MINIMUM DATA SET (MDS) 3.0
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Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

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

A0300. Type of Assessment/Tracking

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 Assessments

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**
- 09. **End of Medicare coverage assessment – EMCA**

Not PPS Assessment
- 99. **Not PPS assessment**

Enter Code

C. PPS Other Medicare Required Assessment – OMRA
- 0. **No**
- 1. **Yes**

Enter Code

D. State Required Assessment
- 0. **No**
- 1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA or PPS) **since the most recent admission?**
- 0. **No**
- 1. **Yes**

Section A Identification Information

A0400. Submission Requirement

Enter Code

1. **Federal required submission**
2. **State but not federal required submission**
3. **Neither federal or state required submission** (e.g. HMO, other insurance, etc.)

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

month day year

A1000. Race/Ethnicity – Complete only for first assessment (OBRA or PPS) since the most recent admission (A0300E = 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**
- [ ] Z. **Unable to determine or unknown**

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 Language
9. **Unable to determine**

B. **Preferred Language**

Section A Identification Information

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)

Enter Code

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. **No**
1. **Yes**
9. **Not a Medicaid certified unit**

A1550. Conditions Related to MR/DD Status

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

MR/DD with organic condition

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

MR/DD without organic condition

- ☐ **E MR/DD with no organic condition**

No MR/DD

- ☐ **Z. Not applicable**

A1600. Entry Date (date of this admission/reentry into the facility)

month – day – year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

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

Section A Identification Information

A2000. Discharge Date

☐☐ - ☐☐ - ☐☐☐☐
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 for significant correction to prior full assessment and significant correction to prior quarterly assessment (A0300A = 05 or 06)

☐☐ - ☐☐ - ☐☐☐☐
month day year

A2300. Assessment Reference Date

Observation end date:

☐☐ - ☐☐ - ☐☐☐☐
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:

☐☐ - ☐☐ - ☐☐☐☐
month day year

C. End date of most recent Medicare stay – Enter 99-99-9999 if stay is ongoing**:**

☐☐ - ☐☐ - ☐☐☐☐
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 [ ]

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
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
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 C0600, Should the Staff Assessment for Mental Status be Conducted?
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

Conduct interview on day before, day of, or day after Assessment Reference Date (A2300)

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

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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 C1100, Procedural Memory
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

C1100. Procedural Memory

Enter Code [ ]

Procedural Memory OK – Can perform all or almost all steps in a multitask sequence without cues. Code for recall of what was learned or known.

0. **Yes**, Memory OK
1. **Memory problem**

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**

- [ ] **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?

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Section C Cognitive Patterns

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 D0400, Should the Staff Assessment of Mood be Conducted?
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Conduct interview on day before, day of, or day after Assessment Reference Date (A2300)

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.

Symptom Presence
0. **No** (Leave column 2 blank)
1. **Yes** (Proceed to column 2)
9. **No Response** (Leave column 2 blank)

Symptom Frequency
0. **1 Day** (Rarely)
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 selected frequency responses in Column 2, Symptom Frequency. Total score may be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency not present for 3 or more items). If Symptom Frequency is not present for 1 or 2 items, the total score is adjusted.

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

D0400. Should the Staff Assessment of Mood be Conducted?

Enter Code [ ]

0. **No** (because Resident Mood Interview was completed) → Skip to E0100, Psychosis
1. **Yes** (because 3 or more items in Resident Mood Interview not completed) → Continue to D0500, Staff Assessment of Mood

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

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Say to staff: "*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.
If yes in column 1, then move to column 2, Symptom Frequency, and indicate symptom frequency.

Symptom Presence
0. **No** (Leave column 2 blank)
1. **Yes** (Proceed to column 2)

Symptom Frequency
0. **1 Day** (Rarely)
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 selected frequency responses in Column 2, Symptom Frequency. Total score may be between 00 and 30. Enter 99 if unable to complete staff assessment (i.e., Symptom Frequency not present for 3 or more items). If Symptom Frequency is not present for 1 or 2 items, the total score is adjusted.

D0650. Follow-Up to D0600I – 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

Coding:

0. **Behavior not exhibited** in the last 7 days
1. **Behavior of this type occurred 1 to 3 days** of the last 7 days
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Codes in Boxes

- ☐ **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2 or 3?

0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**

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

Enter Code ☐ **B. Significantly interfere with the resident's care?**

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

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**

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

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**

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

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**

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

Enter Code ☐ **C. Significantly disrupt care or living environment?**

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

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Section E Behavior

E0800. Rejection of Care – Presence & Frequency

Enter Code [ ]

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

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

E0900. Wandering – Presence & Frequency

Enter Code [ ]

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in 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

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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 F0700, Should the Staff Assessment of Daily and Activity Preferences be Conducted?
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Conduct interview on day before, day of or day after Assessment Reference Date (A2300)

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**

Code	Item
[ ]	**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

Conduct interview on day before, day of or day after Assessment Reference Date (A2300)

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**

Code	Item
[ ]	**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)

End of Daily and Activity Preferences Interview

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

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Section G Functional Status

G0100. Activities of Daily Living (ADL) Assistance

Code for most dependent episode

Coding:

0. **Independent** – resident completes activity with no help or oversight
1. **Set up assistance**
2. **Supervision** – oversight, encouragement or cueing provided throughout the activity
3. **Limited assistance** – guided maneuvering of limbs or other non-weight bearing assistance provided at least once
4. **Extensive assistance, 1 person assist** – resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once
5. **Extensive assistance, 2 + person assist** – resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once
6. **Total dependence, 1 person assist** – full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
7. **Total dependence, 2 + person assist** – full staff performance of activity (requiring 2 or more person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
8. **Activity did not occur** during entire period

↓ Enter Codes in Boxes		
☐	A.	**Bed mobility** – moving to and from lying position, turning side to side and positioning body while in bed
☐	B.	**Transfer** – moving between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet
☐	C.	**Toilet transfer** – how resident gets to and moves on and off toilet or commode
☐	D.	**Toileting** – using the toilet room (or commode, bedpan, urinal); cleaning self after toileting or incontinent episode(s), changing pad, managing ostomy or catheter, adjusting clothes (**excludes** toilet transfer)
☐	E.	**Walk in room** – walking between locations in his/her room
☐	F.	**Walk in facility** – walking in corridor or other places in facility
☐	G.	**Locomotion** – moving about facility, with wheelchair if used
☐	H.	**Dressing upper body** – dressing and undressing above the waist, includes prostheses, orthotics, fasteners, pullovers
☐	I.	**Dressing lower body** – dressing and undressing from the waist down, includes prostheses, orthotics, fasteners, pullovers
☐	J.	**Eating** – includes eating, drinking (regardless of skill) or intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids for hydration)
☐	K.	**Grooming/personal hygiene** – includes combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** bath and shower)
☐	L.	**Bathing** – how resident takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (**excludes** washing of back and hair)

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 human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ Enter Codes in Boxes		
☐	A.	**Moving from seated to standing position**
☐	B.	**Walking** (with assistive device if used)
☐	C.	**Turning around and facing the opposite direction while walking**
☐	D.	**Moving on and off toilet**
☐	E.	**Surface-to-surface transfer** (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.

Coding:

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

↓ Enter Codes in Boxes		
☐	A.	**Upper extremity** (shoulder, elbow, wrist, hand)
☐	B.	**Lower extremity** (hip, knee, ankle, foot)

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Section G Functional Status

G0600. Mobility Devices	
↓ Check all that were normally used	
☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair (manual or electric)**
☐	**D. Lower extremity limb prosthesis**
☐	**Z. None of the above** were used

G0800. Bedfast	
Enter Code ☐	**Has the resident been in bed or in recliner in room** for more than 22 hours on at least 4 of the past 7 days? 0. **No** 1. **Yes**

G0900. Functional Rehabilitation Potential – Complete only for the first assessment (OBRA or PPS) since the most recent admission (A0300E = 1)	
Enter Code ☐	**A. Resident believes he or she is capable of increased independence** in at least some ADLs. 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**B. Direct care staff believe resident is capable of increased independence** in at least some ADLs. 0. **No** 1. **Yes**

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Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

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

H0200. Urinary Toileting Program

Enter Code ☐

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

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

Enter Code ☐

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

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

Enter Code ☐

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

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

H0300. Urinary Continence

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (greater than or equal to 7 with 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 entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

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

H0500. Bowel Toileting Program

Enter Code ☐

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

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

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

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

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Section I Active Disease Diagnosis

Active Diseases in the last 30 days – Check all that apply		
Cancer		
☐	**I0100.**	**Cancer** (with or without metastasis)
Heart/Circulation		
☐	**I0200.**	**Anemia** (includes aplastic, iron deficiency pernicious, and sickle cell)
☐	**I0300.**	**Atrial Fibrillation and Other Dysrhythmias** (includes bradycardias, tachycardias)
☐	**I0400.**	**Coronary Artery Disease (CAD)** (includes angina, myocardial infarction, atherosclerotic heart disease (ASHD))
☐	**I0500.**	**Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE)**
☐	**I0600.**	**Heart Failure** (includes congestive heart failure (CHF), pulmonary edema)
☐	**I0700.**	**Hypertension**
☐	**I0800.**	**Hypotension**
☐	**I0900.**	**Peripheral Vascular Disease/Peripheral Arterial Disease**
Gastrointestinal		
☐	**I1100.**	**Cirrhosis**
☐	**I1200.**	**Gastroesophageal Reflux Disease** (**GERD)/Ulcer** (includes esophageal, gastric, and peptic ulcers)
☐	**I1300.**	**Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease**
Genitourinary		
☐	**I1400.**	**Benign Prostatic Hyperplasia (BPH)**
☐	**I1500.**	**Renal Insufficiency or Renal Failure/End-Stage Renal Disease (ESRD)**
Infections		
☐	**I1600.**	**Human Immunodeficiency Virus (HIV) Infection** (includes Acquired Immunodeficiency Syndrome (AIDS))
☐	**I1700.**	**Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin-Resistant Enterococci (VRE), Clostridium Difficile infection/colonization**
☐	**I2000.**	**Pneumonia**
☐	**I2100.**	**Septicemia**
☐	**I2200.**	**Tuberculosis**
☐	**I2300.**	**Urinary Tract Infection (UTI)**
☐	**I2400.**	**Viral Hepatitis** (includes Hepatitis A, B, C, D, & E)
Metabolic		
☐	**I2900.**	**Diabetes Mellitus (DM)** (includes diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100.**	**Hyponatremia**
☐	**I3200.**	**Hyperkalemia**
☐	**I3300.**	**Hyperlipidemia** (includes hypercholesterolemia)
☐	**I3400.**	**Thyroid Disorder** (includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
Musculoskeletal		
☐	**I3700.**	**Arthritis** (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
☐	**I3800.**	**Osteoporosis**
☐	**I3900.**	**Hip Fracture** (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck) (last 60 days)
☐	**I4000.**	**Other Fracture**
Neurological		
☐	**I4200.**	**Alzheimer's Disease**
☐	**I4300.**	**Aphasia**
☐	**I4400.**	**Cerebral Palsy**
☐	**I4500.**	**Cerebrovascular Accident (CVA)/Transient Ischemic Attack (TIA)/Stroke**
☐	**I4800.**	**Dementia** (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, Huntington's, Pick's or Creutzfeldt-Jakob diseases)
☐	**I4900.**	**Hemiplegia/Hemiparesis**
☐	**I5000.**	**Paraplegia**
☐	**I5100.**	**Quadriplegia**
☐	**I5200.**	**Multiple Sclerosis**
☐	**I5300.**	**Parkinson's Disease**
☐	**I5400.**	**Seizure Disorder**
☐	**I5500.**	**Traumatic Brain Injury**

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Section I Active Disease Diagnosis

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)
- ☐ **I6000. Schizophrenia**
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma/Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease** (includes chronic bronchitis and restrictive lung diseases such as asbestosis)

Vision

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

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 30 days

Other

- ☐ **I8000. Additional Diagnoses**

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

A. ______________________ [| | | | | |]

B. ______________________ [| | | | | |]

C. ______________________ [| | | | | |]

D. ______________________ [| | | | | |]

E. ______________________ [| | | | | |]

F. ______________________ [| | | | | |]

G. ______________________ [| | | | | |]

H. ______________________ [| | | | | |]

I. ______________________ [| | | | | |]

J. ______________________ [| | | | | |]

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

At any time in the last 7 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.

Conduct interview on day before, day of, or day after Assessment Reference Date (A2300).
If resident is comatose, skip to J1100, Shortness of Breath (Dyspnea).

Enter Code
0. **No** (resident is rarely/never understood) → Skip to 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 7 days?”*
0. **No** → Skip to J0800, Indicators of Pain
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 7 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 7 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 7 days,* ***have you limited your day-to-day activities because of pain?***”
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity – Administer 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 7 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 7 days.*” (Show resident verbal scale.)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

End of Pain Assessment Interview

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Section J Health Conditions

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, winces, 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**

J0900. Pain Control

Enter Code ☐

Adequacy of current therapeutic regimen to control pain (from resident's point of view)

0. **No issue of pain**
1. **Pain intensity acceptable to resident, no treatment regimen or change in regimen required**
2. **Controlled adequately by therapeutic regimen**
3. **Controlled when therapeutic regimen followed, but not always followed as ordered**
4. **Therapeutic regimen followed, but pain control not adequate**
5. **No therapeutic regimen being followed for pain; pain not adequately controlled**

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. If not documented, discuss with physician and request supporting documentation).

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

J1500. Problem Conditions

↓ **Check all that apply:**

☐	**A. Fever**
☐	**B. Vomiting**
☐	**D. Dehydrated;** output exceeds input
☐	**H. Internal bleeding**
☐	**Z. None of the above**

Section J Health Conditions

J1700. Fall History on Admission – If this is not the first assessment (OBRA or PPS) since the most recent admission (A0300E = 0) → Skip to J1800, Any Falls Since Last Assessment

Enter Code [ ] **A.** Did the resident fall one or more times in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code [ ] **B.** Did the resident fall one or more times in the **last 1–6 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? This applies to all falls, whether within the facility or during a temporary absence from the facility.
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 Codes in Boxes**

[ ] **A. No injury** – no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

[ ] **B. Injury (except major)** – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

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

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

[ ][ ] 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.)

[ ][ ][ ].[ ] — **C. Body Mass Index (BMI)**
(BMI = K0200B ∗ 703 / K0200A^2)

K0300. Weight Loss

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

Section K Swallowing/Nutritional Status

Code	
[ ] Code	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 parenteral or tube feedings** 1. **500 cc/day or less** 2. **501 cc/day or more**

Section L Oral/Dental Status

L0100. Able to Perform Dental Exam

Enter [ ] Code	0. **No** → Skip to M0100, Determination of Pressure Ulcer Risk 1. **Yes**

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**
[ ]	**Z.**	**None of the above were present**

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Section M Skin Conditions

For all items involving a count of the number of ulcers, if more than 9, enter 9

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** (e.g., Braden, Norton, or other**)**

☐ **C. Clinical judgment**

☐ **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**

M0200. Presence of Pressure Ulcer

A. Date of most recent routine (e.g., weekly) **pressure ulcer assessment:**

☐☐ - ☐☐ - ☐☐☐☐
month - day - year

Enter Number ☐

B. 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 Code ☐

C. Does this resident have one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time?

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes**

M0400. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

A. 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

Enter Number ☐ **1. Number of pressure ulcers at Stage 2** → If 0, skip to M0400B, Stage 3

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

B. 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 includes undermining and tunneling

Enter Number ☐ **1. Number of pressure ulcers at Stage 3** → If 0, skip to M0400C, Stage 4

Enter Number ☐ **2. Number of these 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 onset of Stage 3 pressure ulcers in this facility's care – Enter 99-99-9999 if unknown

A. Oldest or only:

☐☐ - ☐☐ - ☐☐☐☐
month - day - year

B. Newest:

☐☐ - ☐☐ - ☐☐☐☐
month - day - year

M0400 Continued on next page

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M0400. Current Number of Unhealed Pressure Ulcers at Each Stage – Continued

C. 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 pressure ulcers at Stage 4** → If 0, skip to M0400D, Unstageable: Known or likely but not stageable due to non-removable dressing

Enter [ ] Number

2. **Number of these 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 onset of Stage 4 pressure ulcers in this facility's care** – Enter 99-99-9999 if unknown

   A. **Oldest or only:**

   [ ][ ]-[ ][ ]-[ ][ ][ ][ ]
   month day year

   B. **Newest:**

   [ ][ ]-[ ][ ]-[ ][ ][ ][ ]
   month day year

D. Unstageable: Known or likely but not stageable due to non-removable dressing

Enter [ ] Number

1. **Number of pressure ulcers unstageable due to non-removable dressing**→ If 0, skip to M0400E, Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar

Enter [ ] Number

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

E Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar

Enter [ ] Number

1. **Number of pressure ulcers unstageable due to coverage of wound bed by slough and/or eschar** → If 0, skip to M0400F, Unstageable: Suspected deep tissue injury in evolution

Enter [ ] Number

2. **Number of these 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 onset of these unstageable pressure ulcers in this facility's care** – Enter 99-99-9999 if unknown

   A. **Oldest or only:**

   [ ][ ]-[ ][ ]-[ ][ ][ ][ ]
   month day year

   B. **Newest:**

   [ ][ ]-[ ][ ]-[ ][ ][ ][ ]
   month day year

F Unstageable: Suspected deep tissue injury in evolution.

Enter [ ] Number

1. **Number of pressure ulcers unstageable with suspected deep tissue injury in evolution** → If 0, skip to M0500, Number of Unhealed Stage 2 Pressure Ulcers Known to be Present for More Than One Month

Enter [ ] Number

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

M0500. Number of Unhealed Stage 2 Pressure Ulcers Known to be Present for More Than One Month

Enter [ ] Number

If the resident has one or more unhealed Stage 2 pressure ulcers, record the number present today that were first observed more than one month ago.

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Section M Skin Conditions

M0600. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0400B1, M0400C1 or M0400E1 is greater than 0

If the patient has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an eschar, identify the pressure ulcers with the longest dimension and record in centimeters:

☐☐.☐ cm	**A. Pressure Ulcer Length:** Longest length in any direction
☐☐.☐ cm	**B. Pressure Ulcer Width:** Width of the same pressure ulcer, greatest width measured at right angles to length
☐☐-☐☐-☐☐☐☐ month day year	**C. Date Measured**

M0700. Tissue Type for Most Advanced Stage

Enter Code ☐

Select the best description of the most severe type of tissue present in the ulcer bed of the **largest pressure ulcer at the most advanced stage**

1. **Epithelial Tissue** – new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.
2. **Granulation Tissue** – pink or red tissue with shiny, moist, granular appearance
3. **Slough** – yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic Tissue (Eschar)** – 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 this is the first assessment (OBRA or PPS) since the most recent admission (A0300E = 1) → Skip to M1020, Other Ulcers, Wounds and Skin Problems

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 of pressure ulcers in boxes**

☐	**A. Stage 2**
☐	**B. Stage 3**
☐	**C. Stage 4**

M0900. Healed Pressure Ulcers
If this is the first assessment (OBRA or PPS) since the most recent admission (A0300E = 1) → Skip to M1020, Other Ulcers, Wounds and Skin Problems

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA or PPS)?
0. **No** → Skip to M1020, Other Ulcers, Wounds and Skin Problems
1. **Yes** → 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 of pressure ulcers in boxes**

☐	**B. Stage 2**
☐	**C. Stage 3**
☐	**D. Stage 4**

M1020. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

☐	**A. Venous or arterial ulcers**
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other foot or lower extremity open lesion(s) or infection (cellulitis)**
☐	**D. Wound infection other than on foot or lower extremity**
☐	**E. Surgical wound(s)**
☐	**F. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**G. Burn(s)** (second or third degree)
☐	**Z. None of the above** were present

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Section M Skin Conditions

M1100. Number of Venous and Arterial Ulcers – Complete only if M1020A is checked	
Enter ☐ Number	**Enter the total number of venous and arterial ulcers present**

M1200. Skin and Ulcer Treatments		
↓ **Check all that apply**		
☐	**A.**	**Pressure reducing device for chair**
☐	**B.**	**Pressure reducing device for bed**
☐	**C.**	**Turning/repositioning**
☐	**D**	**Nutrition or hydration intervention** to manage skin problems
☐	**E.**	**Ulcer care**
☐	**F.**	**Surgical wound care**
☐	**G.**	**Application of dressings** (with or without topical medications) other than to feet
☐	**H.**	**Applications of ointments/medications** other than to feet
☐	**I.**	**Application of dressings to feet** (with or without topical medications)
☐	**Z.**	**None of the above** were provided

Section N Medications

N0300. Injections	
☐ Days	Record the **number of days that injectable medications were received** 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)
☐	**Z.**	**None of the above were received**

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Section O Special Treatments and Procedures

O0100. Special Treatments and Programs

Indicate whether and when each of the following procedures was performed during the last 14 days.

Procedure performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only code column 1 if resident was admitted IN THE LAST 14 DAYS. If resident was admitted 14 or more days ago, leave column 1 blank. 0. **No** 1. **Yes**	Procedure performed ***while a resident*** of this facility and within the ***last 14 days.*** **Code for all residents**. 0. **No** 1. **Yes**	**1. While NOT a Resident**	**2. While a Resident**
		↓ Enter Codes in Boxes ↓	
Cancer Treatments			
A. Chemotherapy		☐	☐
B. Radiation		☐	☐
Respiratory Treatments			
C. Oxygen Therapy		☐	☐
D. Suctioning		☐	☐
E. Tracheostomy Care		☐	☐
F. Ventilator or respirator		☐	☐
G BIPAP/CPAP machine		☐	☐
Other			
H. IV medications		☐	☐
I. Transfusions		☐	☐
J. Dialysis		☐	☐
K. Hospice care		☐	☐
L. Respite care		☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	☐

O0200. Influenza Vaccine

Enter Code ☐

A. Did the **resident receive the Influenza Vaccine in this facility** for this year's Influenza season (October 1 through March 31)?

0. **No** → Continue to O0200B, If Influenza Vaccine not received, state reason
1. **Yes** → Skip to O0300, Pneumococcal Vaccine
9. **Does not apply because assessment is between July 1 and Sept 30** → Skip to O0300, Pneumococcal Vaccine

Enter Code ☐

B. If Influenza Vaccine not received, state reason:

1. **Not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** – medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine**
9. **None of the above**

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Section O Special Treatments and Procedures

O0300. Pneumococcal Vaccine

Enter Code	
[ ]	**A. Is the resident's Pneumococcal Vaccination up to date?** 0. **No** → Continue to O0300B, If Pneumococcal Vaccine not received, state reason 1. **Yes** → Skip to O0400, Therapies
[ ]	**B. If Pneumococcal Vaccine not received, state reason:** 1. **Not eligible** – medical contraindication 2. **Offered and declined** 3. **Not offered**

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.

	1. Minutes (if minutes = 0000, leave columns 2, 3 and 4 blank)	**2. Days**	**3. Therapy Start Date** (most recent regimen since last assessment) mm/dd/yyyy	**4. Therapy End Date** (enter 99/99/9999 if therapy is ongoing) mm/dd/yyyy
A. Speech/language pathology and audiology services	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____
B. Occupational Therapy	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____
C. Physical Therapy	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____
D. Respiratory Therapy	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____
E. Psychological Therapy (by any licensed mental health professional)	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____
F. Recreational Therapy (includes recreational and music therapy)	[ ][ ][ ][ ]	[ ]	___/___/_____	___/___/_____

O0500. Nursing Rehabilitation/ Restorative Care

Record the number of days each of the following rehabilitative or 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).

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

Section O Special Treatments and Procedures

O0600. Physicial Examinations

☐☐ Days	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

☐☐ **Days**	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, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

Coding:	↓ Enter Codes in Boxes	
0. **Not used** 1. **Used less than daily** 2. **Used daily**		**Used in Bed**
	☐	**A. Bed rail** (any type; e.g., full, half, one side)
	☐	**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**

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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**

Q0200. Return to Community

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

Enter Code

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

Q0300. Resident's Overall Goals – Complete only for the first assessment (OBRA or PPS) since the most recent admission (A0300E = 1)

Enter Code

A. Select one for resident's goals established during assessment process.
1. **Post acute care** – expects to return to live in community
2. **Post acute care** – expects to have continued NH needs
3. **Respite stay** – expects to return home
4. **Other reason for admit** – expects to return to live in community
5. **Long term care** for medical, functional, and/or cognitive impairments
6. **End-of-life care** (includes palliative care and hospice)
9. **Unknown or uncertain**

Enter Code

B. Indicate information source for this item
1. **Resident**
2. If not resident, then **family or significant other**
3. **Not resident, family or significant other**

Section T Therapy Supplement for Medicare PPS

T0100. Ordered Therapies – Complete only if this is a Medicare PPS 5-day scheduled assessment (A0300B = 01) or Medicare PPS readmission/return assessment (A0300B = 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 Administration
1. **Yes**

Enter Code

B. Were therapy evaluations completed?
0. **No** → Skip to Section Z, Assessment Administration
1. **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 minutes

D. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered

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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: ☐☐☐☐☐☐☐☐☐☐

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

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