Resident _____ Identifier _____ Date _____

QM = ⬭

CAA = ▭ PDPM = $

SNF Quality Reporting Program Measure =

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

Section A Identification Information

A0050. Type of Record

Enter Code ☐

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):** ☐☐☐☐☐☐☐☐☐☐

B. **CMS Certification Number (CCN):** ☐☐☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0200. Type of Provider

Enter Code ☐

Type of provider

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

A0300. Optional State Assessment

Complete only if A0200 = 1

Enter Code ☐

A. **Is this assessment for state payment purposes only?**

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

A0310. Type of Assessment

Enter Code ☐☐

A. **Federal OBRA Reason for Assessment**

01. **Admission** assessment (required by **day 14**)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐

B. **PPS Assessment**

PPS Scheduled Assessment for a Medicare Part A Stay

$ 01. **5-day** scheduled assessment (Initial Medicare Assessment)

PPS Unscheduled Assessment for a Medicare Part A Stay

$ 08. **IPA** - Interim Payment Assessment

Not PPS Assessment

99. **None of the above**

A0310 continued on next page

QUALITY MEASURES (QM)

CMS ID	SHORT STAY QUALITY MEASURES:
01.01	Residents who self-report moderate to severe pain
02.01	Residents with pressure ulcers that are new or worsened
03.02	Residents who were assessed and appropriately given the seasonal influenza vaccine
04.02	Residents who received the seasonal influenza vaccine
05.02	Residents who were offered and declined the seasonal influenza vaccine
06.02	Residents who did not receive, due to medical contraindication, the seasonal influenza vaccine
07.01	Residents assessed and appropriately given the pneumococcal vaccine
08.01	Residents who received the pneumococcal vaccine
09.01	Residents who were offered and declined the pneumococcal vaccine
10.01	Residents who did not receive, due to medical contraindication, the pneumococcal vaccine
11.01	Residents who newly received an antipsychotic medication
37.02	Residents who made improvements in function

CMS ID	LONG STAY QUALITY MEASURES:
13.01	Residents experiencing one or more falls with major injury
14.02	Residents who self-report moderate to severe pain
15.02	High-risk residents with pressure ulcers
16.02	Residents assessed and appropriately given the seasonal influenza vaccine
17.02	Residents who received the seasonal influenza vaccine
18.02	Residents who were offered and declined the seasonal influenza vaccine
19.02	Residents who did not receive, due to medical contraindication, the seasonal influenza vaccine
20.01	Residents assessed and appropriately given the pneumococcal vaccine
21.01	Residents who received the pneumococcal vaccine
22.01	Residents who were offered and declined the pneumococcal vaccine
23.01	Residents who did not receive, due to medical contraindication, the pneumococcal vaccine
24.01	Residents with a urinary tract infection

CMS ID	LONG STAY QUALITY MEASURES:
25.01	Low risk residents who lose control of their bowel or bladder
26.02	Residents who have/had a catheter inserted and left in their bladder
27.01	Residents who were physically restrained
28.01	Residents whose need for help with Activities of Daily Living has increased
29.01	Residents who lose too much weight
30.01	Residents who have depressive symptoms
31.02	Residents who received an antipsychotic medication
32.01	Prevalence of falls
33.01	Prevalence of antianxiety/hypnotic use
34.01	Prevalence of behavior symptoms affecting others
35.02	Residents whose ability to move independently worsened
36.01	Residents who used antianxiety or hypnotic medication

⬭ Indicates responses that may impact QM items identified by a number in a solid blue oval ◯ Indicates responses that may impact covariate for the QM identified by a number in an outline blue oval

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code ☐

E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Enter Code ☐☐

F. **Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment - **return not anticipated**
11. **Discharge** assessment - **return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

H. **Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

A0410. Unit Certification or Licensure Designation

Enter Code ☐

1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

A0500. Legal Name of Resident

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle initial:** ☐

C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ☐☐☐ – ☐☐ – ☐☐☐☐

B. **Medicare number:** ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **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**

Section A Identification Information

A1100. Language

Enter Code ☐

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

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

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1200. Marital Status

Enter Code ☐

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

A1300. Optional Resident Items

A. Medical record number:

☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number:

☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1500. Preadmission Screening and Resident Review (PASRR)

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

Enter Code ☐

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

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

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

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

↓ Check all that apply

☐ **A. Serious mental illness**

☐ **B. Intellectual Disability ("mental retardation" in federal regulation)**

☐ **C. Other related conditions**

Section A Identification Information

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

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

	ID/DD With Organic Condition
☐	**A. Down syndrome**
☐	**B. Autism**
☐	**C. Epilepsy**
☐	**D. Other organic condition related to ID/DD**
	ID/DD Without Organic Condition
☐	**E. ID/DD with no organic condition**
	No ID/DD
☐	**Z. None of the above**

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1700. Type of Entry

Enter Code ☐

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

A1800. Entered From

Enter Code ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Section A Identification Information

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

Month – Day – Year

A2300. Assessment Reference Date

Observation end date:

Month – Day – Year

A2400. Medicare Stay

Complete only if A0310G1 = 0

Enter Code

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

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

B. Start date of most recent Medicare stay:

Month – Day – Year

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

Month – Day – Year

Resident _____ Identifier _____ Date _____

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

$ 0. **No** → Continue to B0200, Hearing

$ 1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance 15.02

B0200. Hearing CAA

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) 4
2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 4
3. **Highly impaired** – absence of useful hearing 4

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 CAA

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 4

$ 2. **Sometimes understood** – ability is limited to making concrete requests 4

$ 3. **Rarely/never understood** 4

B0800. Ability To Understand Others CAA

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 4
2. **Sometimes understands** – responds adequately to simple, direct communication only 4
3. **Rarely/never understands** 4

B1000. Vision CAA

Enter Code ☐

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

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

B1200. Corrective Lenses

Enter Code ☐

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

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

3 Visual Function
4 Communication

15.02 High-risk residents with pressure ulcers (Long Stay)

CARE AREA ASSESSMENT LEGEND

1 Delirium
2 Cognitive Loss/Dementia
3 Visual Function
4 Communication
5 ADL Function/ Rehabilitation Potential
6 Urinary Incontinence & Indwelling Catheter
7 Psychosocial Well-Being
8 Mood State
9 Behavioral Symptoms
10 Activities
11 Falls
12 Nutritional Status
13 Feeding Tubes
14 Dehydration/Fluid Maintenance
15 Dental Care
16 Pressure Ulcer
17 Psychotropic Drug Use
18 Physical Restraints
19 Pain
20 Return to Community Referral
2 2 Items Trigger
3 3 or More Items Trigger

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words CAA

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 2
$ 1. **One** 1 2
$ 2. **Two** 1 2
$ 3. **Three** 1 2

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) CAA

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 2
$ 1. **Missed by 2-5 years** 1 2
$ 2. **Missed by 1 year** 1 2
$ 3. **Correct** 1 2

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 2
$ 1. **Missed by 6 days to 1 month** 1 2
$ 2. **Accurate within 5 days** 1 2

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 2
$ 1. **Correct** 1 2

C0400. Recall CAA

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 2
$ 1. **Yes, after cueing** ("something to wear") 1 2
$ 2. **Yes, no cue required** 1 2

Enter Code ☐

B. Able to recall "blue"

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

Enter Code ☐

C. Able to recall "bed"

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

C0500. BIMS Summary Score CAA

Enter Score ☐☐

$ **Add scores** for questions C0200-C0400 and fill in total score (00-15) 00-12 = 2 5
Enter 99 if the resident was unable to complete the interview 13-15 = (14.02)

1 Delirium
2 Cognitive Loss/Dementia
5 ADL Function/Rehabilitation Potential, 2 Items Trigger

(14.02) Residents who self-report moderate to severe pain (Long Stay)

C0500 BIMS Summary Scores suggest:
13-15: Cognitively Intact
8-12: Moderately Impaired
0-7: Severe Impairment

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

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

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK CAA

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem** 2

C0800. Long-term Memory OK CAA

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem** 2

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/hospital swing bed**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making CAA

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** – decisions consistent/reasonable 5 ▷ (14.02)
1. **Modified independence** – some difficulty in new situations only 2 5 ▷ (14.02)
2. **Moderately impaired** – decisions poor; cues/supervision required 2 5 ▷
3. **Severely impaired** – never/rarely made decisions 2

Delirium

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

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

A. Acute Onset Mental Status Change CAA

Enter Code ☐

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

0. **No**
1. **Yes** 1 ▷

Coding:

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

↓ **Enter Codes in Boxes**

- ☐ **B. Inattention** – Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said? 1,2,3 = 1
- ☐ **C. Disorganized Thinking** – Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? 1 or 2 = 1
- ☐ **D. Altered Level of Consciousness** – Did the resident have altered level of consciousness, as indicated by any of the following criteria? 1 or 2 = 2
  - **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

1 ▷ Delirium
2 Cognitive Loss/Dementia
5 ▷ ADL Function/Rehabilitation Potential, 2 Items Trigger

(14.02) Residents who self-report moderate to severe pain (Long Stay)

Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? – Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©) CAA

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) 30.01
3. **12-14 days** (nearly every day) 30.01

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A.	*Little interest or pleasure in doing things* 30.01	☐ 7 10	$ ☐ 8
B.	*Feeling down, depressed, or hopeless* 30.01	☐	$ ☐ 8
C.	*Trouble falling or staying asleep, or sleeping too much*	☐	$ ☐ 8
D.	*Feeling tired or having little energy*	☐	$ ☐ 8
E.	*Poor appetite or overeating*	☐	$ ☐ 8
F.	*Feeling bad about yourself – or that you are a failure or have let yourself or your family down*	☐	$ ☐ 8
G.	*Trouble concentrating on things, such as reading the newspaper or watching television*	☐	$ ☐ 8
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*	☐	$ ☐ 8
I.	*Thoughts that you would be better off dead, or of hurting yourself in some way*	☐ 8	$ ☐ 8

D0300. Total Severity Score CAA

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). 00-27 = 8 3 10-27 = 30.01

7 Psychosocial Well-Being
8 Mood State
8 3 Mood State, 3 or More Items Trigger
10 Activities
30.01 Residents who have depressive symptoms (Long Stay)

D0300 Total Severity Score Interpretation (indicators of possible depression):
1-4: Minimal Depression
5-9: Mild Depression
10-14: Moderate Depression
15-19: Moderately Severe Depression
20-30: Severe Depression

Resident _____ Identifier _____ Date _____

Section D Mood

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

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) 30.01
3. **12-14 days** (nearly every day) 30.01

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things 30.01	7 10	$ 8
B. Feeling or appearing down, depressed, or hopeless 30.01		$ 8
C. Trouble falling or staying asleep, or sleeping too much		$ 8
D. Feeling tired or having little energy		$ 8
E. Poor appetite or overeating		$ 8
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		$ 8
G. Trouble concentrating on things, such as reading the newspaper or watching television		$ 8
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		$ 8
I. States that life isn't worth living, wishes for death, or attempts to harm self	8	$ 8
J. Being short-tempered, easily annoyed		$ 8

D0600. Total Severity Score CAA

Enter Score

$ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 30.
00-30 = 8 3 10-30 = 30.01

7 Psychosocial Well-Being
8 Mood State
8 3 Mood State, 3 or More Items Trigger
10 Activities
30.01 Residents who have depressive symptoms (Long Stay)

D0600 Total Severity Score Interpretation (indicators of possible depression):
1-4: Minimal Depression
5-9: Mild Depression
10-14: Moderate Depression
15-19: Moderately Severe Depression
20-30: Severe Depression

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Potential Indicators of Psychosis

↓ Check all that apply

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

Behavioral Symptoms

E0200. Behavioral Symptom – Presence & Frequency CAA

Note presence of symptoms and their frequency

Coding:
- 0. **Behavior not exhibited**
- 34.01 1. **Behavior of this type occurred 1 to 3 days**
- 34.01 2. **Behavior of this type occurred 4 to 6 days,** but less than daily
- 34.01 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) 1,2,3 = 2 7 3 9 34.01
- ☐ B. $ **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) 1,2,3 = 2 7 3 9 34.01
- ☐ 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) 1,2,3 = 2 9 34.01

E0300. Overall Presence of Behavioral Symptoms CAA

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 9

E0500. Impact on Resident

Enter Code ☐ **Did any of the identified symptom(s):**

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

Enter Code ☐ **Did any of the identified symptom(s):**

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**

E0800. Rejection of Care – Presence & Frequency CAA

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
- $ 0. **Behavior not exhibited**
- 34.01 $ 1. **Behavior of this type occurred 1 to 3 days** 1,2,3 = 2 9
- 34.01 $ 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 1,2,3 = 2 9
- 34.01 $ 3. **Behavior of this type occurred daily** 1,2,3 = 2 9

2 Cognitive Loss/Dementia
7 3 Psychosocial Well-Being, 3 or More Items Trigger
9 Behavioral Symptoms
34.01 Prevalence of behavior symptoms affecting others

Resident _____ Identifier _____ Date _____

Section E Behavior

E0900. Wandering – Presence & Frequency CAA

Enter Code ☐

Has the resident wandered?

$ 0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms

34.01 $ 1. **Behavior of this type occurred 1 to 3 days** 1,2,3 = 2 9 11

34.01 $ 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 1,2,3 = 2 9 11

34.01 $ 3. **Behavior of this type occurred daily** 1,2,3 = 2 9 11

E1000. Wandering – Impact

Enter Code ☐

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

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

Enter Code ☐

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

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

E1100. Change in Behavior or Other Symptoms CAA

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

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

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

2 Cognitive Loss/Dementia
9 Behavioral Symptoms
11 Falls

34.01 Prevalence of behavior symptoms affecting others

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

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

Enter Code ☐

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

F0400. Interview for Daily Preferences

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

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

↓ Enter Codes in Boxes

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

F0500. Interview for Activity Preferences CAA

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

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

↓ Enter Codes in Boxes

☐	**A.**	*how important is it to you to* ***have books, newspapers, and magazines to read?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**B.**	*how important is it to you to* ***listen to music you like?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**C.**	*how important is it to you to* ***be around animals such as pets?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**D.**	*how important is it to you to* ***keep up with the news?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**E.**	*how important is it to you to* ***do things with groups of people?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**F.**	*how important is it to you to* ***do your favorite activities?*** 3 or 4 = 7 [3] 4 or 5 = 10 [3]
☐	**G.**	*how important is it to you to* ***go outside to get fresh air when the weather is good?*** 4 = 7 [3] 4 or 5 = 10 [3]
☐	**H.**	*how important is it to you to* ***participate in religious services or practices?*** 4 = 7 [3] 4 or 5 = 10 [3]

F0600. Daily and Activity Preferences Primary Respondent CAA

Enter Code ☐

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

1. **Resident** 7 [3]
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")

7 [3] Psychosocial Well-Being, 3 or More Items Trigger
10 [3] Activities, 3 or More Items Trigger

Section F Preferences for Customary Routine and Activities

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

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete G0110, Activities of Daily Living (ADL) Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences CAA

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** 10 3
☐	**M.**	**Listening to music** 10 3
☐	**N.**	**Being around animals such as pets** 10 3
☐	**O.**	**Keeping up with the news** 10 3
☐	**P.**	**Doing things with groups of people** 10 3
☐	**Q.**	**Participating in favorite activities** 7 10 3
☐	**R.**	**Spending time away from the nursing home** 10 3
☐	**S.**	**Spending time outdoors** 10 3
☐	**T.**	**Participating in religious activities or practices** 10 3
☐	**Z.**	**None of the above**

7 Psychosocial Well-Being
10 3 Activities, 3 or More Items Trigger

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance CAA

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

Instructions for Rule of 3

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

If none of the above are met, code supervision.

1. ADL Self-Performance

Code for **resident's performance** over all shifts – not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent – except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

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

Activity Occurred 2 or Fewer Times

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

2. ADL Support 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** or family and/or non-facility staff provided care 100% of the time for that activity over the entire **7-day** period

		1. Self-Performance	2. Support
		↓ Enter Codes in Boxes ↓	
A.	**Bed mobility** – how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture 2, 3, 4, 7, 8 = 02.01 3, 4, 7, 8 = 15.02 1, 2, 3, 4, 7, 8 = 28.01	1,2,3,4 = 5 ▶2 or 7 or 8 1,2,3,4,7,8 = 16	
B.	**Transfer** – how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet) 3, 4, 7, 8 = 15.02 1, 2, 3, 4, 7, 8 = 28.01	37.02 1,2,3,4 = 5 ▶2	
C.	**Walk in room** – how resident walks between locations in his/her room	1,2,3,4 = 5 ▶2	
D.	**Walk in corridor** – how resident walks in corridor on unit	37.02 1,2,3,4 = 5 ▶2	
E.	**Locomotion on unit** – how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	37.02 1,2,3,4 = 5 ▶2	
F.	**Locomotion off unit** – how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor,** how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	1,2,3,4 = 5 ▶2	
G.	**Dressing** – how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	1,2,3,4 = 5 ▶2	
H.	**Eating** – how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration) 1, 2, 3, 4, 7, 8 = 28.01	1,2,3,4 = 5 ▶2	
I.	**Toilet use** – how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag 1, 2, 3, 4, 7, 8 = 28.01	1,2,3,4 = 5 ▶2 2,3,4 = 6	
J.	**Personal hygiene** – how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	1,2,3,4 = 5 ▶2	

5 ▶2 ADL Function/Rehabilitation Potential 2 Items Trigger
6 Urinary Incontinence & Indwelling Catheter
16 Pressure Ulcer

02.01 Residents with pressure ulcers that are new or worsened (Short Stay)
15.02 High-risk residents with pressure ulcers (Long Stay)
28.01 Residents whose need for help with Activities of Daily Living has increased (Long Stay)
37.02 Residents who made improvements in function (Short Stay)

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing CAA

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 ☐

A. Self-performance

0. **Independent** – no help provided
1. **Supervision** – oversight help only 5 ▶
2. **Physical help limited to transfer only** 5 ▶
3. **Physical help in part of bathing activity** 5 ▶
4. **Total dependence** 5 ▶
8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire **7-day** period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking CAA

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

Coding:

0. **Steady at all times**
1. **Not steady, but able to stabilize without staff assistance**
2. **Not steady, only able to stabilize with staff assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

☐	**A.**	**Moving from seated to standing position** 1 or 2 = 5 ▶ 11
☐	**B.**	**Walking** (with assistive device if used) 1 or 2 = 5 ▶ 11
☐	**C.**	**Turning around** and facing the opposite direction while walking 1 or 2 = 5 ▶ 11
☐	**D.**	**Moving on and off toilet** 1 or 2 = 5 ▶ 11
☐	**E.**	**Surface-to-surface transfer** (transfer between bed and chair or wheelchair) 1 or 2 = 5 ▶ 11

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)

G0600. Mobility Devices

↓ **Check all that were normally used**

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

G0900. Functional Rehabilitation Potential CAA

Complete only if A0310A = 01

Enter Code ☐

A. Resident believes he or she is capable of increased independence in at least some ADLs

0. **No**
1. **Yes** 5 ▶
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** 5 ▶

5 ▶ ADL Function/Rehabilitation Potential 2 Items Trigger

11 Falls

Section GG Functional Abilities and Goals - Admission (Start of SNF PPS Stay)

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

Coding:

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

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

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

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

NQF #2633 SNF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (included in Risk Adjustment)

NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (included in Risk Adjustment)

Section GG Functional Abilities and Goals - Start of SNF PPS Stay or State PDPM

GG0130. Self-Care (If A0310B = 01, the assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B. If state requires completion with an OBRA assessment, the assessment period is the ARD plus 2 previous days; complete only column 1.)

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
$		**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
$		**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
$		**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
		F. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
		G. Lower body dressing: The ability to dress and undress below the waist; including fasteners; does not include footwear.
		H. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

NQF #2633 SNF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients

NQF #2635 SNF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients

Section GG Functional Abilities and Goals - Start of SNF PPS Stay or State PDPM

GG0170. Mobility (If A0310B = 01, the assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B. If state requires completion with an OBRA assessment, the assessment period is the ARD plus 2 previous days; complete only column 1.)

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. PU/I
		D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to get on and off a toilet or commode.
		G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

PU/I Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [Risk Adjustment Item] (Measure calculated on Part A PPS Discharge) (S038.01)

Section GG Functional Abilities and Goals - Start of SNF PPS Stay or State PDPM

GG0170. Mobility (If A0310B = 01, the assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B. If state requires completion with an OBRA assessment, the assessment period is the ARD plus 2 previous days; complete only column 1.) - Continued

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ **Q1. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

Coding:
Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
⬢ ☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
⬢ ☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
⬢ ☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
⬢ ☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
⬢ ☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
⬢ ☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist; including fasteners; does not include footwear.
⬢ ☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

⬢ NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

⬢ NQF #2633 SNF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients

⬢ NQF #2635 SNF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

Coding:
Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
⬢ ☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
⬢ ☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
⬢ ☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
⬢ ☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
⬢ ☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
⬢ ☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
⬢ ☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
⬢ ☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
⬢ ☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
⬢ ☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

⬢ NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

⬢ NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

⬢ NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - Continued
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

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

Coding:
Safety and **Quality of Performance** – If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
⬢ ☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
⬢ ☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
⬢ ☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
⬢ ☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
⬢ ☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
☐	**Q3. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
☐	**RR3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
☐	**SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

⬢ NQF #2631 Percent of LTCH Part A residents with an admission and discharge functional assessment and a care plan that addresses function

⬢ NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients

⬢ NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances CAA

↓ Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube) ✓ = 6 (26.02)
- ☐ B. **External catheter** ✓ = 6
- ☐ C. $ **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. $ **Intermittent catheterization** ✓ = 6
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

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

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

Enter Code ☐

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

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

Enter Code ☐

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

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

H0300. Urinary Continence CAA

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) 6
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 6 16 (25.01)
3. **Always incontinent** (no episodes of continent voiding) 6 16 (25.01)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire **7 days**

H0400. Bowel Continence CAA ⬢

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence) (02.01)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 16 (02.01) (25.01) (26.02)
3. **Always incontinent** (no episodes of continent bowel movements) 16 (02.01) (25.01) (26.02)
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 CAA

Enter Code ☐

Constipation present?

0. **No**
1. **Yes** 14

6 Urinary Incontinence & Indwelling Catheter
14 Dehydration/Fluid Maintenance
16 Pressure Ulcer

(02.01) Residents with pressure ulcers that are new or worsened (Short Stay)
(25.01) Low risk residents who lose control of their bowel or bladder (Long Stay)
(26.02) Residents who have/had a catheter inserted and left in their bladder (Long Stay)

⬢ Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [Risk Adjustment Item] (Measure calculated on Part A PPS Discharge) (S038.01)

Section I Active Diagnoses

I0020. Indicate the resident's primary medical condition category

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

Enter Code

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

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

I0020B. ICD Code $

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

⬢ NQF #2633 SNF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (included in Risk Adjustment)

⬢ NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (included in Risk Adjustment)

⬢ NQF #2635 SNF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (included in Risk Adjustment)

⬢ NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (included in Risk Adjustment)

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Cancer

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

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias, tachycardias)
- ☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)** (02.01) ⬢

Gastrointestinal

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

Genitourinary

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

Infections CAA

- ☐ **I1700. $ Multidrug-Resistant Organism (MDRO)** ✓ = 14
- ☐ **I2000. $ Pneumonia** ✓ = 14
- ☐ **I2100. $ Septicemia** ✓ = 14
- ☐ **I2200. Tuberculosis** ✓ = 14
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)** ✓ = 14 (24.01)
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E) ✓ = 14
- ☐ **I2500. $ Wound Infection** (other than foot) ✓ = 14

Metabolic

- ☐ **I2900. $ Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy) (02.01) ⬢
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

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

Neurological CAA

- ☐ **I4200. Alzheimer's Disease** ✓ = 7 3
- ☐ **I4300. $ Aphasia**
- ☐ **I4400. $ Cerebral Palsy**
- ☐ **I4500. $ Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) ✓ = 7 3

Neurological Diagnoses continued on next page

7 3 Psychosocial Well-Being, 3 or More Items Trigger
14 Dehydration/Fluid Maintenance
(02.01) Residents with pressure ulcers that are new or worsened (Short Stay)
(24.01) Residents with a urinary tract infection (Long Stay)
⬢ Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [Risk Adjustment Item] (Measure calculated on Part A PPS Discharge) (S038.01)

Section I Active Diagnoses

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

Neurological – Continued

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

Nutritional

- ☐ I5600. $ **Malnutrition** (protein or calorie) or at risk for malnutrition 15.02

Psychiatric/Mood Disorder

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

Pulmonary

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

Vision CAA

- ☐ I6500. **Cataracts, Glaucoma, or Macular Degeneration** ✓ = 3

None of Above

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

Other

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

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

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

3 Visual Function

15.02 High-risk residents with pressure ulcers (Long Stay)

Section J Health Conditions

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

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted?

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

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

Pain Assessment Interview

J0300. Pain Presence

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

J0400. Pain Frequency CAA

Enter Code ☐ Ask resident: *"**How much of the time have you experienced pain or hurting** over the last **5 days**?"*
1. **Almost constantly** 19▶ 01.01 14.02
2. **Frequently** 19▶ 01.01 14.02
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** 19
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** 19
9. **Unable to answer**

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

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident *"Please rate your worst pain over the last **5 days** on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00-10 pain scale)
Enter two-digit response. Enter 99 if unable to answer. 4-10 = 19▶ 05-10 = 01.01 05-10 = 14.02

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** 19▶ 01.01 14.02
3. **Severe** 19▶ 01.01 14.02
4. **Very severe, horrible** 19▶ 01.01 14.02
9. **Unable to answer**

19 Pain
19▶ Pain, 2 Items Trigger
01.01 Residents who self-report moderate to severe pain (Short Stay)
14.02 Residents who self-report moderate to severe pain (Long Stay)

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

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

Staff Assessment for Pain

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

↓ Check all that apply

- ☐ **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning) ✓ = 19
- ☐ **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop) ✓ = 19
- ☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) ✓ = 19
- ☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) ✓ = 19
- ☐ **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

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

Enter Code ☐

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

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

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. $ Shortness of breath** or trouble breathing **when lying flat**
- ☐ **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 CAA

↓ Check all that apply

- ☐ **A. $ Fever** ✓ = 14
- ☐ **B. $ Vomiting** ✓ = 14
- ☐ **C. Dehydrated** ✓ = 12 14
- ☐ **D. Internal bleeding** ✓ = 14
- ☐ **Z. None of the above**

12 Nutritional Status
14 Dehydration/Fluid Maintenance
19 Pain

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission/Entry or Reentry CAA

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?
0. **No**
1. **Yes** 11
9. **Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2-6 months** prior to admission/entry or reentry?
0. **No**
1. **Yes** 11
9. **Unable to determine**

Enter Code ☐

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

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?
0. **No** → Skip to J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) 11 32.01

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:
0. **None**
13.01 1. **One**
13.01 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 1 or 2 = 13.01

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐

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

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

Enter Code ☐

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

11 Falls
11 Falls, 2 Items Trigger

13.01 Residents experiencing one or more falls with major injury (Long Stay)
32.01 Prevalence of falls (Long Stay)

NQF #2633 SNF Functional Outcome Measure: Change in Self-Care for Medical Rehabilitation Patients (included in Risk Adjustment)
NQF #2634 SNF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (included in Risk Adjustment)
NQF #2635 SNF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (included in Risk Adjustment)
NQF #2636 SNF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (included in Risk Adjustment)

Section J Health Conditions

Surgical Procedures – Complete only if J2100 = 1

↓ **Check all that apply**

	Major Joint Replacement
☐	**J2300.** $ **Knee Replacement** - partial or total
☐	**J2310.** $ **Hip Replacement** - partial or total
☐	**J2320.** $ **Ankle Replacement** - partial or total
☐	**J2330.** $ **Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400.** $ **Involving the spinal cord or major spinal nerves**
☐	**J2410.** $ **Involving fusion of spinal bones**
☐	**J2420.** $ **Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**
	Other Orthopedic Surgery
☐	**J2500.** $ **Repair fractures of the shoulder** - (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510.** $ **Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520.** $ **Repair but not replace joints**
☐	**J2530.** $ **Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600.** $ **Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610.** $ **Involving the peripheral or automatic nervous system** - open or percutaneous
☐	**J2620.** $ **Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700.** $ **Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710.** $ **Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800.** $ **Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810.** $ **Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies
☐	**J2899. Other major genitourinary surgery**
	Other Major Surgery
☐	**J2900.** $ **Involving tendons, ligaments, or muscles**
☐	**J2910.** $ **Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐	**J2920.** $ **Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐	**J2930.** $ **Involving the breast**
☐	**J2940.** $ **Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐	**J5000. Other major surgery not listed above**

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

↓ Check all that apply

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

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

inches ☐☐

pounds ☐☐☐

A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry ⬢ $ BMI ≥40

BMI (<18.5 or >24.9) = 12

BMI ≥12 and ≤19.0 (02.01)

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.) ⬢ $ BMI ≥40

BMI (<18.5 or >24.9) = 12

BMI ≥12 and ≤19.0 (02.01)

K0300. Weight Loss CAA

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 12
- $ 2. **Yes, not on** physician-prescribed weight-loss regimen 12 16 (29.01)

K0310. Weight Gain CAA

Enter Code ☐

Gain of 5% or more in the last month or gain of 10% or more in last 6 months

- 0. **No** or unknown
- 1. **Yes, on** physician-prescribed weight-gain regimen 12
- 2. **Yes, not on** physician-prescribed weight-gain regimen 12

K0510. Nutritional Approaches CAA

Check all of the following nutritional approaches that were performed during the **last 7 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***

		1. While NOT a Resident	2. While a Resident
		↓ Check all that apply ↓	
A.	**Parenteral/IV feeding** 12 14	$ ☐	$ ☐
B.	**Feeding tube** – nasogastric or abdominal (PEG) 13 14	$ ☐	$ ☐
C.	**Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids) 12		$ ☐
D.	**Therapeutic diet** (e.g., low salt, diabetic, low cholesterol) 12		☐
Z.	**None of the above**	☐	☐

12 Nutritional Status
13 Feeding Tubes
14 Dehydration/Fluid Maintenance
16 Pressure Ulcer

(02.01) Residents with pressure ulcers that are new or worsened (Short Stay)
(29.01) Residents who lose too much weight (Long Stay)

⬢ Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [Risk Adjustment Item] (Measure calculated on Part A PPS Discharge) (S038.01)

Section K Swallowing/Nutritional Status

K0710. Percent Intake by Artificial Route – Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

2. **While a Resident**
Performed ***while a resident*** of this facility and within the ***last 7 days***

3. **During Entire 7 Days**
Performed during the entire ***last 7 days***

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

Section L Oral/Dental Status

L0200. Dental CAA

↓ Check all that apply

☐	A.	**Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose) ✓ = 15
☐	B.	**No natural teeth or tooth fragment(s)** (edentulous) ✓ = 15
☐	C.	**Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn) ✓ = 15
☐	D.	**Obvious or likely cavity or broken natural teeth** ✓ = 15
☐	E.	**Inflamed or bleeding gums or loose natural teeth** ✓ = 15
☐	F.	**Mouth or facial pain, discomfort or difficulty with chewing** ✓ = 15
☐	G.	**Unable to examine**
☐	Z.	**None of the above were present**

15 Dental Care

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

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

M0100. Determination of Pressure Ulcer/Injury Risk

↓ Check all that apply

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

M0150. Risk of Pressure Ulcers/Injuries CAA

Enter Code ☐

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

0. **No**
1. **Yes** 16

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

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

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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

Enter Number ☐

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues 1-9 = 16

1. Number of Stage 1 pressure injuries

Enter Number ☐

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

1. $ Number of Stage 2 pressure ulcers – If 0 → Skip to M0300C, Stage 3 12 1-9 = 16 02.01 1-9 = 15.02 1-9 = 26.02

Enter Number ☐

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

M0300B1 - M0300B2 > 0

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 12 1-9 = 16 02.01 1-9 = 15.02 1-9 = 26.02

Enter Number ☐

2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

M0300C1 - M0300C2 > 0

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 12 1-9 = 16 1-9 = 15.02

1. $ Number of Stage 4 pressure ulcers – If 0 → Skip to M0300E, Unstageable – Non-removable dressing/device 02.01 1-9 = 26.02

Enter Number ☐

2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry

M0300D1 - M0300D2 > 0

M0300 continued on next page

12 Nutritional Status
16 Pressure Ulcer
02.01 Residents with pressure ulcers that are new or worsened (Short Stay)
15.02 High-risk residents with pressure ulcers (Long Stay)
26.02 Residents who have/had a catheter inserted and left in their bladder (Long Stay)
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Measure calculated on Part A PPS Discharge) (S038.01)

Section M Skin Conditions

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

Enter Number ☐

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

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** – If 0 → Skip to M0300F, Unstageable - Slough and/or eschar 12 1-9 = 16

Enter Number ☐

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

⬢ M0300E1 - M0300E2 > 0

Enter Number ☐

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

$ 1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** – If 0 → Skip to M0300G, Unstageable - Deep tissue injury 12 1-9 = 16

Enter Number ☐

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

⬢ M0300F1 - M0300F2 > 0

Enter Number ☐

G. Unstageable – Deep tissue injury:

1. **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 → Skip to M1030, Number of Venous and Arterial Ulcers 12 1-9 = 16

Enter Number ☐

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

⬢ M0300G1 - M0300G2 > 0

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐

$ **Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems CAA

↓ **Check all that apply**

Foot Problems

☐ A. $ **Infection of the foot** (e.g., cellulitis, purulent drainage) ✓ = 14

☐ B. $ **Diabetic foot ulcer(s)**

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

Other Problems

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

☐ E. $ **Surgical wound(s)**

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

☐ G. **Skin tear(s)**

☐ H. **Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage) ✓ = 6

None of the Above

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

12 Nutritional Status
16 Pressure Ulcer
6 Urinary Incontinence & Indwelling Catheter
14 Dehydration/Fluid Maintenance

⬢ Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury (Measure calculated on Part A PPS Discharge) (S038.01)

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

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

6 Urinary Incontinence & Indwelling Catheter
14 Dehydration/Fluid Maintenance

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

Enter Days ☐

Record the number of days that injections of any type were received during the last **7 days** or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, 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/entry or reentry if less than 7 days

Enter Days ☐

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

N0410. Medications Received CAA

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

Enter Days ☐ **A. Antipsychotic** 17 1-7 = 11.01 1-7 = 31.02

Enter Days ☐ **B. Antianxiety** 11 17 1-7 = 33.01 36.01

Enter Days ☐ **C. Antidepressant** 11 17

Enter Days ☐ **D. Hypnotic** 17 1-7 = 33.01 36.01

Enter Days ☐ **E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)

Enter Days ☐ **F. Antibiotic**

Enter Days ☐ **G. Diuretic**

Enter Days ☐ **H. Opioid**

N0450. Antipsychotic Medication Review

Enter Code ☐

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

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

Enter Code ☐

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

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

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

N0450 continued on next page

11 Falls
17 Psychotropic Drug Use

11.01 Residents who newly received an antipsychotic medication (Short Stay)
31.02 Residents who newly received an antipsychotic medication (Long Stay)
33.01 Prevalence of antianxiety/hypnotic use (Long Stay)
36.01 Residents who used antianxiety or hypnotic medication (Long Stay)

Section N Medications

N0450. Antipsychotic Medication Review - Continued

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

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

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

Enter Code ☐

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

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

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

Enter Code ☐

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

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

N2005. Medication Intervention - Complete only if A0310H = 01

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

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

Drug Regimen Review (DRR) conducted with follow-up for identified issues (S007.01)

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

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

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	$ ☐
B. Radiation	☐	$ ☐
Respiratory Treatments		
C. Oxygen therapy	☐	$ ☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	$ ☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	$ ☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐	☐
Other		
H. IV medications	☐	$ ☐
I. Transfusions	☐	$ ☐
J. Dialysis	☐	$ ☐
K. Hospice care	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	$ ☐
None of the Above		
Z. None of the above	☐	☐

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

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?
0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received (03.02) (04.02) (16.02) (17.02)

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. **If Influenza vaccine not received, state reason:**
1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility** (03.02) (04.02) (16.02) (17.02)
3. **Not eligible** – medical contraindication (03.02) (06.02) (16.02) (19.02)
4. **Offered and declined** (03.02) (05.02) (16.02) (18.02)
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. **Is the resident's Pneumococcal vaccination up to date?**
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies (07.01) (20.01)

Enter Code ☐

B. **If Pneumococcal vaccine not received, state reason:**
1. **Not eligible** – medical contraindication (07.01) (20.01)
2. **Offered and declined** (07.01) (20.01)
3. **Not offered**

(03.02) Residents who were assessed and appropriately given the seasonal influenza vaccine (Short Stay)
(04.02) Residents who received the seasonal influenza vaccine (Short Stay)
(05.02) Residents who were offered and declined the seasonal influenza vaccine (Short Stay)
(06.02) Residents who did not receive, due to medical contraindication, the seasonal influenza vaccine (Short Stay)
(7.01) Residents accessed and appropriately given the pneumococcal vaccine (Short Stay)
(16.02) Residents assessed and appropriately given the seasonal influenza vaccine (Long Stay)
(17.02) Residents who received the seasonal influenza vaccine (Long Stay)
(18.02) Residents who were offered and declined the seasonal influenza vaccine (Long Stay)
(19.02) Residents who did not receive, due to medical contraindication, the seasonal influenza vaccine (Long Stay)
(20.01) Residents assessed and appropriately given the pneumococcal vaccine (Long Stay)

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

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

Enter Number of Minutes

2. **Concurrent minutes** – record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last **7 days**

Enter Number of Minutes

3. **Group minutes** – record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last **7 days**

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

Enter Number of Minutes

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

Enter Number of Days

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

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

Month – Day – Year

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

Month – Day – Year

B. Occupational Therapy

Enter Number of Minutes

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

Enter Number of Minutes

2. **Concurrent minutes** – record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last **7 days**

Enter Number of Minutes

3. **Group minutes** – record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last **7 days**

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

Enter Number of Minutes

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

Enter Number of Days

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

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

Month – Day – Year

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

Month – Day – Year

O0400 continued on next page

Section O Special Treatments, Procedures, and Programs

O0400. Therapies – Continued

C. Physical Therapy

Enter Number of Minutes

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

Enter Number of Minutes

2. **Concurrent minutes** – record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last **7 days**

Enter Number of Minutes

3. **Group minutes** – record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last **7 days**

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

Enter Number of Minutes

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

Enter Number of Days

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

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

Month – Day – Year

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

Month – Day – Year

D. Respiratory Therapy

Enter Number of Minutes

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

Enter Number of Days

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

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

Enter Number of Minutes

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

Enter Number of Days

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

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes

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

Enter Number of Days

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

O0420. Distinct Calendar Days of Therapy

Enter Number of Days

Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Section O Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Complete only if A0310H = 1

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

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

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Days [ ][ ][ ]

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

B. Occupational Therapy

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

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

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Days [ ][ ][ ]

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

C. Physical Therapy

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Minutes [ ][ ][ ][ ]

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

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy

Enter Number of Minutes [ ][ ][ ][ ]

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

Enter Number of Days [ ][ ][ ]

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

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days [ ][ ][ ]

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

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0500. Restorative Nursing Programs

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

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

O0600. Physician Examinations +

Enter Days ☐☐

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 ☐☐

Over the last **14 days**, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

[+ NOTE: CMS does not require completion of this item; however some states continue to require its completion. Check with your state for requirement.]

Resident _____ Identifier _____ Date _____

Section P Restraints and Alarms

P0100. Physical Restraints CAA

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

Coding:
0. **Not used**
1. **Used less than daily**
27.01 2. **Used daily**

↓ Enter Codes in Boxes

	Used in Bed
☐	**A. Bed rail** 1 or 2 = 18
☐	**B. Trunk restraint** 1 or 2 = 11 1 or 2 = 16 18 27.01
☐	**C. Limb restraint** 1 or 2 = 18 27.01
☐	**D. Other** 1 or 2 = 18
	Used in Chair or Out of Bed
☐	**E. Trunk restraint** 1 or 2 = 11 1 or 2 = 16 18 27.01
☐	**F. Limb restraint** 1 or 2 = 18 27.01
☐	**G. Chair prevents rising** 1 or 2 = 18 27.01
☐	**H. Other** 1 or 2 = 18

P0200. Alarms

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

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

↓ Enter Codes in Boxes

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

11 Falls
16 Pressure Ulcer
18 Physical Restraints
27.01 Residents who were physically restrained (Long Stay)

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. **Resident has no family or significant other**

Enter Code ☐

C. Guardian or legally authorized representative participated in assessment
0. **No**
1. **Yes**
9. **Resident has no guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

A. Select one for resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **Unknown or uncertain**

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

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

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0550. Resident's Preferences to Avoid Being Asked Question Q0500B Again

Enter Code ☐

A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.)
0. **No** – then document in resident's clinical record and ask again only on the next comprehensive assessment
1. **Yes**
8. **Information not available**

Enter Code ☐

B. Indicate information source for Q0550A
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**

Q0600. Referral CAA

Enter Code ☐

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)
0. **No** – referral not needed
1. **No** – referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 20
2. **Yes** – referral made

20 Return to Community Referral

Resident _____ Identifier _____ Date _____

Section V Care Area Assessment (CAA) Summary

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

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

Enter Code

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

01. **Admission** assessment (required by **day 14**)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. None of the above

Enter Code

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

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

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

Month – Day – Year

Enter Code

D. **Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score** (C0500 value from prior assessment) 1 2

Enter Code

E. **Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score** (D0300 value from prior assessment) 8 3

Enter Code

F. **Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score** (D0600 value from prior assessment) 8 3

1 2 Delirium, 2 Items Trigger
8 3 Mood State, 3 or More Items Trigger

Section V Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

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

A. CAA Results

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

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

1. Signature

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

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

1. Signature

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

Resident _____ Identifier _____ Date _____

Section X Correction Request

Complete Section X only if A0050 = 2 or 3

Identification of Record to be Modified/Inactivated – The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect.
This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider (A0200 on existing record to be modified/inactivated)

Enter Code ☐

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

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender (A0800 on existing record to be modified/inactivated)

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

X0570. Optional State Assessment (A0300A on existing record to be modified/inactivated)

Enter Code ☐

A. Is this assessment for state payment purposes only?
0. **No**
1. **Yes**

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by **day 14**)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment (Initial Medicare Assessment)

PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment

Not PPS Assessment
99. **None of the above**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** tracking record
10. **Discharge** assessment - **return not anticipated**
11. **Discharge** assessment - **return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code ☐

H. Is this a SNF Part A PPS Discharge Assessment?
0. **No**
1. **Yes**

Section X Correction Request

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

A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) – Complete only if X0600F = 99

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Correction Attestation Section – Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ Check all that apply

☐ **A. Transcription error**

☐ **B. Data entry error**

☐ **C. Software product error**

☐ **D. Item coding error**

☐ **Z. Other error requiring modification**
If "Other" checked, please specify: _____

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

↓ Check all that apply

☐ **A. Event did not occur**

☐ **Z. Other error requiring inactivation**
If "Other" checked, please specify: _____

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

☐☐☐☐☐☐☐☐☐☐☐☐

B. Attesting individual's last name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

C. Attesting individual's title:

D. Signature

E. Attestation date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code

B. Version code:

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

A. Case Mix group:

B. Version code:

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

A. Case Mix group:

B. Version code:

Z0300. Insurance Billing

A. Billing code:

B. Billing version:

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature	Title	Sections	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month – Day – Year

RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14th calendar day of the resident's admission (admission date +13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f) (3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f) (3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

PPS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional Assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Claims-Based Measures		
Measure	**Data Source**	**Program**
Discharge to Community: Percent of short-stay residents who were successfully discharged to the community after a nursing home admission	Inpatient/ FSS Medicare Claims	Five-Star NHC
Potentially Preventable 30-Days Post-Discharge Readmission: Percentage of Medicare residents who readmitted to an acute care hospital or LTCH with a diagnosis considered to be potentially preventable	Inpatient/ FSS Medicare Claims	QRP
SNF 30-Day All-Cause Readmission: Number of Medicare residents who have an unplanned readmission to acute hospital within 30 days of discharge from prior hospitalization	Inpatient/ FSS Medicare Claims	QRP VBP
Medicare Spending Per Beneficiary: Average risk-adjusted episode spending across all episodes for SNF and other healthcare providers	All Medicare Claims	QRP
Outpatient ED Visit: Percentage of short-stay residents who entered or reentered a nursing home from a hospital and visited an ED with 30 days of the start of stay with this visit not resulting in inpatient or observation stay	Inpatient/ FSS Medicare Claims	Five-Star NHC
Discharge to Community	Inpatient/ FSS Medicare Claims	QRP
Rehospitalized After Nursing Home Admission: Percent of short-stay residents who were rehospitalized after admission to a nursing home	Inpatient/ FSS Medicare Claims	Five-Star NHC

Program Key:
Five-Star = Five-Star Quality Rating System
NHC = Nursing Home Compare
QRP = Quality Reporting Program (SNF)
VBP = Value-Based Purchasing Program

ADL Self-Performance Rule of 3 Algorithm

START HERE – Review these instructions for Rule of 3 before using the algorithm. **Follow steps in sequence and stop at first level that applies. Start by counting the number of episodes at each ADL Self-Performance Level.**

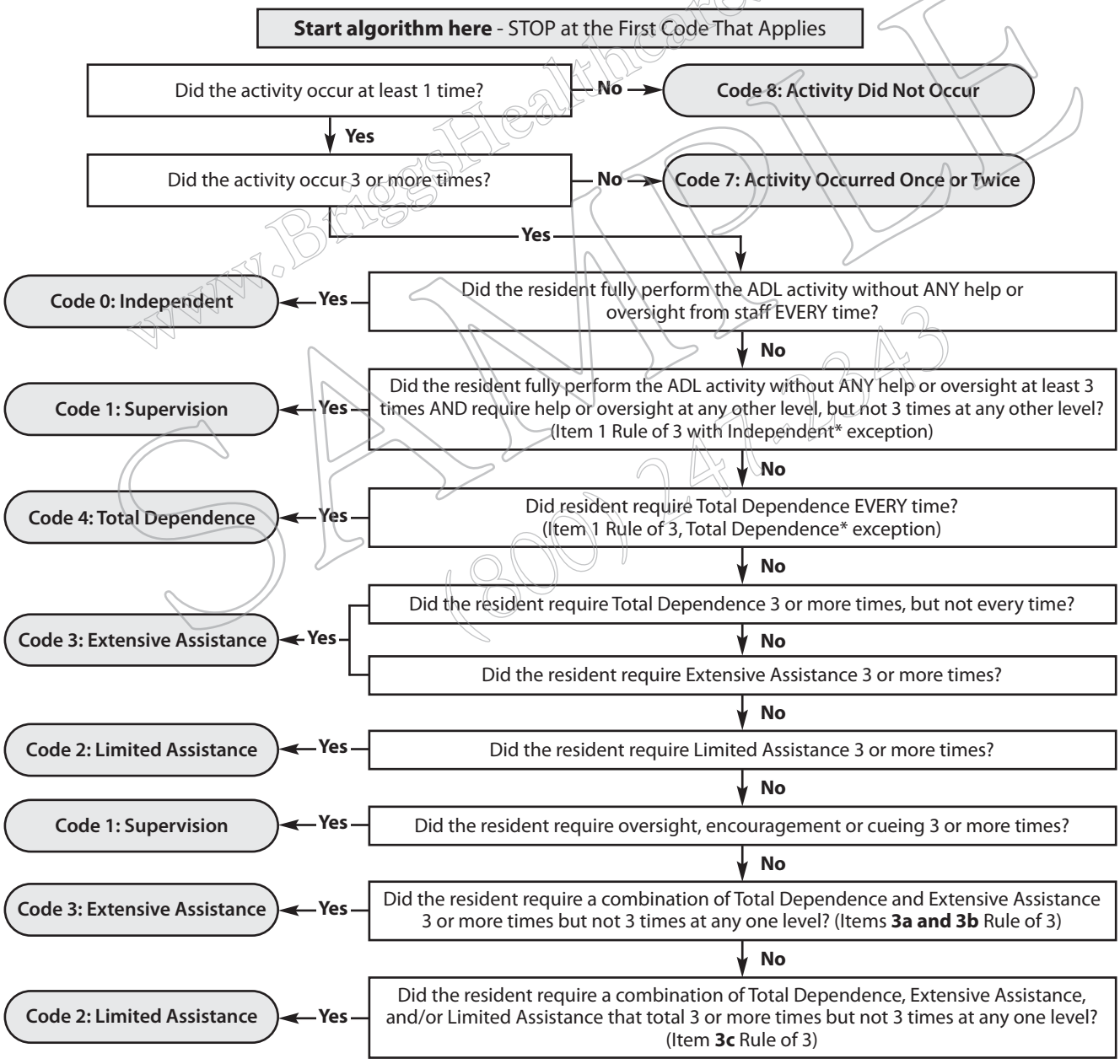
*** Exceptions to Rule of 3:**

- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

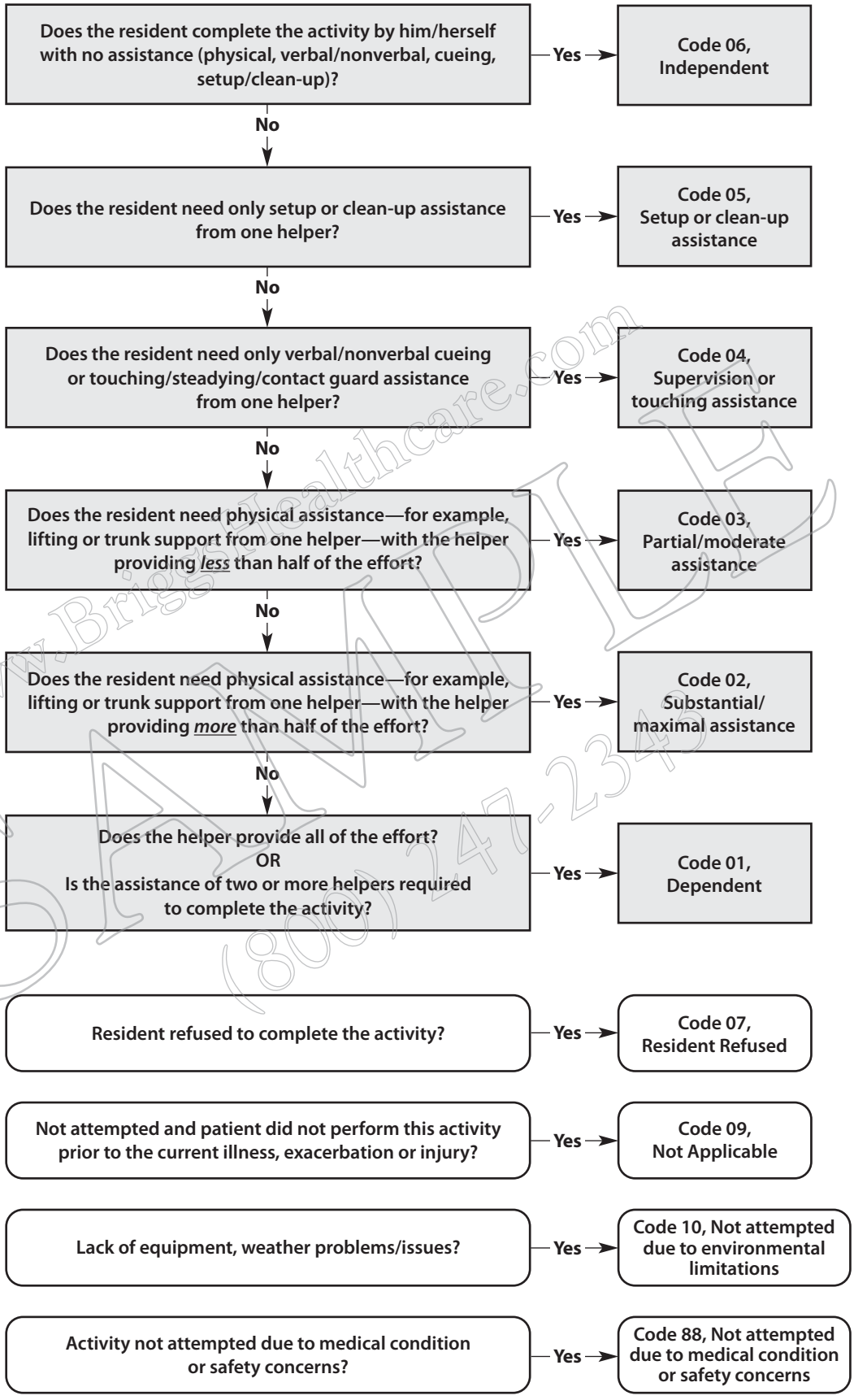
Rule of 3:

1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule ***only*** applies if there are **NOT ANY LEVELS that are 3 or more episodes at any one level.** DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

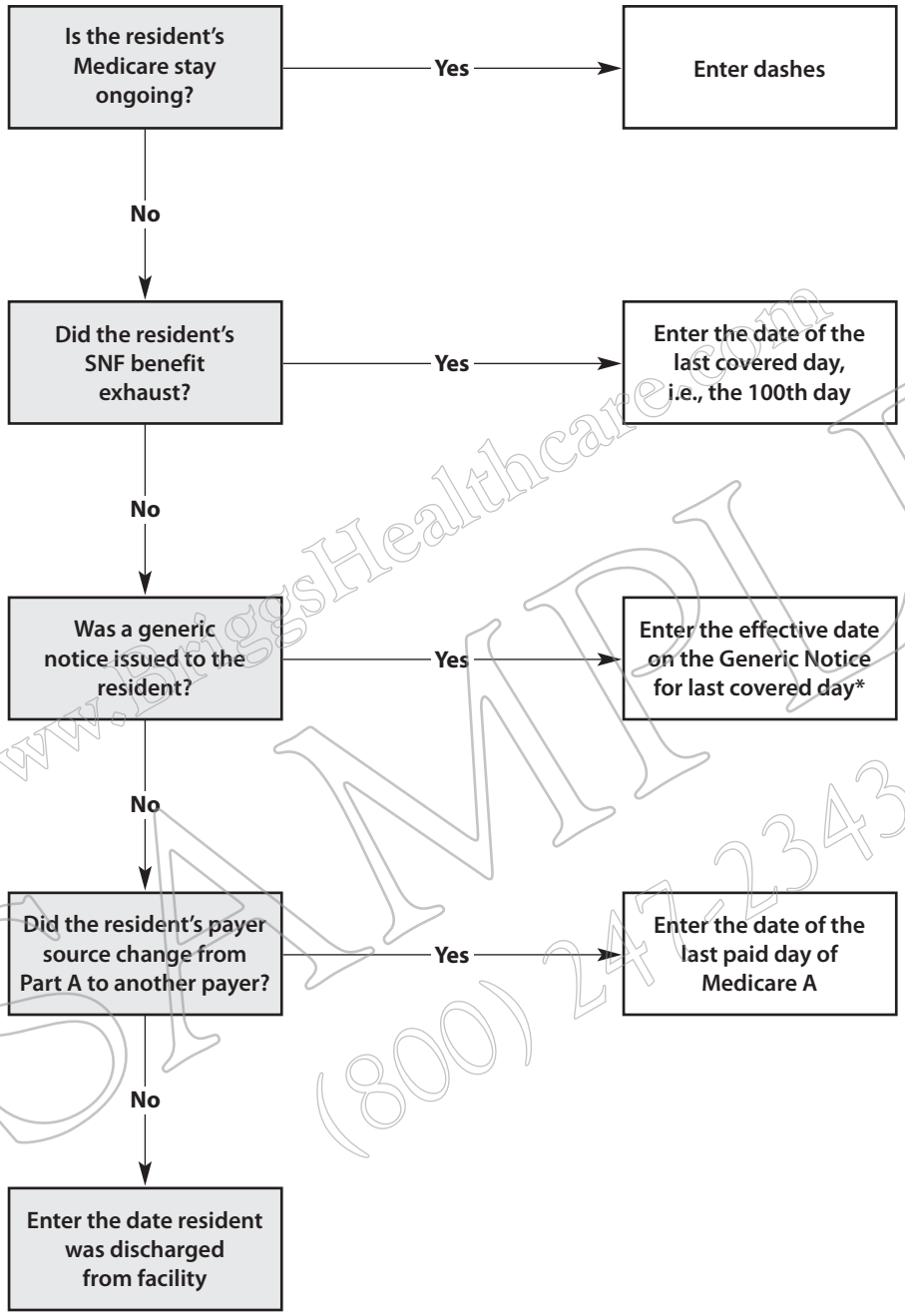
   If none of the above are met, code Supervision (1).



Section GG Coding Decision Tree



Medicare Stay End Date Algorithm
A2400C



*If resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

MDS and PDPM Online Resources

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Patient Driven Payment Model – Fact Sheets, PDPM FAQs, PDPM Training Presentation, PDPM Resources (Grouper Logic and ICD-10 Mappings)
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PDPM Calculation Worksheet for SNFs
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/SNF_PDPM_Classification_Walkthrough_20181116.pdf

QIES Technical Office Support
https://qtso.cms.gov/

QIES Technical Office Support – Nursing Home/Swing Bed Providers (News & Updates)
https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers

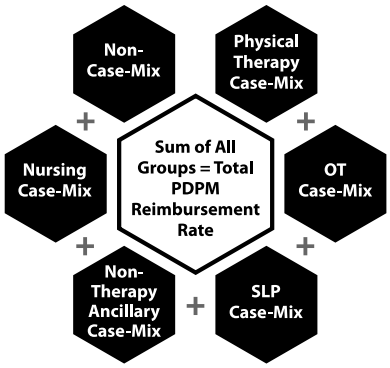
QIES Technical Support – Nursing Home/Swing Bed Providers – Reference and Manuals (CASPER Reporting User's Guide for MDS Providers, MDS 3.0 Provider User's Guide, CMSNet Installation Guide & FAQs, etc.)
https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals

QIES Technical Support – Nursing Home/Swing Bed Providers – Access Forms
https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/access-forms

Skilled Nursing Facility (SNF) Quality Reporting Program Measures and Technical Information
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information.html

Quality Measures
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/User-Manuals.zip

Patient Driven Payment Model (PDPM) Classification



http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

PHYSICAL THERAPY COMPONENT

I0020B ICD Code:_____ **Default Primary Diagnosis Clinical Category:**_____

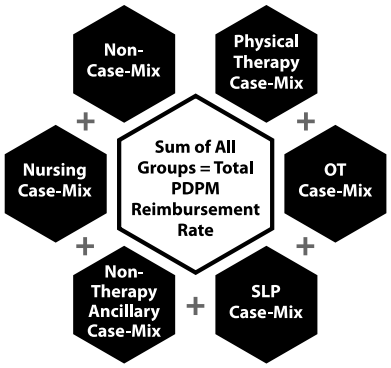
Primary Diagnosis Clinical Category	PT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

Section GG Function Item for PT Payment	Description	Score	Admission (Column 1) or Interim (Column 5) Section GG Function Performance	Function Score
GG0130A1	Self-Care: Eating	0 - 4	05, 06 Set up or independent	4
GG0130B1	Self-Care: Oral Hygiene	0 - 4	04 Supervision or touch assist	3
GG0130C1	Self-Care: Toileting Hygiene	0 - 4	03 Partial or moderate assist	2
GG0170B1	Self-Care: Sit to lying	0 - 4 (Average of these 2 mobility items)	02 Substantial/maximal assist	1
GG0170C1	Self-Care: Lying to sitting on side of bed		01, 07, 09, 88, missing value Dependent, refused, not applicable, not attempted	0
GG0170D1	Mobility: Sit to stand	0 - 4 (Average of these 3 transfer items)		
GG0170E1	Mobility: Chair/bed-to-chair transfer			
GG0170F1	Mobility: Toilet transfer			
GG0170J1	Mobility: Walk 50 feet with 2 turns	0 - 4 (Average of these 2 walking items)		
GG0170K1	Mobility: Walk 150 feet			

PDPM Function Score for PT Payment ranges from 0 - 24

Clinical Category	Section GG Function Score	PT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0 - 5	TA
Major Joint Replacement or Spinal Surgery	6 - 9	TB
Major Joint Replacement or Spinal Surgery	10 - 23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0 - 5	TE
Other Orthopedic	6 - 9	TF
Other Orthopedic	10 - 23	TG
Other Orthopedic	24	TH
Medical Management	0 - 5	TI
Medical Management	6 - 9	TJ
Medical Management	10 - 23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0 - 5	TM
Non-Orthopedic Surgery and Acute Neurologic	6 - 9	TN
Non-Orthopedic Surgery and Acute Neurologic	10 - 23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

Patient Driven Payment Model (PDPM) Classification



http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

OCCUPATIONAL THERAPY COMPONENT

I0020B ICD Code:_____ **Default Primary Diagnosis Clinical Category:**_____

Primary Diagnosis Clinical Category	OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

Section GG Function Item for OT Payment	Description	Score
GG0130A1	Self-Care: Eating	0 - 4
GG0130B1	Self-Care: Oral Hygiene	0 - 4
GG0130C1	Self-Care: Toileting Hygiene	0 - 4
GG0170B1	Self-Care: Sit to lying	0 - 4 (Average of these 2 mobility items)
GG0170C1	Self-Care: Lying to sitting on side of bed	
GG0170D1	Mobility: Sit to stand	0 - 4 (Average of these 3 transfer items)
GG0170E1	Mobility: Chair/bed-to-chair transfer	
GG0170F1	Mobility: Toilet transfer	
GG0170J1	Mobility: Walk 50 feet with 2 turns	0 - 4 (Average of these 2 walking items)
GG0170K1	Mobility: Walk 150 feet	

Admission (Column 1) or Interim (Column 5) Section GG Function Performance	Function Score
05, 06 Set up or independent	4
04 Supervision or touch assist	3
03 Partial or moderate assist	2
02 Substantial/maximal assist	1
01, 07, 09, 88, missing value Dependent, refused, not applicable, not attempted	0

PDPM Function Score for OT Payment ranges from 0 - 24

Clinical Category	Section GG Function Score	OT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0 - 5	TA
Major Joint Replacement or Spinal Surgery	6 - 9	TB
Major Joint Replacement or Spinal Surgery	10 - 23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0 - 5	TE
Other Orthopedic	6 - 9	TF
Other Orthopedic	10 - 23	TG
Other Orthopedic	24	TH
Medical Management	0 - 5	TI
Medical Management	6 - 9	TJ
Medical Management	10 - 23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0 - 5	TM
Non-Orthopedic Surgery and Acute Neurologic	6 - 9	TN
Non-Orthopedic Surgery and Acute Neurologic	10 - 23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

Patient Driven Payment Model (PDPM) Classification

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

SPEECH-LANGUAGE PATHOLOGY COMPONENT

I0020B ICD Code:_____ **Default Primary Diagnosis Clinical Category:**_____

PDPM Cognitive Level	BIMS Interview Score (C0500)	CPS Score (Staff Assessment)
Cognitively Intact	13 - 15	0
Mildly Impaired	8 - 12	1 - 2
Moderately Impaired	0 - 7	3 - 4
Severely Impaired	–	5 - 6

Impairment Count (Sum)	PDPM Cognitive Level
Severe Impairment Count = 1 or 2 **and** Basic Impairment Count = 2 or 3	Moderately Impaired
Basic Impairment Count = 1 **and** Severe Impairment Count = 0, 1 or 2 **OR** Basic Impairment Count = 2 or 3 **and** Severe Impairment Count = 0	Mildly Impaired
Severe Impairment Count **and** Basic Impairment Count = 0	Cognitively Intact

Staff Assessment for Mental Status Elements	Impairment Count
Comatose (B0100=1) **and** GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1 and GG0170F1 = 01, 09 or 88 (at admission) **OR** Severely impaired Cognitive Skills for Daily Decision Making (C1000=3) **AND** **Add one:** Cognitive Skills for Daily Decision Making (C1000=2) **Add one:** Makes Self Understood (B0700=2 or 3)	Severe Impairment Count **Sum:** _____
Add one: Cognitive Skills for Daily Decision Making (C1000=1 or 2) **Add one:** Makes Self Understood (B0700=1, 2 or 3) **Add one:** Memory Problem (C0700=1)	Basic Impairment Count **Sum:** _____ (Add each of these 3 items; total sum will be 0 – 3)

Primary Diagnosis Clinical Category	SLP Clinical Category
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Non-Neurologic
Non-Orthopedic Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Pulmonary	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Acute Neurologic	Acute Neurologic
Cancer	Non-Neurologic
Medical Management	Non-Neurologic

SLP-Related Comorbidities

MDS Item	Description	Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
I4300	Aphasia	None	Neither	SA
I4500	CVA, TIA or Stroke	None	Either	SB
I4900	Hemiplegia or Hemiparesis	None	Both	SC
I5500	Traumatic Brain Injury (TBI)	Any one	Neither	SD
I8000	Laryngeal Cancer	Any one	Either	SE
I8000	Apraxia (I69.990)	Any one	Both	SF
I8000	Dysphagia (I69.991)	Any two	Neither	SG
I8000	ALS (G12.21)	Any two	Either	SH
I8000	Oral Cancers	Any two	Both	SI
I8000	Speech and Language Deficits	Any three	Neither	SJ
O0100E2	Tracheostomy Care While a Patient	Any three	Either	SK
O0100F2	Ventilator or Respirator While a Patient	Any three	Both	SL

Patient Driven Payment Model (PDPM) Classification

NON-THERAPY ANCILLARIES COMPONENT

NTA Comorbidity Score Calculation

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	N/A (SNF Claim)	8
Parenteral IV Feeding: Level High	K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medications Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	O0100F2	4
Parenteral IV Feeding: Level Low	K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments Programs: Transfusion Post-admit Code	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma, COPD, Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1
Stage 4 Unhealed Pressure Ulcer Currently present[1]	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A, M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	H0100D	1
Inflammatory Bowel Disease	I8000	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Patient: Feeding Tube	K0510B2	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

NTA Score Range	NTA Case-Mix Grp	NTA Score Range	NTA Case-Mix Grp
12+	NA	3 - 5	ND
9 - 11	NB	1 - 2	NE
6 - 8	NC	0	NF

[1] If the number of Stage 4 Unhealed Pressure Ulcers is recorded as greater than 0, it will add one point to the NTA comorbidity score calculation. Only the presence, not the count, of Stage 4 Unhealed Pressure Ulcers affects the PDPM NTA co-morbidity score calculation.

Patient Driven Payment Model (PDPM) Classification

NURSING COMPONENT

Section GG Admission Function Items for Nursing Payment	Description	Score	Admission (Column 1) Section GG Function Performance	Function Score
GG0130A1	Self-Care: Eating	0 - 4	05, 06 Set up or independent	4
GG0130C1	Self-Care: Toileting hygiene	0 - 4	04 Supervision or touch assist	3
GG0170B1	Self-Care: Sit to lying	0 - 4	03 Partial or moderate assist	2
GG0170C1	Self-Care: Lying to sitting on side of bed	(Average of these 2 mobility items)	02 Substantial/maximal assist	1
GG0170D1	Mobility: Sit to stand	0 - 4	01, 07, 09, 88, missing value Dependent, refused, not applicable, not attempted	0
GG0170E1	Mobility: Chair/bed-to-chair transfer	(Average of these 3 transfer items)		
GG0170F1	Mobility: Toilet transfer			

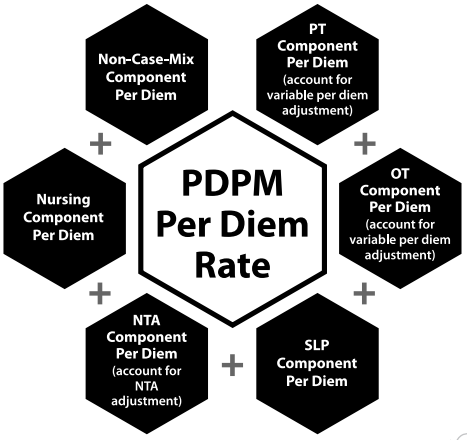
Nursing Category	Criteria	Conditions/ Services Provided	Conditions/ Services Present	Nursing Function Score	Nursing Case-Mix Group	Nursing CMI
Extensive Services	Tracheostomy Care, Ventilator Care and/or Infection Isolation While a Resident	Tracheostomy **AND** Ventilator	Yes	0 – 14	ES3	4.04
	If Nursing Function Score is 15 - 16, the resident meeting this criteria will drop to Clinically Complex	Tracheostomy **OR** Ventilator	Yes	0 – 14	ES2	3.06
		Isolation for Active Infection (no trach care or ventilator)	Yes	0 - 14	ES1	2.91
Special Care High	Comatose, Septicemia, Quadriplegia, COPD **and** SOB lying flat, Fever and Pneumonia, Vomiting, Weight Loss, Feeding Tube, Parenteral/IV Feedings, Respiratory Therapy all 7 days, DM with BOTH insulin QD **and** insulin order changes on 2+ days	Depressed (PHQ-9 ≥ 10)	Yes	0 - 5	HDE2	2.39
		Depressed	No	0 - 5	HDE1	1.99
		Depressed (PHQ-9 ≥ 10)	Yes	6 - 14	HBC2	2.23
		Depressed	No	6 - 14	HBC1	1.85
	If Nursing Function Score is 15 - 16, the resident meeting this criteria will drop to Clinically Complex					
Special Care Low	CP, MS, Parkinson's, Respiratory Failure **and** Oxygen, Feeding Tube*, Radiation, Dialysis, 2+ Skin Treatments^ for the following wounds: 2+ Stage 2, Stage 3 or Stage 4, 2+ venous/arterial ulcers, 1 Stage 2 and 1 venous/arterial ulcer, foot infection, open lesion to the foot	Depressed (PHQ-9 ≥ 10)	Yes	0 - 5	LDE2	2.07
		Depressed	No	0 - 5	LDE1	1.72
		Depressed (PHQ-9 ≥ 10)	Yes	6 - 14	LBC2	1.71
		Depressed	No	6 - 14	LBC1	1.43
	If Nursing Function Score is 15 - 16, the resident meeting this criteria will drop to Clinically Complex					
Clinically Complex	Chemotherapy, Oxygen, IV Medications, Transfusions, Hemiplegia/Hemiparesis, Open Lesion, Surgical Wound, Burns While a Resident	Depressed (PHQ-9 ≥ 10)	Yes	0 - 5	CDE2	1.86
		Depressed	No	0 - 5	CDE1	1.62
		Depressed (PHQ-9 ≥ 10)	Yes	6 - 14	CBC2	1.54
		Depressed (PHQ-9 ≥ 10)	Yes	15 - 16	CA2	1.08
		Depressed	No	6 - 14	CBC1	1.34
		Depressed	No	15 - 16	CA1	0.94
Behavior Symptoms Cognition	BIMS Score ≤ 9, Severely/moderately impaired in decision making, Delusions, Hallucinations, Physical/verbal/other behaviors directed toward others, Rejection of Care, Wandering	Restorative Nursing	2 or more	11 - 16	BAB2	1.04
		Restorative Nursing	0 - 1	11 - 16	BAB1	0.99
Reduced Physical Functioning	All other resident who do not meet the requirements for other categories are placed into this category as residents who require assistance with some ADLs	Restorative Nursing	2 or more	0 - 5	PDE2	1.57
		Restorative Nursing	0 - 1	0 - 5	PDE1	1.47
		Restorative Nursing	2 or more	6 - 14	PBC2	1.21
		Restorative Nursing	2 or more	15 - 16	PA2	0.70
		Restorative Nursing	0 - 1	6 - 14	PBC1	1.13
		Restorative Nursing	0 - 1	15 - 16	PA1	0.66

*To qualify for Special Care Low: K0710A3 = 51% or more of total calories **OR** K0710A3 = 26% to 50% of total calories **AND** K0710B3 is 501cc or more fluid per day of enteral intake in the last 7 days.

^Selected skin/wound treatments are:

- M1200A, B…Pressure relieving chair and/or bed
- M1200C…Turning/repositioning
- M1200D…Nutrition or hydration intervention
- M1200E…Pressure ulcer care
- M1200G…Application of dressing (not to feet)
- M1200H…Application or ointments (not to feet)

Patient Driven Payment Model (PDPM) Classification



http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

CALCULATION OF VARIABLE PER DIEM PAYMENT ADJUSTMENT

Day In Stay	PT and OT Adjustment Factor	Day In Stay	NTA Adjustment Factor
1 - 20	1.00	1 - 3	3.00
21 - 27	0.98	4 - 100	1.00
28 - 34	0.96		
35 - 41	0.94		
42 - 48	0.92		
49 - 55	0.90		
56 - 62	0.88		
63 - 69	0.86		
70 - 76	0.84		
77 - 83	0.82		
84 - 90	0.80		
91 - 97	0.78		
98 - 100	0.76		

Notes:

Notes