resident Performed while a resident of this facility and within the last 14 days</p>	1. While NOT a Resident	2. While a Resident
↓ Check all that apply ↓		

Cancer Treatments

A. Chemotherapy	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
B. Radiation	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>

Respiratory Treatments

C. Oxygen therapy	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
D. Suctioning	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/>
E. Tracheostomy care	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
F. Ventilator or respirator	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
G. BiPAP/CPAP	<input type="checkbox"/>	<input type="checkbox"/>

Other

H. IV medications	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
I. Transfusions	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
J. Dialysis	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
L. Respite care		<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/> RUG IV <input type="checkbox"/>

None of the Above

Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>
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00250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code <input type="checkbox"/>	<p>A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?</p> <p>0. No → Skip to O0250C, If influenza vaccine not received, state reason</p> <p>1. Yes → Continue to O0250B, Date influenza vaccine received</p>
	<p>B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?</p> <p style="text-align: center;"> _____ - _____ - _____ Month Day Year </p>
Enter Code <input type="checkbox"/>	<p>C. If influenza vaccine not received, state reason:</p> <p>1. Resident not in this facility during this year's influenza vaccination season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible - medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain influenza vaccine due to a declared shortage</p> <p>9. None of the above</p>

00300. Pneumococcal Vaccine

Enter Code <input type="checkbox"/>	<p>A. Is the resident's Pneumococcal vaccination up to date?</p> <p>0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason</p> <p>1. Yes → Skip to O0400, Therapies</p>
Enter Code <input type="checkbox"/>	<p>B. If Pneumococcal vaccine not received, state reason:</p> <p>1. Not eligible - medical contraindication</p> <p>2. Offered and declined</p> <p>3. Not offered</p>

Section O**Special Treatments, Procedures, and Programs****O0400. Therapies****A. Speech-Language Pathology and Audiology Services**

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

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

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 RUG III RUG IV

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 RUG III RUG IV

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

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

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

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

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

— — — RUG IV
Month Day Year

— — — RUG IV
Month Day Year

B. Occupational Therapy

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

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

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 RUG III RUG IV

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 RUG III RUG IV

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

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

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

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

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

— — — RUG IV
Month Day Year

— — — RUG IV
Month Day Year

O0400 continued on next page

Section O Special Treatments, Procedures, and Programs

00400. Therapies - Continued

Enter Number of Minutes <input style="width:100%; height:20px;" type="text"/> Enter Number of Days <input style="width:100%; height:20px;" type="text"/>	<p>C. Physical Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days RUG III RUG IV</p> <p>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 RUG III RUG IV</p> <p>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 RUG III RUG IV</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <p>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</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days RUG III RUG IV</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started RUG IV</p> <p style="text-align:center;"> _____ Month Day Year </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing RUG IV</p> <p style="text-align:center;"> _____ Month Day Year </p> <p>D. Respiratory Therapy</p> <p>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</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days RUG III RUG IV</p> <p>E. Psychological Therapy (by any licensed mental health professional)</p> <p>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</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>F. Recreational Therapy (includes recreational and music therapy)</p> <p>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</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
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00420. Distinct Calendar Days of Therapy

Enter Number of Days <input style="width:100%; height:20px;" type="text"/>	<p>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. RUG IV</p>
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00450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code <input style="width:100%; height:20px;" type="text"/>	<p>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline? RUG IV</p> <p>0. No → Skip to O0500, Restorative Nursing Programs</p> <p>1. Yes</p> <p>B. Date on which therapy regimen resumed:</p> <p style="text-align:center;"> _____ Month Day Year </p>
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Section O Special Treatments, Procedures, and Programs

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	
<input type="text"/>	A. Range of motion (passive)	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	B. Range of motion (active)	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	C. Splint or brace assistance	<input type="text"/> RUG III <input type="text"/> RUG IV
Number of Days	Training and Skill Practice In:	
<input type="text"/>	D. Bed mobility	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	E. Transfer	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	F. Walking	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	G. Dressing and/or grooming	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	H. Eating and/or swallowing	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	I. Amputation/prostheses care	<input type="text"/> RUG III <input type="text"/> RUG IV
<input type="text"/>	J. Communication	<input type="text"/> RUG III <input type="text"/> RUG IV

O0600. Physician Examinations

Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident? <input type="text"/> RUG III
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O0700. Physician Orders

Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders? <input type="text"/> RUG III
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Section P Restraints

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

<p>Coding:</p> <ul style="list-style-type: none"> 0. Not used 1. Used less than daily 2. Used daily 	↓ Enter Codes in Boxes
	Used in Bed
	<input type="checkbox"/> A. Bed rail <input type="text" value="CATs"/>
	<input type="checkbox"/> B. Trunk restraint <input type="text" value="CATs"/>
	<input type="checkbox"/> C. Limb restraint <input type="text" value="CATs"/>
	<input type="checkbox"/> D. Other <input type="text" value="CATs"/>
	Used in Chair or Out of Bed
	<input type="checkbox"/> E. Trunk restraint <input type="text" value="CATs"/>
	<input type="checkbox"/> F. Limb restraint <input type="text" value="CATs"/>
	<input type="checkbox"/> G. Chair prevents rising <input type="text" value="CATs"/>
<input type="checkbox"/> H. Other <input type="text" value="CATs"/>	

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. Resident has no family or significant other
Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code <input type="checkbox"/>	A. Select one for resident's overall goal established during assessment process 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain

Q0400. Discharge Plan

Enter Code <input type="checkbox"/>	A. Is active discharge planning already occurring for the resident to return to the community? 0. No 1. Yes → Skip to Q0600, Referral
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Section Q**Participation in Assessment and Goal Setting****Q0490. Resident's Preference to Avoid Being Asked Question Q0500B**

Complete only if A0310A = 02, 06, or 99

Enter Code <input type="text"/>	<p>Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</p> <p>0. No 1. Yes → Skip to Q0600, Referral 8. Information not available</p>
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Q0500. Return to Community

Enter Code <input type="text"/>	<p>B. Ask the resident (or family or significant other or guardian or legally authorized representative 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?"</p> <p>0. No 1. Yes 9. Unknown or uncertain</p>
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Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again

Enter Code <input type="text"/>	<p>A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) want to be asked about returning to the community on <u>all</u> assessments? (Rather than only on comprehensive assessments.)</p> <p>0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. Yes 8. Information not available</p>
Enter Code <input type="text"/>	<p>B. Indicate information source for Q0550A</p> <p>1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 8. No information source available</p>

Q0600. Referral

Enter Code <input type="text"/>	<p>Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)</p> <p>0. No - referral not needed 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. Yes - referral made</p>	
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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- 06

Enter Code <input type="text"/>	A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment) <ol style="list-style-type: none"> 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code <input type="text"/>	B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment) <ol style="list-style-type: none"> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) 99. None of the above
	C. Prior Assessment Reference Date (A2300 value from prior assessment) <p style="text-align: center;"> — — Month Day Year </p>
Enter Score <input type="text"/>	D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment) 
Enter Score <input type="text"/>	E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment) 
Enter Score <input type="text"/>	F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment) 

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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	
09. Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
10. Activities	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dehydration/Fluid Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	
15. Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	
16. Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychotropic Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
18. Physical Restraints	<input type="checkbox"/>	<input type="checkbox"/>	
19. Pain	<input type="checkbox"/>	<input type="checkbox"/>	
20. Return to Community Referral	<input type="checkbox"/>	<input type="checkbox"/>	

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

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
<input type="text"/>	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
<input type="text"/>	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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X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code	A. Federal OBRA Reason for Assessment
<input type="text"/>	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
<input type="text"/>	PPS Scheduled Assessments for a Medicare Part A Stay
	01. 5-day scheduled assessment
	02. 14-day scheduled assessment
	03. 30-day scheduled assessment
	04. 60-day scheduled assessment
	05. 90-day scheduled assessment
	PPS Unscheduled Assessments for a Medicare Part A Stay
	07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)
	Not PPS Assessment
	99. None of the above

Enter Code	C. PPS Other Medicare Required Assessment - OMRA
<input type="text"/>	0. No
	1. Start of therapy assessment
	2. End of therapy assessment
	3. Both Start and End of therapy assessment
	4. Change of therapy assessment

X0600 continued on next page

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

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

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

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

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

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

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

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

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

Section X

Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month Day Year

Section Z**Assessment Administration****Z0100. Medicare Part A Billing**

Enter Code <input style="width: 40px; height: 20px;" type="text"/>	A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):
	B. RUG version code:
	C. Is this a Medicare Short Stay assessment? 0. No 1. Yes

Z0150. Medicare Part A Non-Therapy Billing

	A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):
	B. RUG version code:

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

	A. RUG Case Mix group:
	B. RUG version code:

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

	A. RUG Case Mix group:
	B. RUG version code:

Z0300. Insurance Billing

	A. RUG billing code:
	B. RUG billing version:

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

<p>A. Signature:</p>	<p>B. Date RN Assessment Coordinator signed assessment as complete:</p> <p style="text-align: center;"> _____ Month Day Year </p>
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