



**Section A****Identification Information****A0410. Submission Requirement**

Enter Code

1. **Neither federal nor state required submission** (e.g. HMO, other insurance, etc.)
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

**A0500. Legal Name of Resident****A. First Name:****B. Middle Initial:****C. Last Name:****D. Suffix:****A0600. Social Security and Medicare Numbers****A. Social Security Number:****B. Medicare number** (or comparable railroad insurance number):**A0700. Medicaid Number** – Enter “+” if pending, “N” if not a Medicaid recipient**A0800. Gender**

Enter Code

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

**A0900. Birth Date**

<input type="text"/>							
month		day		year			

**A1000. Race/Ethnicity**

Complete only if A0310F = 1

↓ Check all that apply

**A. American Indian or Alaska Native****B. Asian****C. Black or African American****D. Hispanic or Latino****E. Native Hawaiian or Other Pacific Islander****F. White****A1100. Language**

Enter Code

**A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?**0. **No**1. **Yes** → Specify in A1100B, Preferred Language9. **Unable to determine****B. Preferred Language**



**Section A****Identification Information****A2000. Discharge Date**

<input type="text"/>					
month		day	year		

**A2100. Discharge Status**

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. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

**A2200. Previous Assessment Reference Date for Significant Correction**

Complete only if A0310A = 05 or 06

<input type="text"/>					
month		day	year		

**A2300. Assessment Reference Date**

Observation end date:

<input type="text"/>					
month		day	year		

**A2400. Medicare Stay**

Enter Code

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

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

**B. Start date of most recent Medicare stay:**

<input type="text"/>					
month		day	year		

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

<input type="text"/>					
month		day	year		

**Look back period for all items is 7 days unless another time frame is indicated.**

**Section B****Hearing, Speech, and Vision****B0100. Comatose**

Enter Code

**Persistent vegetative state/no discernible consciousness**

0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0100, Activities of Daily Living (ADL) Assistance

**B0200. Hearing**

Enter Code

**Ability to hear** (with hearing aid or hearing appliances if normally used)

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

**B0300. Hearing Aid**

Enter Code

**Hearing aid or other hearing appliance used** in completing B0200, Hearing

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

**B0600. Speech Clarity**

Enter Code

**Select best description of speech pattern**

0. **Clear speech** – distinct intelligible words
1. **Unclear speech** – slurred or mumbled words
2. **No speech** – absence of spoken words

**B0700. Makes Self Understood**

Enter Code

**Ability to express ideas and wants**, consider both verbal and non-verbal expression

0. **Understood**
1. **Usually understood** – difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** – ability is limited to making concrete requests
3. **Rarely/never understood**

**B0800. Ability To Understand Others**

Enter Code

**Understanding verbal content, however able** (with hearing aid or device if used)

0. **Understands** – clear comprehension
1. **Usually understands** – misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** – responds adequately to simple, direct communication only
3. **Rarely/never understands**

**B1000. Vision**

Enter Code

**Ability to see in adequate light** (with glasses or other visual appliances)

0. **Adequate** – sees fine detail, including regular print in newspapers/books
1. **Impaired** – sees large print, but not regular print in newspapers/books
2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** – object identification in question, but eyes appear to follow objects
4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

**B1200. Corrective Lenses**

Enter Code

**Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision

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

**Section C****Cognitive Patterns****C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**

Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C0700 – C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

**Brief Interview for Mental Status (BIMS)****C0200. Repetition of Three Words**

Enter Code

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

**Number of words repeated after first attempt**

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

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

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

Enter Code

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

**A. Able to report correct year**

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

Enter Code

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

**B. Able to report correct month**

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

Enter Code

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

**C. Able to report correct day of the week**

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

**C0400. Recall**

Enter Code

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

**A. Able to recall "sock"**

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

Enter Code

**B. Able to recall "blue"**

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

Enter Code

**C. Able to recall "bed"**

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

**C0500. Summary Score**

Enter Score

**Add scores** for questions C0200–C0400 and fill in total score (00–15)**Enter 99 if unable to complete one or more questions of the interview**

**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

**Staff Assessment for Mental Status**

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

**C0700. Short-term Memory OK**

Enter Code

**Seems or appears to recall after 5 minutes.**

0. **Memory OK**  
 1. **Memory problem**

**C0800. Long-term Memory OK**

Enter Code

**Seems or appears to recall long past.**

0. **Memory OK**  
 1. **Memory problem**

**C0900. Memory/Recall Ability**

↓ Check all that the resident was normally able to recall

**A. Current season****B. Location of own room****C. Staff names and faces****D That 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

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

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

↓ Enter Codes in Boxes

**Coding:**

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

**A. Inattention** – Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?**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)?**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)**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**

**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 – D0650, 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**

0. **No** (Enter 0 in column 2)
1. **Yes** (Enter 0-3 in column 2)
9. **No Response** (Leave column 2 blank)

**2. Symptom Frequency**

0. **Never or 1 Day**
1. **2–6 Days** (Several days)
2. **7–11 Days** (Half or more of the days)
3. **12–14 Days** (Nearly every day)

1. Symptom Presence	2. Symptom Frequency
↓ Enter Scores in Boxes ↓	

**A. Little interest or pleasure in doing things****B. Feeling down, depressed, or hopeless****C. Trouble falling or staying asleep, or sleeping too much****D. Feeling tired or having little energy****E. Poor appetite or overeating****F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down****G. Trouble concentrating on things, such as reading the newspaper or watching television****H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual****I. Thoughts that you would be better off dead, or of hurting yourself in some way****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. Follow-Up to D0200I** – 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**

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**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**

0. **No** (Enter 0 in column 2)  
 1. **Yes** (Enter 0-3 in column 2)

**2. Symptom Frequency**

0. **Never or 1 Day**  
 1. **2-6 Days** (Several days)  
 2. **7-11 Days** (Half or more of the days)  
 3. **12-14 Days** (Nearly every day)

1. Symptom Presence	2. Symptom Frequency
---------------------------	----------------------------

↓ Enter Scores in Boxes ↓

A. Little interest or pleasure in doing things

B. Feeling or appearing down, depressed, or hopeless

C. Trouble falling or staying asleep, or sleeping too much

D. Feeling tired or having little energy

E. Poor appetite or overeating

F. Indicating that s/he feels bad about self, is a failure, or has let self or family down

G. Trouble concentrating on things, such as reading the newspaper or watching television

H. Moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that s/he has been moving around a lot more than usual

I. States that life isn't worth living, wishes for death, or attempts to harm self

J. Being short-tempered, easily annoyed

**D0600. Total Severity Score**

Enter Score

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

**D0650. Follow-Up to D0500I – 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**

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**Section E****Behavior****E0100. Psychosis**

↓ Check all that apply

- A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- B. Illusions** (misperceptions in the presence of real external sensory stimuli)
- C. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- Z. None of the above**

**Behavioral Symptoms****E0200. Behavioral Symptom – Presence & Frequency**

Note presence of symptoms and their frequency

	↓ Enter Codes in Boxes
<b>Coding:</b>	<input type="checkbox"/> <b>A. Physical behavioral symptoms directed toward others</b> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
0. Behavior not exhibited	<input type="checkbox"/> <b>B. Verbal behavioral symptoms directed toward others</b> (e.g., threatening others, screaming at others, cursing at others)
1. Behavior of this type occurred 1 to 3 days	<input type="checkbox"/> <b>C. Other behavioral symptoms not directed toward others</b> (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)
2. Behavior of this type occurred 4 to 6 days, but less than daily	
3. Behavior of this type occurred daily	

**E0300. Overall Presence of Behavioral Symptoms**

Enter Code	<b>Were any behavioral symptoms in questions E0200 coded 1, 2 or 3?</b>
<input type="checkbox"/>	0. <b>No</b> → Skip to E0800, Rejection of Care
	1. <b>Yes</b> → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

**E0500. Impact on Resident**

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

**E0600. Impact on Others**

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

**E0800. Rejection of Care – Presence & Frequency**

	<b>Did the resident reject evaluation or care</b> (e.g., bloodwork, taking medications, ADL assistance) <b>that is necessary to achieve the resident's goals for health and well-being?</b> Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.
Enter Code	0. <b>Behavior not exhibited</b>
<input type="checkbox"/>	1. <b>Behavior of this type occurred 1 to 3 days</b>
	2. <b>Behavior of this type occurred 4 to 6 days, but less than daily</b>
	3. <b>Behavior of this type occurred daily</b>

**Section E****Behavior****E0900. Wandering – Presence & Frequency**

Enter Code

**Has the resident wandered?**

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

**E1000. Wandering – Impact**

Enter Code

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

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

Enter Code

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

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

**E1100. Change in Behavioral or Other Symptoms**

Consider all of the symptoms assessed in items E0100 through E1000.

Enter Code

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

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

**Section F****Preferences for Customary Routine and Activities**

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

Enter Code

0. **No** (resident is rarely/never understood and family 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...**”

↓ Enter Codes in Boxes

Coding:

1. Important
2. Not important
3. Important, but can't do or no choice
9. No response or non-responsive

A. how important is it to you to **choose what clothes to wear?**B. how important is it to you to **take care of your personal belongings or things?**C. how important is it to you to **choose between a tub bath, shower, bed bath, or sponge bath?**D. how important is it to you to **have snacks available between meals?**E. how important is it to you to **choose your own bedtime?**F. how important is it to you to **have your family or a close friend involved in discussions about your care?**G. how important is it to you to **be able to use the phone in private?**H. how important is it to you to **have a place to lock your things to keep them safe?****F0500. Interview for Activity Preferences**

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

↓ Enter Codes in Boxes

Coding:

1. Important
2. Not important
3. Important, but can't do or no choice
9. No response or non-responsive

A. how important is it to you to have **books, newspapers, and magazines to read?**B. how important is it to you to **listen to music you like?**C. how important is it to you to **be around animals such as pets?**D. how important is it to you to **keep up with the news?**E. how important is it to you to **do things with groups of people?**F. how important is it to you to **do your favorite activities?**G. how important is it to you to **go outside to get fresh air when the weather is good?**H. how important is it to you to **participate in religious services or practices?****F0600. Daily and Activity Preferences Primary Respondent**

Enter Code

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

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



**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 G0100, 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"/> | M. Listening to music  |
| <input type="checkbox"/> | N. Being around animals such as pets                           |
| <input type="checkbox"/> | O. Keeping up with the news                                    |
| <input type="checkbox"/> | P. Doing things with groups of people                          |
| <input type="checkbox"/> | Q. Participating in favorite activities                        |
| <input type="checkbox"/> | R. Spending time away from the nursing home                    |
| <input type="checkbox"/> | S. Spending time outdoors                                      |
| <input type="checkbox"/> | T. Participating in religious activities or practices          |
| <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

**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
- 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 (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

**2. ADL Support Provided**

Code 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 during entire period

	1.Self-Performance	2.Support
↓ Enter Codes in Boxes ↓		
<b>A. Bed mobility</b> – how resident moves to and from lying position, turns side to side, and positions body while in bed	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Transfer</b> – how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position ( <b>excludes</b> to/from bath/toilet)	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Walk in room</b> – how resident walks between locations in his/her room	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Walk in corridor</b> – how resident walks in corridor on unit	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Locomotion on unit</b> – how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Locomotion off unit</b> – how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). <b>If facility has only one floor</b> , how resident moves to and from distant areas on the floor. If in wheel chair, self-sufficiency once in chair	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Dressing</b> – 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	<input type="checkbox"/>	<input type="checkbox"/>
<b>H. Eating</b> – 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)	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Toilet use</b> – 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 or bedside commode	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Personal hygiene</b> – how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands ( <b>excludes</b> baths and showers)	<input type="checkbox"/>	<input type="checkbox"/>

**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="checkbox"/>	<p><b>A. Self-performance</b></p> <ul style="list-style-type: none"> <li>0. <b>Independent</b> – no help provided</li> <li>1. <b>Supervision</b> – oversight help only</li> <li>2. <b>Physical help limited to transfer only</b></li> <li>3. <b>Physical help in part of bathing activity</b></li> <li>4. <b>Total dependence</b></li> <li>8. <b>Activity itself did not occur</b> during the entire period</li> </ul>
Enter Code <input type="checkbox"/>	<p><b>B. Support provided</b> (Bathing support codes are as defined in Item <b>G0110 column 2, ADL Support Provided</b>, above)</p>

**Section G****Functional Status****G0300. Balance During Transitions and Walking**After observing the resident, **code the following walking and transition items for most dependent**

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

**G0400. Functional Limitation in Range of Motion**

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

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

**G0600. Mobility Devices**

↓ Check all that were normally used

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

**G0900. Functional Rehabilitation Potential**

Complete only if A0310F = 1

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

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

↓ Check all that apply

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

**H0200. Urinary Toileting Program**

- |  |   |
|--|---|
| Enter Code<br><input type="checkbox"/> | <b>A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility?</b><br>0. <b>No</b> → Skip to H0300, Urinary Continence<br>1. <b>Yes</b> → Continue to H0200B, Response<br>9. <b>Unable to determine</b> → Skip to H0200C, Current toileting program or trial |
| Enter Code<br><input type="checkbox"/> | <b>B. Response</b> – What was the resident's response to the trial program?<br>0. <b>No improvement</b><br>1. <b>Decreased wetness</b><br>2. <b>Completely dry</b> (continent)<br>9. <b>Unable to determine</b> or trial in progress  |
| Enter Code<br><input type="checkbox"/> | <b>C. Current toileting program or trial</b> – Is a toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?<br>0. <b>No</b><br>1. <b>Yes</b>  |

**H0300. Urinary Continence**

- |  |  |
|--|--|
| Enter Code<br><input type="checkbox"/> | <b>Urinary continence</b> – Select the one category that best describes the resident<br>0. <b>Always continent</b><br>1. <b>Occasionally incontinent</b> (less than 7 episodes of incontinence)<br>2. <b>Frequently incontinent</b> (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)<br>3. <b>Always incontinent</b> (no episodes of continent voiding)<br>9. <b>Not rated</b> , resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days |
|--|--|

**H0400. Bowel Continence**

- |  |  |
|--|--|
| Enter Code<br><input type="checkbox"/> | <b>Bowel continence</b> – Select the one category that best describes the resident<br>0. <b>Always continent</b><br>1. <b>Occasionally incontinent</b> (one episode of bowel incontinence)<br>2. <b>Frequently incontinent</b> (2 or more episodes of bowel incontinence, but at least one continent bowel movement)<br>3. <b>Always incontinent</b> (no episodes of continent bowel movements)<br>9. <b>Not rated</b> , resident had an ostomy or did not have a bowel movement for the entire 7 days |
|--|--|

**H0500. Bowel Toileting Program**

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

**H0600. Bowel Patterns**

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

**Section I****Active Disease Diagnosis****Active Diseases in the last 7 days – Check all that apply**

<input type="checkbox"/>	<b>Cancer</b>
<input type="checkbox"/>	<b>I0100. Cancer</b> (with or without metastasis)
<input type="checkbox"/>	<b>Heart/Circulation</b>
<input type="checkbox"/>	<b>I0200. Anemia</b> (includes aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	<b>I0300. Atrial Fibrillation and Other Dysrhythmias</b> (includes bradycardias, tachycardias)
<input type="checkbox"/>	<b>I0400. Coronary Artery Disease (CAD)</b> (includes angina, myocardial infarction, atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	<b>I0500. Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE)</b>
<input type="checkbox"/>	<b>I0600. Heart Failure</b> (includes congestive heart failure (CHF), pulmonary edema)
<input type="checkbox"/>	<b>I0700. Hypertension</b>
<input type="checkbox"/>	<b>I0800. Ortho-Static Hypotension</b>
<input type="checkbox"/>	<b>I0900. Peripheral Vascular Disease/Peripheral Arterial Disease</b>
<input type="checkbox"/>	<b>Gastrointestinal</b>
<input type="checkbox"/>	<b>I1100. Cirrhosis</b>
<input type="checkbox"/>	<b>I1200. Gastroesophageal Reflux Disease (GERD)/Ulcer</b> (includes esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	<b>I1300. Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease</b>
<input type="checkbox"/>	<b>Genitourinary</b>
<input type="checkbox"/>	<b>I1400. Benign Prostatic Hyperplasia (BPH)</b>
<input type="checkbox"/>	<b>I1500. Renal Insufficiency or Renal Failure/End-Stage Renal Disease (ESRD)</b>
<input type="checkbox"/>	<b>I1550. Neurogenic Bladder</b>
<input type="checkbox"/>	<b>I1650. Obstructive Uropathy</b>
<input type="checkbox"/>	<b>Infections</b>
<input type="checkbox"/>	<b>I1700. Multi-Drug Resistant Organism (MDRO)</b>
<input type="checkbox"/>	<b>I2000. Pneumonia</b>
<input type="checkbox"/>	<b>I2100. Septicemia</b>
<input type="checkbox"/>	<b>I2200. Tuberculosis</b>
<input type="checkbox"/>	<b>I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)</b>
<input type="checkbox"/>	<b>I2400. Viral Hepatitis</b> (includes Hepatitis A, B, C, D, & E)
<input type="checkbox"/>	<b>I2500. Wound infection</b> (other than foot)
<input type="checkbox"/>	<b>Metabolic</b>
<input type="checkbox"/>	<b>I2900. Diabetes Mellitus (DM)</b> (includes diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	<b>I3100. Hyponatremia</b>
<input type="checkbox"/>	<b>I3200. Hyperkalemia</b>
<input type="checkbox"/>	<b>I3300. Hyperlipidemia</b> (includes hypercholesterolemia)
<input type="checkbox"/>	<b>I3400. Thyroid Disorder</b> (includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	<b>Musculoskeletal</b>
<input type="checkbox"/>	<b>I3700. Arthritis</b> (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
<input type="checkbox"/>	<b>I3800. Osteoporosis</b>
<input type="checkbox"/>	<b>I3900. Hip Fracture</b> (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck)
<input type="checkbox"/>	<b>I4000. Other Fracture</b>
<input type="checkbox"/>	<b>Neurological</b>
<input type="checkbox"/>	<b>I4200. Alzheimer's Disease</b>
<input type="checkbox"/>	<b>I4300. Aphasia</b>
<input type="checkbox"/>	<b>I4400. Cerebral Palsy</b>
<input type="checkbox"/>	<b>I4500. Cerebrovascular Accident (CVA)/Transient Ischemic Attack (TIA)/Stroke</b>
<input type="checkbox"/>	<b>I4800. Dementia</b> (Non-Alzheimer's dementia, including vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia (e.g., Pick's disease), and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
<input type="checkbox"/>	<b>I4900. Hemiplegia/Hemiparesis</b>
<input type="checkbox"/>	<b>I5000. Paraplegia</b>

**Section I Active Disease Diagnosis**

<b>Neurological - Continued</b>									
<input type="checkbox"/>	<b>I5100. Quadriplegia</b>								
<input type="checkbox"/>	<b>I5200. Multiple Sclerosis</b>								
<input type="checkbox"/>	<b>I5250. Huntington's Disease</b>								
<input type="checkbox"/>	<b>I5300. Parkinson's Disease</b>								
<input type="checkbox"/>	<b>I5350. Tourette's Syndrome</b>								
<input type="checkbox"/>	<b>I5400. Seizure Disorder</b>								
<input type="checkbox"/>	<b>I5500. Traumatic Brain Injury</b>								
<b>Nutritional</b>									
<input type="checkbox"/>	<b>I5600. Malnutrition</b> (protein or calorie) or at risk for malnutrition								
<b>Psychiatric/Mood Disorder</b>									
<input type="checkbox"/>	<b>I5700 Anxiety Disorder</b>								
<input type="checkbox"/>	<b>I5800. Depression</b> (other than Bipolar)								
<input type="checkbox"/>	<b>I5900. Manic Depression</b> (Bipolar Disease)								
<input type="checkbox"/>	<b>I5950. Psychotic Disorder</b> (other than Schizophrenia)								
<input type="checkbox"/>	<b>I6000. Schizophrenia</b> (including Schizoaffective and Schizophreniform disorders)								
<input type="checkbox"/>	<b>I6100. Post Traumatic Stress Disorder (PTSD)</b>								
<b>Pulmonary</b>									
<input type="checkbox"/>	<b>I6200. Asthma/Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease</b> (includes chronic bronchitis and restrictive lung diseases such as asbestosis)								
<b>Vision</b>									
<input type="checkbox"/>	<b>I6500. Cataracts, Glaucoma, or Macular Degeneration</b>								
<b>None of Above</b>									
<input type="checkbox"/>	<b>I7900. None of the above active diagnoses</b> within the last 7 days								
<b>Other</b>									
<input type="checkbox"/>	<b>I8000. Additional Active Diagnoses</b>								
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.									
A. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
B. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
C. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
D. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
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G. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
H. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
I. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								
J. _____	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 15px;"> </td><td style="width: 15px;"> </td> </tr> </table>								

**Section J****Health Conditions****J0100. Pain Management** – Complete for all residents, regardless of current pain level

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

Enter Code  **A. Been on a scheduled pain medication regimen?**  
 0. No  
 1. Yes

Enter Code  **B. Received PRN pain medications?**  
 0. No  
 1. Yes

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

**J0200. Should Pain Assessment Interview be Conducted?**

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

Enter Code  0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain  
 1. **Yes** → Continue to J0300, Pain Presence

**Pain Assessment Interview****J0300. Pain Presence**

Enter Code  Ask resident: ***“Have you had pain or hurting at any time in the last 5 days?”***  
 0. **No** → Skip to J1100, Shortness of Breath  
 1. **Yes** → Continue to J0400, Pain Frequency  
 9. **Unable to answer** → Skip to J0800, Indicators of Pain

**J0400. Pain Frequency**

Enter Code  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  **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  **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   **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 0–10 pain scale.)  
**Enter two-digit response. Enter 99 if unable to answer.**

Enter Code  **B. Verbal Descriptor Scale**  
 Ask resident: ***“Please rate the intensity of your worst pain over the last 5 days.”*** (Show resident verbal scale.)  
 1. **Mild**  
 2. **Moderate**  
 3. **Severe**  
 4. **Very severe, horrible**  
 9. **Unable to answer**

**Section J****Health Conditions****J0700. Should the Staff Assessment for Pain be Conducted?**

Enter Code

0. **No** (J0300=0 or J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)  
 1. **Yes** (J0200=0 or J0300=9 or J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain

**Staff Assessment for Pain****J0800. Indicators of Pain or Possible Pain**

↓ Check all that apply

- A. Non-verbal sounds** (crying, whining, gasping, moaning, or groaning)  
 **B. Vocal complaints of pain** (that hurts, ouch, stop)  
 **C. Facial expressions** (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)  
 **D. Protective body movements or postures** (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)  
 **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

**J0850. Frequency of Indicator of Pain or Possible Pain**

Enter Code

Frequency with which resident complains or shows evidence of pain

1. Indicators of pain observed **1 to 3 days**  
 2. Indicators of pain observed **4 to 6 days**  
 3. Indicators of 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**  
 **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**  
 **B. Vomiting**  
 **C. Dehydrated**  
 **D. Internal bleeding**  
 **Z. None of the above**

**Section J****Health Conditions****J1700. Fall History on Admission**

If A0310F = 0 → Skip to J1800, Any Falls Since Last Assessment

Enter Code

- A.** Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
  1. **Yes**
  9. **Unable to determine**

Enter Code

- B.** Did the resident have a fall any time in the **last 2–6 months** prior to admission?
0. **No**
  1. **Yes**
  9. **Unable to determine**

Enter Code

- C.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
  1. **Yes**
  9. **Unable to determine**

**J1800. Any Falls Since Admission or Prior Assessment (OBRA or PPS), whichever is more recent**

Enter Code

- Has the resident **had any falls since admission or the prior assessment** (OBRA or PPS), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
  1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA or PPS), whichever is more recent

**J1900. Number of Falls Since Admission or Prior Assessment (OBRA or PPS), whichever is more recent****Coding:**

0. **None**
1. **One**
2. **Two or more**

Enter Code

- 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

Enter Code

- 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

Enter Code

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

**Section K****Swallowing/Nutritional Status****K0100. Swallowing Disorder**

Signs and symptoms of possible swallowing disorder

↓ Check all that apply

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

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

--	--

inches

A. **Height** (in inches). Record most recent height measure since admission.

--	--	--

pounds

B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.).**K0300. Weight Loss**

Enter Code

**Loss of 5% or more in the last month or loss of 10% or more in last 6 months.**

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

**K0500. Nutritional Approaches**

↓ Check all that apply

- A. Parenteral/IV feeding
- B. Feeding-tube – nasogastric or abdominal (PEG)
- C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- Z. None of the above

**K0700. Percent Intake by Artificial Route** – Complete K0700 only if K0500A or K0500B is checked

Enter Code

A. Proportion of total calories the resident received through parenteral or tube feedings

1. 25% or less
2. 26–50%
3. 51% or more

Enter Code

B. Average fluid intake per day by IV or tube feeding

1. 500 cc/day or less
2. 501 cc/day or more

**Section L****Oral/Dental Status****L0200. Dental**

↓ Check all that apply

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

**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?

0. No  
1. Yes

**M0210. Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

Enter Code

0. No → skip to M0900, Healed Pressure Ulcers  
1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

**M0300. Current Number of Unhealed (non-epithelialized) 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 serum-filled blister

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

Enter Number

2. **Number of Stage 2 pressure ulcers that were present upon admission/reentry** – enter how many were noted within 48 hours of admission/reentry and not acquired in the facility

**3. Date of oldest Stage 2 pressure ulcer:**

-   -

month      day      year

Enter Number

**C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

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

Enter Number

2. **Number of Stage 3 pressure ulcers that were present upon admission/reentry** – enter how many were noted within 48 hours of admission/reentry and not acquired in the facility

Enter Number

**D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

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

Enter Number

2. **Number of Stage 4 pressure ulcers that were present upon admission/reentry** – enter how many were noted within 48 hours of admission/reentry and not acquired in the facility

**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"/>	<b>E. Unstageable – Non-removable dressing:</b> Known or likely but not stageable due to non-removable dressing/device <b>1. Number of unstageable pressure ulcers due to non-removable dressing/device</b> → If 0, skip to M0300F, Unstageable: Slough and/or eschar  <b>2. Number of these unstageable pressure ulcers that were present upon admission/reentry</b> – enter how many were noted within 48 hours of admission/reentry and not acquired in the facility
Enter Number <input type="text"/>	
Enter Number <input type="text"/>	<b>F. Unstageable – Slough and/or eschar:</b> Known or likely but not stageable due to coverage of wound bed by slough and/or eschar <b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> → If 0, skip to M0300G, Unstageable: Deep tissue  <b>2. Number of these unstageable pressure ulcers that were present upon admission/reentry</b> – enter how many were noted within 48 hours of admission/reentry and not acquired in the facility
Enter Number <input type="text"/>	
Enter Number <input type="text"/>	<b>G. Unstageable – Deep tissue:</b> Suspected deep tissue injury in evolution. <b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> → If 0, skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  <b>2. Number of these unstageable pressure ulcers that were present upon admission/reentry</b> – enter how many were noted within 48 hours of admission and not acquired in the facility
Enter Number <input type="text"/>	

**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 (non-epithelialized) Stage 3 or 4 pressure ulcers or an eschar, identify the pressure ulcers with the largest surface area (length x width) and record in centimeters:

<input type="text"/> <input type="text"/> <input type="text"/> cm	<b>A. Pressure Ulcer Length:</b> Longest length from head to toe
<input type="text"/> <input type="text"/> <input type="text"/> cm	<b>B. Pressure Ulcer Width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> <input type="text"/> <input type="text"/> cm	<b>C. Pressure Ulcer Depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

Enter Code <input type="text"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed <b>1. Epithelial Tissue</b> – new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin. <b>2. Granulation Tissue</b> – pink or red tissue with shiny, moist, granular appearance <b>3. Slough</b> – yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous <b>4. Necrotic Tissue (Eschar)</b> – black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
------------------------------------	--

**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or PPS)**

If A0310F = 1 → Skip to M1030, Number of Venous and Arterial Ulcers

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

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

**Section M****Skin Conditions****M0900. Healed Pressure Ulcers**

If A0310F = 1 → Skip to M1030, Number of Venous and Arterial Ulcers

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

**M1030. Number of Venous and Arterial Ulcers**

Enter Number <input type="checkbox"/>	Enter the total number of venous and arterial ulcers present
--	--

**M1040. Other Ulcers, Wounds and Skin Problems**

↓ Check all that apply

<b>Foot Problems</b>	
<input type="checkbox"/>	<b>A. Infection of the foot</b> (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	<b>B. Diabetic foot ulcer(s)</b>
<input type="checkbox"/>	<b>C. Other open lesion(s) on the foot</b>
<b>Other Problems</b>	
<input type="checkbox"/>	<b>D. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
<input type="checkbox"/>	<b>E. Surgical wound(s)</b>
<input type="checkbox"/>	<b>F. Burn(s)</b> (second or third degree)
<b>None of the Above</b>	
<input type="checkbox"/>	<b>Z. None of the above</b> were present

**M1200. Skin and Ulcer Treatments**

↓ Check all that apply

<input type="checkbox"/>	<b>A. Pressure reducing device for chair</b>
<input type="checkbox"/>	<b>B. Pressure reducing device for bed</b>
<input type="checkbox"/>	<b>C. Turning/repositioning program</b>
<input type="checkbox"/>	<b>D. Nutrition or hydration intervention</b> to manage skin problems
<input type="checkbox"/>	<b>E. Ulcer care</b>
<input type="checkbox"/>	<b>F. Surgical wound care</b>
<input type="checkbox"/>	<b>G. Application of dressings</b> (with or without topical medications) other than to feet
<input type="checkbox"/>	<b>H. Applications of ointments/medications</b> other than to feet
<input type="checkbox"/>	<b>I. Application of dressings to feet</b> (with or without topical medications)
<input type="checkbox"/>	<b>Z. None of the above</b> were provided

**Section N****Medications****N0300. Injections**

Enter Days

Record the **number of days that injections of any type were received** during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received**N0350. Insulin**

Enter Days

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

Enter Days

**B. Orders for insulin** – Record the **number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/reentry if less than 7 days**N0400. Medications Received**

↓ Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days

**A. Antipsychotic****B. Antianxiety****C. Antidepressant****D. Hypnotic****E. Anticoagulant** (warfarin, heparin, or low-molecular weight heparin)**F. Antibiotic****G. Diuretic****Z. None of the above were received**

**Section O Special Treatments and Procedures**

**O0100. Special Treatments and Programs**  
 Check all of the following treatments, programs and procedures that were performed during the last 14 days

<b>1. While NOT a Resident</b> Procedure performed <i>while NOT a resident</i> of this facility and within the <b>last 14 days</b> . 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.  <b>2. While a Resident</b> Procedure performed <i>while a resident</i> of this facility and within the <b>last 14 days</b> .	<b>1. While NOT a Resident</b>	<b>2. While a Resident</b>
↓ Check all that apply ↓		

<b>Cancer Treatments</b>		
<b>A. Chemotherapy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Radiation</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Treatments</b>		
<b>C. Oxygen Therapy</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Suctioning</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Tracheostomy Care</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Ventilator or respirator</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>G BIPAP/CPAP</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>		
<b>H. IV medications</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Transfusions</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Dialysis</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>K. Hospice care</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>L. Respite care</b>		<input type="checkbox"/>
<b>M. Isolation or quarantine for active infectious disease</b> (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Z. None of the above</b>	<input type="checkbox"/>	<input type="checkbox"/>

**O0250. Influenza Vaccine – Refer to current version of RAI manual for current flu season and reporting period**

Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Did the resident receive the Influenza Vaccine <u>in this facility</u> for this year's Influenza season?</b> 0. <b>No</b> → Skip to O0250C, If Influenza Vaccine not received, state reason 1. <b>Yes</b> → Continue to O0250B, Date Vaccine Received
	<b>B. Date Vaccine Received</b> → Complete date and skip to O0300A, Is the resident's Pneumococcal Vaccination up to date? <div style="display: flex; align-items: center; margin-top: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="margin-left: 5px;">month      year</div> </div>
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>C. If Influenza Vaccine not received, state reason:</b> 1. <b>Resident not in facility</b> during this year's flu season 2. <b>Received outside of this facility</b> 3. <b>Not eligible</b> – medical contraindication 4. <b>Offered and declined</b> 5. <b>Not offered</b> 6. <b>Inability to obtain vaccine</b> due to a declared shortage 9. <b>None of the above</b>

**O0300. Pneumococcal Vaccine**

Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Is the resident's Pneumococcal Vaccination up to date?</b> 0. <b>No</b> → Continue to O0300B, If Pneumococcal Vaccine not received, state reason 1. <b>Yes</b> → Skip to O0400, Therapies
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>B. If Pneumococcal Vaccine not received, state reason:</b> 1. <b>Not eligible</b> – medical contraindication 2. <b>Offered and declined</b> 3. <b>Not offered</b>

**Section O****Special Treatments and Procedures****O0400. Therapies**

Record the **total number of minutes** each of the following therapies was administered in the last 7 days in Column 1, Minutes.

Record the **number of days** each therapy was administered, for at least 15 minutes a day in the last 7 days, in Column 2, Days.

Record the **dates** the most recent therapy regimen (since the last assessment) started and ended in Columns 3, Therapy Start Date, and 4, Therapy End Date.

	<b>1. Minutes</b> (if minutes = 0000, leave columns 2, 3 and 4 blank)	<b>2. Days</b>	<b>3. Therapy Start Date</b> (most recent regimen since last assessment) mm/dd/yyyy	<b>4. Therapy End Date</b> (enter dashes if therapy is ongoing) mm/dd/yyyy
<b>A. Speech/language pathology and audiology services</b>	<input type="text"/>	<input type="checkbox"/>	___/___/___	___/___/___
<b>B. Occupational Therapy</b>	<input type="text"/>	<input type="checkbox"/>	___/___/___	___/___/___
<b>C. Physical Therapy</b>	<input type="text"/>	<input type="checkbox"/>	___/___/___	___/___/___
<b>D. Respiratory Therapy</b>	<input type="text"/>	<input type="checkbox"/>		
<b>E. Psychological Therapy (by any licensed mental health professional)</b>	<input type="text"/>	<input type="checkbox"/>		
<b>F. Recreational Therapy (includes recreational and music therapy)</b>	<input type="text"/>	<input type="checkbox"/>		

**O0500. Restorative Nursing Care**

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

<b>Number of Days</b>	<b>Technique</b>
<input type="checkbox"/>	<b>A. Range of motion (passive)</b>
<input type="checkbox"/>	<b>B. Range of motion (active)</b>
<input type="checkbox"/>	<b>C. Splint or brace assistance</b>
<b>Number of Days</b>	<b>Training and skill practice in:</b>
<input type="checkbox"/>	<b>D. Bed mobility</b>
<input type="checkbox"/>	<b>E. Transfer</b>
<input type="checkbox"/>	<b>F. Walking</b>
<input type="checkbox"/>	<b>G. Dressing and/or grooming</b>
<input type="checkbox"/>	<b>H. Eating and/or swallowing</b>
<input type="checkbox"/>	<b>I. Amputation/prostheses care</b>
<input type="checkbox"/>	<b>J. Communication</b>

**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?
------------------------------------	---

**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?
------------------------------------	---

**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.

↓ Enter Codes in Boxes

**Used in Bed****A. Bed rail****B. Trunk restraint****C. Limb restraint****D. Other****Used in Chair or Out of Bed****E. Trunk restraint****F. Limb restraint****G. Chair prevents rising****H. Other****Coding:**

0. Not used

1. Used less than daily

2. Used daily

**Section Q****Participation in Assessment and Goal Setting****Q0100. Participation in Assessment**

Enter Code

**A. Resident participated in assessment**

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

Enter Code

**B. Family or significant other participated in assessment**

- 0. **No**
- 1. **Yes**
- 9. **No family or significant other**

Enter Code

**C. Guardian or legally authorized representative participated in assessment**

- 0. **No**
- 1. **Yes**
- 9. **No guardian or legally authorized representative**

**Q0300. Resident's Overall Expectation**

Complete only if A0310F = 1

Enter Code

**A. 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

**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. **None of the above**

**Q0400. Discharge Plan**

Enter Code

**A. Is there an active discharge plan in place for the resident to return to the community?**

- 0. **No**
- 1. **Yes** → Skip to Q0600, Referral

Enter Code

**B. What determination was made by the resident and the care planning team regarding discharge to the community?**

- 0. **Determination not made**
- 1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
- 2. **Discharge to community determined to be not feasible** → Skip to next active section (T, V, or X)

**Q0500. Return to Community**

Enter Code

**A. Has the resident been asked about returning to the community?**

- 0. **No**
- 1. **Yes** – previous response was “**no**”
- 2. **Yes** – previous response was “**yes**” → Skip to Q0600, Referral
- 3. **Yes** – previous response was “**unknown**”

Enter Code

**B. Ask the resident (or family or significant other if resident is unable to respond): “Do you want to talk to someone about the possibility of returning to the community?”**

- 0. **No**
- 1. **Yes**
- 9. **Unknown or uncertain**

**Q0600. Referral**

Enter Code

**Has a referral been made to the Local Contact Agency?**

- 0. **No** – determination has been made by the resident and the care planning team that contact is not required
- 1. **No** – referral not made
- 2. **Yes**

**Section T****Therapy Supplement for Medicare PPS****T0100. Ordered Therapies**

Complete only if A0310B = 01 or 06

Enter Code

**A.** Has the physician ordered any of the following therapies to begin in first 14 days of stay: physical therapy, occupational therapy, or speech/language pathology service?0. **No** → Skip to Section Z, Assessment Administration1. **Yes**

Enter Code

**B. Were therapy evaluations completed?**0. **No** → Skip to Section Z, Assessment Administration1. **Yes**

Enter Number of Days

**C.** Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered

Enter Number of Min.

**D.** Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered**Section V****Care Area Trigger (CAT) Summary****V0100. Items From the Most Recent Prior OBRA or PPS Assessment**

If A0310F = 1 → Skip to V0200, CATs and Care Planning

Enter Code

**A. Prior Assessment Federal OBRA Reason for Assessment/Tracking** (A0310A value from prior assessment)01. **Admission assessment** (required by day 14)

02. Quarterly review assessment

03. Annual assessment

04. Significant change in status assessment

05. Significant correction to prior full assessment

06. Significant correction to prior quarterly assessment

99. Not OBRA required assessment/tracking

Enter Code

**B. Prior Assessment PPS Reason for Assessment** (A0310B value from prior assessment)

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 change, or significant correction assessment)**C. Prior Assessment Reference Date** (A2300 value from prior assessment)

month

day

year

Enter Score

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

Enter Score

**E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score** (D0300 value from prior assessment)

Enter Score

**F. Prior Assessment Staff Assessment of Resident Mood (PHQ-OV9©) Total Severity Score** (D0600 value from prior assessment)

## Section V Care Area Trigger (CAT) Summary

### V0200. CATs 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 problem area. The Addressed in Care Plan column must be completed within 7 days of completing the RAI (MDS and CAT). Check column B if the CAT is addressed in the care plan.
3. Indicate in the Location of CAT Assessment Documentation column where information related to the CAT assessment can be found. CAT assessment documentation must/should include information on the complicating factors, risks, and any referrals for this resident for this problem area.

#### A. CAT Results

CAT Problem Area	A. Care Area Triggered	B. Addressed in Care Plan	Location and Date of CAT Assessment Information
	↓ 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 Tubes	<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 CAT Assessment Process and Date Signed

1. Signature \_\_\_\_\_

2. Date

month	day	year			

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

1. Signature \_\_\_\_\_

2. Date

month	day	year			

## Section X Correction Request

### X0100. Type of Transaction

Enter Code

1. **Add new record** → Skip to Z0100, Assessment Administration
2. **Modify existing record** → Continue to X0200, Name of Resident on record to be corrected
3. **Inactivate existing record** → Continue to X0200, Name of Resident on record to be corrected

**Identification of Record to be Modified/Inactivated** – The following items identify the existing assessment or tracking 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.

### X0200. Name of Resident on existing record to be modified/inactivated

**A. First Name:**

**B. Middle Initial:**

**C. Last Name:**

**D. Suffix:**

### X0300. Gender on existing record to be modified/inactivated

Enter Code

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

### X0400. Birth Date on existing record to be modified/inactivated

		-			-				
month			day			year			

### X0500. Social Security Number on existing record to be modified/inactivated

--

### X0600. Type of Assessment/Tracking on existing record to be modified/inactivated

Enter Code

**A. Federal OBRA Reason for Assessment/Tracking**

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 full assessment
06. Significant correction to prior quarterly assessment
10. Discharge transaction-return not anticipated
11. Discharge transaction-return anticipated
20. Entry transaction
99. Not OBRA required assessment/tracking

Enter Code

**B. PPS Assessment**

**PPS Scheduled Assessments for a Medicare Part A Stay**

01. 5-day scheduled assessment
02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
06. Readmission/return assessment

**PPS Unscheduled Assessments for a Medicare Part A Stay**

07. **Unscheduled assessment used for PPS** (OMRA, significant change, or significant correction assessment)
  08. Swing Bed clinical change assessment
- Not PPS Assessment**
99. Not PPS assessment

Enter Code

**C. End of Medicare Coverage Assessment – EMCA**

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

Enter Code

**D. PPS Other Medicare Required Assessment – OMRA**

0. **No**
1. **Start of therapy assessment**
2. **End of therapy assessment**
3. **Both Start and End of therapy assessment**



**Section Z Assessment Administration**

**Z0100 Medicare Part A Billing**

A. Medicare Part A HIPPS code for billing:

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

(RUG group followed by assessment type indicator)

B. RUG version code:

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

**Z0150 Medicare Non-Therapy Part A Billing**

A. Medicare non-therapy Part A HIPPS code for billing:

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

(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:

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

**Z0300. Insurance Billing**

A. RUG Case Mix group:

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

B. RUG version code:

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

**Z0400. Signature of Persons Completing the Assessment**

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

**Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**

A. Signature

B. Date RN Assessment Coordinator signed assessment as complete:

				month			day					year