MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Optional State Assessment (OSA) 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

Enter Code ☐

A. Is this assessment for state payment purposes only?

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

Enter Code ☐

B. Assessment type

1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

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: ☐☐☐☐☐☐☐☐☐☐☐☐

Section A - Identification Information

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A1005. Ethnicity

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

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

A1010. Race

What is your race?

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

Section A - Identification Information

A1110. Language

A. What is your preferred language?

Enter Code

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

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:

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month - Day - Year

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

Month - Day - Year

A2300. Assessment Reference Date

Observation end date:

Month - Day - Year

A2400. 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

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 B0700, Makes Self Understood
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0700. Makes Self Understood

Enter Code ☐

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

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

Section C - Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code ☐

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

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

Enter Code ☐

Number of words repeated after first attempt

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

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

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

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

Enter Code ☐

A. Able to report correct year

1. **Missed by > 5 years** or no answer
2. **Missed by 2-5 years**
3. **Missed by 1 year**
4. **Correct**

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

Enter Code ☐

B. Able to report correct month

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

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

Enter Code ☐

C. Able to report correct day of the week

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

Section C - Cognitive Patterns

C0400. Recall

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

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Code ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

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 D0100, Should Resident Mood Interview be conducted?
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code ☐

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

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

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

Section D - Mood

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

Enter Code ☐

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

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: ***"Over the last 2 weeks, have you been bothered by any of the following problems?"***

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: *"About* **how often** *have you been bothered by this?"*

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

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

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure, or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Section D - Mood

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

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

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

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

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

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

D0600. Total Severity Score

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

Section E - Behavior

E0100. Potential Indicators of Psychosis

Check all that apply

↓

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

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:

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

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

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

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

E0800. Rejection of Care - Presence & Frequency

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.

Enter Code ☐

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

E0900. Wandering - Presence & Frequency

Has the resident wandered?

Enter Code ☐

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

Section G - Functional Status

G0110. Activities of Daily Living (ADL) Assistance

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

Instructions for Rule of 3

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

If none of the above are met, code supervision.

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

Coding:

Activity Occurred 3 or More Times

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

Activity Occurred 2 or Fewer Times

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

2. ADL Support 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	☐	☐
B.	**Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
H.	**Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I.	**Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐

Section H - Bladder and Bowel

H0200. Urinary Toileting Program

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**

H0500. Bowel Toileting Program

Enter Code ☐

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

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

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

Infections

- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)

Neurological

- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5300. Parkinson's Disease**

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**

None of Above

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

Section J - Health Conditions

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1550. Problem Conditions

↓ **Check all that apply**

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

Section K - Swallowing/Nutritional Status

K0300. Weight Loss

Enter Code ☐

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

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

K0510. Nutritional Approaches

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	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
Z. None of the above	☐	☐

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

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

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

Section M - Skin Conditions

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

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐

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

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

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

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

Enter Number ☐

1. Number of Stage 1 pressure injuries

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

Enter Number ☐

1. Number of Stage 2 pressure ulcers

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

Enter Number ☐

1. Number of Stage 3 pressure ulcers

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

Enter Number ☐

1. Number of Stage 4 pressure ulcers

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

Enter Number ☐

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

Section M - Skin Conditions

M1030. Number of Venous and Arterial Ulcers

Enter Number

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

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

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

Other Problems

- ☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- ☐ **E. Surgical wound(s)**
- ☐ **F. Burn(s)** (second or third degree)

None of the Above

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

M1200. Skin and Ulcer/Injury Treatments

↓ **Check all that apply**

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

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 O0100, Special Treatments, Procedures, and Programs

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

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)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	[redacted]	☐
Other		
Z. None of the above	☐	☐

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 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 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

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 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 Days

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

Section O - Special Treatments, Procedures, and Programs

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.

O0450. Resumption of Therapy

Enter Code ☐

A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?

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

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?**

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)**

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/B on existing record to be modified/inactivated)

Enter Code ☐

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

Enter Code ☐

B. Assessment type
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment
5. **Other payment** assessment

X0700. Date on existing record to be modified/inactivated

A. Assessment Reference Date (A2300 on existing record to be modified/inactivated)

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Section X - Correction Request

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

X0800. Correction Number

Enter Number

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

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

↓ **Check all that apply**

- ☐ **A. Transcription error**
- ☐ **B. Data entry error**
- ☐ **C. Software product error**
- ☐ **D. Item coding error**
- ☐ **Z. Other error requiring modification**
  If "Other" checked, please specify: _____

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

↓ **Check all that apply**

- ☐ **A. Event did not occur**
- ☐ **Z. Other error requiring inactivation**
  If "Other" checked, please specify: _____

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

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B. Attesting individual's last name:

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C. Attesting individual's title:

D. Signature

E. Attestation date

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Section Z - Assessment Administration

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

A. Case Mix group:

B. Version code:

Enter Code

C. Is this a Short Stay assessment?

0. No
1. Yes

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