

# **MDS 3.0: Recommended Form**



**A1. Facility Provider Numbers**

**a. National Provider Identifier (NPI)**

\_\_\_\_\_

**b. CMS Certification Number (CCN)**

\_\_\_\_\_

**c. State Provider Number**

\_\_\_\_\_

**A2. Legal Name of Resident**

\_\_\_\_\_

a. (First)

b. (Middle Initial)

c. (Last)

d. (Suffix)

**A3. Social Security and Medicare Numbers**

**a. Social Security Number**

\_\_\_\_\_

**b. Medicare number** (or comparable railroad insurance number)

\_\_\_\_\_

**A4. Medicaid Number** (enter "+" if pending, "N" if not a Medicaid recipient)

\_\_\_\_\_

**A5. Gender**

Enter  
  
Code

1. **Male**

2. **Female**

**A6. Birthdate**

\_\_\_\_\_

month

day

year

**A8. Language**—complete only on admission, annual, and significant change assessment (A10a = 01, 03, or 04)

Enter  
  
Code

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

0. **No**

1. **Yes** → If yes, specify preferred language: **b.** \_\_\_\_\_

9. **Unable to determine**

**A10. Type of Assessment/Tracking**

Enter <input type="checkbox"/> <input type="checkbox"/> Code	<p><b>a. Federal OBRA Reason for Assessment/Tracking</b></p> <p>01. Admission assessment (required by day 14)</p> <p>02. Quarterly review assessment</p> <p>03. Annual assessment</p> <p>04. Significant change in status assessment</p> <p>05. Significant correction to prior full assessment</p> <p>06. Significant correction to prior quarterly assessment</p> <p>99. Not OBRA required assessment/tracking</p>
Enter <input type="checkbox"/> Code	<p><b>b. PPS Assessments</b></p> <p><b>PPS Scheduled Assessments for a Medicare Part A Stay</b></p> <p>1. 5-day scheduled assessment</p> <p>2. 14-day scheduled assessment</p> <p>3. 30-day scheduled assessment</p> <p>4. 60-day scheduled assessment</p> <p>5. 90-day scheduled assessment</p> <p>6. Readmission/return assessment</p> <p><b>PPS Unscheduled Assessments for a Medicare Part A Stay</b></p> <p>7. Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)</p> <p>9. Not PPS assessment</p>
Enter <input type="checkbox"/> Code	<p><b>c. PPS Other Medicare Required Assessment—OMRA (required when all rehabilitation therapy discontinued)</b></p> <p>0. No</p> <p>1. Yes</p>

**A11. Submission Requirement**

Enter <input type="checkbox"/> Code	<p><b>a. Federal required submission</b></p> <p>0. No</p> <p>1. Yes</p>
Enter <input type="checkbox"/> Code	<p><b>b. State required submission</b></p> <p>0. No</p> <p>1. Yes</p>
Enter <input type="checkbox"/> Code	<p><b>c. Submission only required for other reasons (e.g. HMO, other insurance, etc.)</b></p> <p>0. No</p> <p>1. Yes</p>

**A12. Preadmission Screening and Resident Review (PASRR)—Complete only if A9a = 01, 03, or 04**

Enter <input type="checkbox"/> Code	<p>Has the resident been evaluated by Level II PASRR, and determined to have a serious mental illness and/or mental retardation or a related condition?</p> <p>0. No</p> <p>1. Yes</p> <p>9. Not a Medicaid certified unit</p>
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**A13. Medicare Stay**

Enter <input type="checkbox"/> Code	<p><b>a. Is the resident currently in a Medicare-covered stay?</b></p> <p>0. No → Skip to A13, State Case Mix Group</p> <p>1. Yes → Continue to A12b</p>
	<p><b>b. Start date of current Medicare stay</b></p> <p>___ ___ ___ ___ ___ ___</p> <p>month            day            year</p>
	<p><b>c. Medicare Part A HIPPS code for billing</b></p> <p>___ ___ ___ ___</p> <p>(RUG-III group followed by HIPPS modifier based on type of assessment)</p>

**A14. State Case Mix Group** (If required by the state)

\_\_\_\_\_

**A15. Optional Facility 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

\_\_\_\_\_

**A16. Assessment Reference Date**

**Observation end date**

\_\_\_\_\_

month          day          year

**A22. Signature of Persons Completing the Assessment**

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

Signature	Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

**A23. Signature of RN Assessment Coordinator Verifying Assessment Completion**

**a. Signature**

**b. Date RN Assessment Coordinator signed assessment as complete**

\_\_\_\_\_

month          day          year

# Section B Hearing, Speech, and Vision

## B1. Comatose

Enter  
  
 Code

**Persistent vegetative state/no discernible consciousness** in last 5 days.

0. **No** → Continue to B2, Hearing
1. **Yes** → Skip to G1, Activities of Daily Living (ADL) Assistance

## B2. Hearing

Enter  
  
 Code

**Ability to hear** (with hearing aid or hearing appliances if normally used) in last 5 days.

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

## B3. Hearing Aid

Enter  
  
 Code

**Hearing aid or other hearing appliance used in above 5-day assessment.**

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

## B4. Speech Clarity

Enter  
  
 Code

**Select best description of speech pattern in last 5 days.**

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

## B5. Makes Self Understood

Enter  
  
 Code

**Ability to express ideas and wants**, consider both verbal and non-verbal expression in last 5 days.

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**

## B6. Ability to Understand Others

Enter  
  
 Code

**Understanding verbal content**, however able (with hearing aid or device if used) in last 5 days.

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

## B7. Vision

Enter  
  
 Code

**Ability to see in adequate light** (with glasses or other visual appliances) in last 5 days.

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

## B8. Corrective Lenses

Enter  
  
 Code

**Corrective lenses (contacts, glasses, or magnifying glass) used in above 5-day assessment.**

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

# Section C Cognitive Patterns

## C1. Should Brief Interview for Mental Status be Conducted?—Attempt to conduct interview with all residents

Enter  
  
Code

0. **No** (resident is rarely/never understood) → instead complete C7-C10, Staff Assessment for Mental Status
1. **Yes** → Continue to C2, Repetition of Three Words

### Brief Interview for Mental Status (BIMS)

#### C2. 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.

#### C3. Temporal Orientation (orientation to year, month, and day)

Enter  
  
Code

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

- a. **Able to report correct year**
3. **Correct**
2. **Missed by 1 year**
1. **Missed by 2–5 years**
0. **Missed by > 5 years** or no answer

Enter  
  
Code

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

- b. **Able to report correct month**
2. **Accurate within 5 days**
1. **Missed by 6 days to 1 month**
0. **Missed by >1 month** or no answer

Enter  
  
Code

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

- c. **Able to report correct day of the week**
1. **Correct**
0. **Incorrect** or no answer

#### C4. 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"

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

Enter  
  
Code

##### b. Able to recall "blue"

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

Enter  
  
Code

##### c. Able to recall "bed"

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

#### C5. Summary Score

Enter Numbers

**Add scores** for questions C2–C4 and fill in total score (00–15)

**Enter 99 if unable to complete interview**



# Section C Cognitive Patterns

## C6. Should the Staff Assessment for Mental Status (C7-C10) be Conducted?

Enter

Code

- 0. **No** (resident was able to complete interview) → Skip to C11, Signs and Symptoms of Delirium
- 1. **Yes** (resident was unable to complete interview) → Continue to C7, Short-term Memory OK

## Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C2-C5) was completed

## C7. Short-term Memory OK

Enter

Code

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

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

## C8. Long-term Memory OK

Enter

Code

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

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

## C9. Memory/Recall Ability

Check all that the resident was normally able to recall during the last 5 days:

Check all that apply.

a. **Current season**

b. **Location of own room**

c. **Staff names and faces**

d. **That he or she is in a nursing home**

e. **None of the above** were recalled

## C10. 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 C Cognitive Patterns

**Delirium**—Complete on all residents

## C11. Signs and Symptoms of Delirium (from CAM<sup>®</sup>)

After completing Brief Interview for Mental Status or Staff Assessment and reviewing medical record, **code a-d** for the last 5 days.

**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

Enter  
  
Code

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

Enter  
  
Code

**b. Disorganized thinking**—Was the resident’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

Enter  
  
Code

**c. Altered level of consciousness**—Did the resident have altered level of consciousness? (e.g., **vigilant**—startled easily to any sound or touch; **lethargic**—repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous**—very difficult to arouse and keep aroused for the interview; **comatose**—could not be aroused)

Enter  
  
Code

**d. Psychomotor retardation**—Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

## C12. Acute Onset Mental Status Change

Enter  
  
Code

**Is there evidence of an acute change in mental status** from the resident’s baseline in last 5 days?

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

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# Section D Mood

## D1. Should Resident Mood Interview be Conducted?—Attempt to conduct interview with all residents

- Enter  Code
0. **No** (resident is rarely/never understood) → Instead complete (D5-D6) Staff Assessment of Mood
1. **Yes** → Continue to D2, Resident Mood Interview

## D2. Resident Mood Interview (PHQ-9®)

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

### I. Symptom Presence

If symptom is present, enter yes (1), then obtain symptom frequency in Column II.

### II. Symptom Frequency

If yes in column I, Symptom Presence, 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 below.

	Enter <input type="text"/> Code	I. Symptom Presence 0. No 1. Yes → 9. No response	1 Day	2–6 Days	7–11 Days	12–14 Days
			“Rarely”	“Several days”	“More than half the days”	“Nearly every day”
a. <b>Little interest or pleasure in doing things</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
b. <b>Feeling down, depressed, or hopeless</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
c. <b>Trouble falling or staying asleep, or sleeping too much</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
d. <b>Feeling tired or having little energy</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
e. <b>Poor appetite or overeating</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
f. <b>Feeling bad about yourself—or that you are a failure or have let yourself or your family down</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
g. <b>Trouble concentrating on things, such as reading the newspaper or watching television</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
h. <b>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</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
i. <b>Thoughts that you would be better off dead, or of hurting yourself in some way</b>  ii) If “Yes”, check here to indicate that responsible staff or provider has been informed: <input type="checkbox"/>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3

## D3. Total Severity Score

Enter Numbers

Add scores for all selected frequency responses in Column II, Symptom Frequency. Score may be between 00 and 27. Enter 99 if unable to complete interview (i.e., “No response” to 3 or more items).



# Section D Mood

## D4. Should the Staff Assessment of Mood be Conducted?

Enter  
  
Code

0. **No** (because Resident Mood Interview was completed) → Skip to Section E, Behavior
1. **Yes** (because 3 or more items in Resident Mood Interview not completed) → Continue to D5, Staff Assessment of Mood

## D5. Staff Assessment of Mood (PHQ-9-OV)

Do not conduct if Resident Mood Interview (D2-D3) was completed

**Say to staff:** "Over the last 2 weeks, did the resident have any of the following problems or behaviors?"

### I. Symptom Presence

If symptom is present, enter yes (1), then move to column II and select symptom frequency.

### II. Symptom Frequency

If yes in column I, Symptom Presence, select frequency.

	Enter <input type="text"/> Code		1 Day	2-6 Days	7-11 Days	12-14 Days
			"Rarely"	"Several days"	"More than half the days"	"Nearly every day"
<b>a. Little interest or pleasure in doing things</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>b. Feeling or appearing down, depressed, or hopeless</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>c. Trouble falling or staying asleep, or sleeping too much</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>d. Feeling tired or having little energy</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>e. Poor appetite or overeating</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>f. Indicating that s/he feels bad about self, is a failure, or has let self or family down</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>g. Trouble concentrating on things, such as reading the newspaper or watching television</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>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</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>i. States that life isn't worth living, wishes for death, or attempts to harm self.</b> ii) If "Yes", check here to indicate that responsible staff or provider has been informed: <input type="checkbox"/>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
<b>j. Being short-tempered, easily annoyed</b>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3

## D6. Total Severity Score

Enter Numbers

**Add scores for all selected frequency responses** in column II, Symptom Frequency.  
Score may be between 00 and 30.

# Section E Behavior

## E1. Psychosis

Check all that apply.

Check if problem condition was present at any time in last 5 days:

- a. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli) **or illusions** (misperceptions in the presence of real external sensory stimuli)
- b. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- c. **None of the above**

## Behavioral Symptoms

### E2. Behavioral Symptom—Presence & Frequency

Note presence of symptoms and their frequency in the last 5 days:

<b>Coding:</b> 0. <b>Not present</b> in last 5 days 1. <b>Present 1–2 days</b> 2. <b>Present 3 or more days</b>	Enter Codes in Boxes → <input type="text"/> Enter Code <input type="text"/> Enter Code <input type="text"/> →	a. <b>Physical behavioral symptoms directed toward others</b> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
		b. <b>Verbal behavioral symptoms directed toward others</b> (e.g., threatening others, screaming at others, cursing at others)
		c. <b>Other behavioral symptoms not directed toward others</b> (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

### E3. Overall Presence of Behavioral Symptoms in the last 5 days

Enter <input type="text"/> Code	<b>Were any behavioral symptoms in questions E2 coded 1 or 2?</b> 0. <b>No</b> → Skip to E6, Rejection of Care 1. <b>Yes</b> → Considering all of E2, Behavioral Symptoms, answer E4 and E5 below
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### E4. Impact on Resident

Did any of the identified symptom(s):

Enter <input type="text"/> Code	a. <b>Put the resident at significant risk for physical illness or injury?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter <input type="text"/> Code	b. <b>Significantly interfere with the resident’s care?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter <input type="text"/> Code	c. <b>Significantly interfere with the resident’s participation in activities or social interactions?</b> 0. <b>No</b> 1. <b>Yes</b>

### E5. Impact on Others

Did any of the identified symptom(s):

Enter <input type="text"/> Code	a. <b>Put others at significant risk for physical injury?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter <input type="text"/> Code	b. <b>Significantly intrude on the privacy or activity of others?</b> 0. <b>No</b> 1. <b>Yes</b>
Enter <input type="text"/> Code	c. <b>Significantly disrupt care or living environment?</b> 0. <b>No</b> 1. <b>Yes</b>

# Section E Behavior

<b>E6. Rejection of Care—Presence &amp; Frequency</b>	
Enter <input type="text"/> Code	In the last 5 days, <b>did the resident reject evaluation or care</b> (e.g., bloodwork, taking medications, ADL assistance) <b>that is necessary to achieve the resident’s goals for health and well-being?</b> Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals. <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes, present 1-2 days</b></li> <li>2. <b>Yes, present 3 or more days</b></li> </ol>
<b>E7. Wandering—Presence &amp; Frequency</b>	
Enter <input type="text"/> Code	In the last 5 days, <b>has the resident wandered?</b> <ol style="list-style-type: none"> <li>0. <b>No</b> → Skip to E9, Change in Behavioral Symptoms</li> <li>1. <b>Yes, present 1-2 days</b></li> <li>2. <b>Yes, present 3 or more days</b></li> </ol>
<b>E8. Wandering—Impact</b>	
Enter <input type="text"/> Code	a. <b>Does the wandering place the resident at significant risk of getting to a potentially dangerous place</b> (e.g., stairs, outside of the facility)? <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>
Enter <input type="text"/> Code	b. <b>Does the wandering significantly intrude on the privacy or activities of others?</b> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>
<b>E9. Change in Behavioral or Other Symptoms—Consider all of the symptoms assessed in items E1 through E8.</b>	
Enter <input type="text"/> Code	How does resident’s current behavior status, care rejection, or wandering <b>compare to prior assessment?</b> <ol style="list-style-type: none"> <li>0. <b>Same</b></li> <li>1. <b>Improved</b></li> <li>2. <b>Worse</b></li> <li>9. <b>N/A</b> because no prior MDS assessment</li> </ol>

# Section F

# Preferences for Customary Routine and Activities

**F1. 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<br><input type="text"/> | 0. <b>No</b> (resident is rarely/never understood and family not available) → Instead complete F6, Staff Assessment of Daily and Activity Preferences |
| Code<br><input type="text"/>  | 1. <b>Yes</b> → Continue to F2, Interview for Daily Preferences   |

## F2. Interview for Daily Preferences

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

<p><b>Coding:</b></p> <ol style="list-style-type: none"> <li>1. <b>Very important</b></li> <li>2. <b>Somewhat important</b></li> <li>3. <b>Not very important</b></li> <li>4. <b>Not important at all</b></li> <li>5. <b>Important, but can’t do or no choice</b></li> <li>9. <b>No response or non-responsive</b></li> </ol>	→ Enter Codes in Boxes → ↓	Enter Code <input type="text"/>	a. <i>how important is it to you to <b>choose what clothes to wear?</b></i>
		Enter Code <input type="text"/>	b. <i>how important is it to you to <b>take care of your personal belongings or things?</b></i>
		Enter Code <input type="text"/>	c. <i>how important is it to you to <b>choose between a tub bath, shower, bed bath, or sponge bath?</b></i>
		Enter Code <input type="text"/>	d. <i>how important is it to you to <b>have snacks available between meals?</b></i>
		Enter Code <input type="text"/>	e. <i>how important is it to you to <b>choose your own bedtime?</b></i>
		Enter Code <input type="text"/>	f. <i>how important is it to you to <b>have your family or a close friend involved in discussions about your care?</b></i>
		Enter Code <input type="text"/>	g. <i>how important is it to you to <b>be able to use the phone in private?</b></i>
		Enter Code <input type="text"/>	h. <i>how important is it to you to <b>have a place to lock your things to keep them safe?</b></i>

## F3. Interview for Activity Preferences

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

<p><b>Coding:</b></p> <ol style="list-style-type: none"> <li>1. <b>Very important</b></li> <li>2. <b>Somewhat important</b></li> <li>3. <b>Not very important</b></li> <li>4. <b>Not important at all</b></li> <li>5. <b>Important, but can’t do or no choice</b></li> <li>9. <b>No response or non-responsive</b></li> </ol>	→ Enter Codes in Boxes → ↓	Enter Code <input type="text"/>	a. <i>how important is it to you to <b>have books, newspapers, and magazines to read?</b></i>
		Enter Code <input type="text"/>	b. <i>how important is it to you to <b>listen to music you like?</b></i>
		Enter Code <input type="text"/>	c. <i>how important is it to you to <b>be around animals such as pets?</b></i>
		Enter Code <input type="text"/>	d. <i>how important is it to you to <b>keep up with the news?</b></i>
		Enter Code <input type="text"/>	e. <i>how important is it to you to <b>do things with groups of people?</b></i>
		Enter Code <input type="text"/>	f. <i>how important is it to you to <b>do your favorite activities?</b></i>
		Enter Code <input type="text"/>	g. <i>how important is it to you to <b>go outside to get fresh air when the weather is good?</b></i>
		Enter Code <input type="text"/>	h. <i>how important is it to you to <b>participate in religious services or practices?</b></i>



# Section F

# Preferences for Customary Routine and Activities

## F4. Daily and Activity Preferences Primary Respondent

Enter  
  
Code

Indicate primary respondent for Daily and Activity Preferences (F2 and F3).

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

## F5. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter  
  
Code

0. **No** (because Interview for Daily and Activity Preferences (F2 and F3) was completed by resident or family/significant other) → Skip to G1, Activities of Daily Living Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F2 and F3) were not completed by resident or family/significant other) → Continue to F6, Staff Assessment of Daily and Activity Preferences

## F6. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F2 – F3) was completed

### Resident Prefers:

Check all that apply.	<input type="checkbox"/>	a. Choosing clothes to wear	Check all that apply.	<input type="checkbox"/>	k. Place to lock personal belongings
	<input type="checkbox"/>	b. Caring for personal belongings		<input type="checkbox"/>	l. Reading books, newspapers, or magazines
	<input type="checkbox"/>	c. Receiving tub bath		<input type="checkbox"/>	m. Listening to music
	<input type="checkbox"/>	d. Receiving shower		<input type="checkbox"/>	n. Being around animals such as pets
	<input type="checkbox"/>	e. Receiving bed bath		<input type="checkbox"/>	o. Keeping up with the news
	<input type="checkbox"/>	f. Receiving sponge bath		<input type="checkbox"/>	p. Doing things with groups of people
	<input type="checkbox"/>	g. Snacks between meals		<input type="checkbox"/>	q. Participating in favorite activities
	<input type="checkbox"/>	h. Staying up past 8:00 p.m.		<input type="checkbox"/>	r. Spending time away from the nursing home
	<input type="checkbox"/>	i. Family or significant other involvement in care discussions		<input type="checkbox"/>	s. Spending time outdoors
	<input type="checkbox"/>	j. Use of phone in private		<input type="checkbox"/>	t. Participating in religious activities or practices
			<input type="checkbox"/>	u. None of the above	

# Section G Functional Status

## G1. Activities of Daily Living (ADL) Assistance

Code for most dependent episode in last 5 days:

### Coding:

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

Enter Codes in Boxes

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

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

## G2. Mobility Prior to Admission—complete only on admission assessment (A10a = 01)

- |                                       |   |
|---------------------------------------|---|
| Enter<br><input type="text"/><br>Code | <p>a. Did resident have a <b>hip fracture, hip replacement, or knee replacement</b> in the 30 days prior to this admission?</p> <p>0. <b>No</b> → Skip to G3, Balance During Transitions and Walking</p> <p>1. <b>Yes</b> → Continue to G2b</p> |
| Check all that apply.                 | <p>b. <b>If yes, check all that apply for tasks in which the resident was independent prior to fracture/replacement.</b></p>  |
|                                       | <p>1. <b>Transfer</b></p>   |
|                                       | <p>2. <b>Walk across room</b></p>   |
|                                       | <p>3. <b>Walk 1 block on a level surface</b></p>  |
|                                       | <p>4. <b>Resident was not independent in any of these activities</b></p>  |
| <p>9. <b>Unable to determine</b></p>  |   |

# Section G Functional Status

## G3. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent** over the last 5 days:

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

## G4. Functional Limitation in Range of Motion

**Code for limitation** during last 5 days that interfered with daily functions or placed resident at risk of injury.

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

## G5. Mobility Devices

**Check all that were normally used** in the past 5 days:

Check all that apply.	<input type="checkbox"/>	<b>a. Cane/crutch</b>
	<input type="checkbox"/>	<b>b. Walker</b>
	<input type="checkbox"/>	<b>c. Wheelchair (manual or electric)</b>
	<input type="checkbox"/>	<b>d. Lower extremity limb prosthesis</b>
	<input type="checkbox"/>	<b>e. None of the above</b> were used

## G6. Bedfast

Enter <input type="text"/> Code	<b>Has the resident been in bed or in recliner in room</b> for more than 22 hours on at least three of the past 5 days? 0. <b>No</b> 1. <b>Yes</b>
---------------------------------------	--

## G7. Functional Rehabilitation Potential—complete only on full assessment (A10a = 01)

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

# Section H Bladder and Bowel

## H1. Appliances

Check all that applied in last 5 days:

- Check all that apply:
- a. Indwelling bladder catheter
  - b. External (condom) catheter
  - c. Ostomy (including suprapubic catheter, ileostomy, and colostomy)
  - d. Intermittent catheterization
  - e. None of the above

## H2. 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 or since urinary incontinence was noted in this facility?
- 0. **No** → Skip to H3, Urinary Continence
  - 1. **Yes** → Continue to H2b
  - 9. **Unable to determine** → Skip to H2c
- 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**

## H3. Urinary Continence

- Enter  Code
- Urinary continence** in last 5 days. Select the one category that best describes the resident over the last 5 days:
- 0. **Always continent**
  - 1. **Occasionally incontinent** (less than 5 episodes of incontinence)
  - 2. **Frequently incontinent** (5 or more episodes of incontinence but at least one episode of continent voiding)
  - 3. **Always incontinent** (no episodes of continent voiding)
  - 9. **Not rated**, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 5 days

## H4. Bowel Continence

- Enter  Code
- Bowel continence** in last 5 days. Select the one category that best describes the resident over the last 5 days:
- 0. **Always continent**
  - 1. **Occasionally incontinent** (one episode of bowel incontinence)
  - 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
  - 3. **Always incontinent** (no episodes of continent bowel movements)
  - 9. **Not rated**, resident had an ostomy or did not have a bowel movement for the entire 5 days

## H5. Bowel Toileting Program

- Enter  Code
- Is a toileting program currently being used to manage the resident’s bowel continence?**
- 0. **No**
  - 1. **Yes**

## H6. Bowel Patterns

- Enter  Code
- Constipation present** in the past 5 days?
- 0. **No**
  - 1. **Yes**

# Section I Active Disease Diagnosis

Active Diseases in the last 30 days	
<b>Cancer</b>	Check all that apply.
<input type="checkbox"/> 1. <b>Cancer</b> (with or without metastasis)	
<b>Heart/Circulation</b>	
<input type="checkbox"/> 2. <b>Anemia</b> (includes aplastic, iron deficiency pernicious, and sickle cell)	
<input type="checkbox"/> 3. <b>Atrial Fibrillation and Other Dysrhythmias</b> (includes bradycardias, tachycardias)	
<input type="checkbox"/> 4. <b>Coronary Artery Disease (CAD)</b> (includes angina, myocardial infarction, ASHD)	
<input type="checkbox"/> 5. <b>Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE or PTE)</b>	
<input type="checkbox"/> 6. <b>Heart Failure</b> (includes CHF, pulmonary edema)	
<input type="checkbox"/> 7. <b>Hypertension</b>	
<input type="checkbox"/> 8. <b>Peripheral Vascular Disease/Peripheral Arterial Disease</b>	
<b>Gastrointestinal</b>	
<input type="checkbox"/> 9. <b>Cirrhosis</b>	
<input type="checkbox"/> 10. <b>GERD/Ulcer</b> (includes esophageal, gastric, and peptic ulcers)	
<input type="checkbox"/> 11. <b>Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease</b>	
<b>Genitourinary</b>	
<input type="checkbox"/> 12. <b>Benign Prostatic Hyperplasia (BPH)</b>	
<input type="checkbox"/> 13. <b>Renal Insufficiency or Renal Failure (ESRD)</b>	
<b>Infections</b>	
<input type="checkbox"/> 14. <b>Human Immunodeficiency Virus (HIV) Infection</b> (includes AIDS)	
<input type="checkbox"/> 15. <b>MRSA, VRE, Clostridium diff. Infection/Colonization</b>	
<input type="checkbox"/> 16. <b>Pneumonia</b>	
<input type="checkbox"/> 17. <b>Septicemia</b>	
<input type="checkbox"/> 18. <b>Tuberculosis</b>	
<input type="checkbox"/> 19. <b>Urinary Tract Infection (UTI)</b>	
<input type="checkbox"/> 20. <b>Viral Hepatitis</b> (includes Hepatitis A, B, C, D, and E)	
<input type="checkbox"/> 21. <b>Wound Infection</b>	
<b>Metabolic</b>	
<input type="checkbox"/> 22. <b>Diabetes Mellitus (DM)</b> (includes diabetic retinopathy, nephropathy, and neuropathy)	
<input type="checkbox"/> 23. <b>Hyponatremia</b>	
<input type="checkbox"/> 24. <b>Hyperkalemia</b>	
<input type="checkbox"/> 25. <b>Hyperlipidemia</b> (includes hypercholesterolemia)	
<input type="checkbox"/> 26. <b>Thyroid Disorder</b> (Includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)	
<b>Musculoskeletal</b>	
<input type="checkbox"/> 27. <b>Arthritis</b> (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))	
<input type="checkbox"/> 28. <b>Osteoporosis</b>	
<input type="checkbox"/> 29. <b>Hip Fracture</b> (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck) (last 60 days)	
<input type="checkbox"/> 30. <b>Other Fracture</b>	
<b>Neurological</b>	
<input type="checkbox"/> 31. <b>Alzheimer's Disease</b>	
<input type="checkbox"/> 32. <b>Aphasia</b>	
<input type="checkbox"/> 33. <b>Cerebral Palsy</b>	
<input type="checkbox"/> 34. <b>CVA/TIA/Stroke</b>	
<input type="checkbox"/> 35. <b>Dementia</b> (Non-Alzheimer's dementia, including vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia (e.g., Pick's disease), and dementia related to stroke, Parkinson's, Huntington's, or Creutzfeldt-Jakob diseases)	
<input type="checkbox"/> 36. <b>Hemiplegia/Hemiparesis/Paraplegia</b>	
<input type="checkbox"/> 37. <b>Quadriplegia</b>	
<input type="checkbox"/> 38. <b>Multiple Sclerosis</b>	
<input type="checkbox"/> 39. <b>Parkinson's Disease</b>	
<input type="checkbox"/> 40. <b>Seizure Disorder</b>	
<input type="checkbox"/> 41. <b>Traumatic Brain Injury</b>	
<b>Nutritional</b>	
<input type="checkbox"/> 42. <b>Malnutrition</b> (protein or calorie) or at risk for malnutrition	
<b>Psychiatric/Mood Disorder</b>	
<input type="checkbox"/> 43. <b>Anxiety Disorder</b>	
<input type="checkbox"/> 44. <b>Depression</b> (other than Bipolar)	
<input type="checkbox"/> 45. <b>Manic Depression</b> (Bipolar Disease)	
<input type="checkbox"/> 46. <b>Schizophrenia</b>	
<b>Pulmonary</b>	
<input type="checkbox"/> 47. <b>Asthma/COPD or Chronic Lung Disease</b> (includes chronic bronchitis and restrictive lung diseases such as asbestosis)	
<b>Vision</b>	
<input type="checkbox"/> 48. <b>Cataracts, Glaucoma, or Macular Degeneration</b>	
<b>Other</b>	
<input type="checkbox"/> 49. <b>Additional Diagnoses</b> Enter ICD-9 and diagnosis.	
a. _____	
b. _____	
c. _____	
d. _____	
e. _____	
f. _____	

# Section J Health Conditions

## J1. Pain Management (answer for all residents, regardless of current pain level)

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

Enter <input type="checkbox"/> Code	<p><b>a. Been on a scheduled pain medication regimen?</b></p> <p>0. No 1. Yes</p>
Enter <input type="checkbox"/> Code	<p><b>b. Received PRN pain medications?</b></p> <p>0. No 1. Yes</p>
Enter <input type="checkbox"/> Code	<p><b>c. Received non-medication intervention for pain?</b></p> <p>0. No 1. Yes</p>

## J2. Should Pain Assessment Interview be Conducted?—Attempt to conduct interview with all residents

- |   |   |
|---|---|
| Enter<br><input type="checkbox"/><br>Code | <p>0. <b>No</b> (resident is rarely/never understood) → Instead complete J8, Staff Assessment for Pain</p> <p>1. <b>Yes</b> → Continue to J3, Pain Presence</p> |
|---|---|

### Pain Assessment Interview

## J3. Pain Presence

Enter <input type="checkbox"/> Code	<p>Ask resident: <b><i>“Have you had pain or hurting at any time in the last 5 days?”</i></b></p> <p>0. <b>No</b> → Skip to J9, Shortness of Breath 1. <b>Yes</b> → Continue to J4, Pain Frequency 9. <b>Unable to answer</b> → Skip to J8, Staff Assessment for Pain</p>
---	---

## J4. Pain Frequency

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

## J5. Pain Effect on Function

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



# Section J Health Conditions

## J6. Pain Intensity—Administer **one** of the following pain intensity questions (a or b)

  
  
 Enter Number

### a. Numeric Rating Scale (00–10)

Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 0–10 pain scale.)

**Enter two-digit response. Enter 99 if unable to answer.**

 Enter  
  
 Code

### b. Verbal Descriptor Scale

Ask resident: "Please rate the intensity of your worst pain over the last 5 days" (Show resident verbal scale.)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

## J7. Should the Staff Assessment for Pain be Completed?

 Enter  
  
 Code

0. **No** (resident completed Pain Assessment Interview) → Skip to J9, Shortness of Breath

1. **Yes** (resident was unable to complete Pain Assessment Interview) → Continue to J8, Staff Assessment for Pain

### Staff Assessment for Pain

Do not conduct if Pain Assessment Interview (J2–J6) completed.

## J8. Indicators of pain or possible pain.

Select all that apply in last 5 days:

- Check all that apply.
- a. **Non-verbal sounds** (crying, whining, gasping, moaning, or groaning)
  - b. **Vocal complaints of pain** (that hurts, ouch, stop)
  - c. **Facial expressions** (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
  - d. **Protective body movements or postures** (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
  - e. **None of these signs observed or documented**

## Other Health Conditions—Complete for all residents

### J9. Shortness of Breath (dyspnea)

Select all that apply in last 5 days:

- 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**
  - d. **None of the above**

### J10. Current Tobacco Use

 Enter  
  
 Code

**Tobacco use** in last 5 days.

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

### J11. Prognosis

 Enter  
  
 Code

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation. If not documented, discuss with physician and request supporting documentation.)

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

### J12. Problem Conditions. Select all that apply in last 5 days:

- Check all that apply.
- a. **Fever**
  - b. **Vomiting**
  - c. **None of the above**



# Section J Health Conditions

## J13. Should the Fall History on Admission or Fall History Since Last Assessment be Completed?

Enter  
  
 Code

What assessment type are you completing?

1. **Admission assessment** → Continue to J14, Fall History
2. **Follow-up assessment (quarterly or annual)** → Skip to J15, Any Falls Since Last Assessment

## J14. Fall History on Admission—complete only on admission assessment (A10a = 01)

Enter  
  
 Code

**a.** Did the resident fall one or more times in the **30 days** (i.e., month) before admission?  
 0. **No**  
 1. **Yes**  
 9. **Unable to determine**

Enter  
  
 Code

**b.** Did the resident fall one or more times in the **31–180 days** (i.e., 1–6 months) before admission?  
 0. **No**  
 1. **Yes**  
 9. **Unable to determine**

Enter  
  
 Code

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

Enter  
  
 Code

**d.** Has the resident **fallen since admission** to the nursing home?  
 0. **No** → Skip to Section K, Swallowing  
 1. **Yes** → Skip to Section K, Swallowing

## J15. Any Falls Since Last Assessment—complete on quarterly, annual, or significant change assessments (A10a = 02, 03, or 04)

Enter  
  
 Code

Has the resident **had any falls since the last assessment**?

0. **No** → Skip to Section K, Swallowing
1. **Yes** → Continue to J16, Number of Falls Since Last Assessment

## J16. Number of Falls Since Last Assessment

Code the number of falls in each category since the last assessment.

- Coding:**
0. **None**
  1. **One**
  2. **Two or more**

→ Enter Codes in Boxes →

Enter  
  
 Code

Enter  
  
 Code

Enter  
  
 Code

- a. No injury**—no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
- b. Injury (except major)**—skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
- c. Major injury**—bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

## Section K Swallowing and Nutritional Status

### K1. Swallowing Disorder

Signs and symptoms of possible swallowing disorder. Check all that applied in last 5 days:

- |                       |                          |  |
|-----------------------|--------------------------|--|
| Check all that apply. | <input type="checkbox"/> | a. <b>Loss of liquids/solids from mouth when eating or drinking</b>          |
|                       | <input type="checkbox"/> | b. <b>Holding food in mouth/cheeks or residual food in mouth after meals</b> |
|                       | <input type="checkbox"/> | c. <b>Coughing or choking during meals or when swallowing medications</b>    |
|                       | <input type="checkbox"/> | d. <b>Complaints of difficulty or pain with swallowing</b>                   |
|                       | <input type="checkbox"/> | e. <b>None of the above</b>  |

### K2. Height and Weight

- |  |   |
|--|---|
| <input type="text"/><br><input type="text"/><br>inches                         | a. <b>Height</b> (in inches). Record most recent height measure since admission. (If height includes a fraction, round up to nearest inch.)   |
| <input type="text"/><br><input type="text"/><br><input type="text"/><br>pounds | b. <b>Weight</b> (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). (If weight includes a fraction, round up to nearest pound.) |

### K3. Weight Loss

- |                                       |   |
|---------------------------------------|---|
| Enter<br><input type="text"/><br>Code | <b>Loss of 5% or more in last 30 days</b> (or since last assessment if sooner) <b>or loss of 10% or more in last 180 days.</b><br>0. <b>No</b> or unknown<br>1. <b>Yes, on</b> physician-prescribed weight-loss regimen<br>2. <b>Yes, not on</b> physician-prescribed weight-loss regimen |
|---------------------------------------|---|

### K4. Nutritional Approaches

Check all that applied in last 5 days:

- |                       |                          |  |
|-----------------------|--------------------------|--|
| Check all that apply. | <input type="checkbox"/> | a. <b>Parenteral/IV feeding</b>  |
|                       | <input type="checkbox"/> | b. <b>Feeding-tube</b> —nasogastric or abdominal (PEG)   |
|                       | <input type="checkbox"/> | c. <b>Mechanically altered diet</b> —require change in texture of food or liquids (e.g., pureed food, thickened liquids) |
|                       | <input type="checkbox"/> | d. <b>Therapeutic diet</b> (e.g., low salt, diabetic, low cholesterol)   |
|                       | <input type="checkbox"/> | e. <b>None of the above</b>  |

### K5. Percent Intake by Artificial Route—Complete K5 only if K4a or K4b is checked

- |                                       |  |
|---------------------------------------|--|
| Enter<br><input type="text"/><br>Code | a. <b>Proportion of total calories the resident received through parenteral or tube feedings</b> in the last 5 days.<br>1. <b>25% or less</b><br>2. <b>26–50%</b><br>3. <b>51% or more</b> |
| Enter<br><input type="text"/><br>Code | b. <b>Average fluid intake per day by IV or tube</b> in last 5 days.<br>1. <b>500 cc/day or less</b><br>2. <b>501 cc/day or more</b>   |

## Section L Oral/Dental Status

### L1. Dental

Check all that applied in last 5 days:

- |                       |                          |   |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. <b>Broken or loosely fitting full or partial denture</b> (chipped, cracked, uncleanable, or loose)             |
|                       | <input type="checkbox"/> | b. <b>No natural teeth or tooth fragment(s)</b> (edentulous)  |
|                       | <input type="checkbox"/> | c. <b>Abnormal mouth tissue</b> (ulcers, masses, oral lesions, including under denture or partial if one is worn) |
|                       | <input type="checkbox"/> | d. <b>Obvious or likely cavity or broken natural teeth</b>  |
|                       | <input type="checkbox"/> | e. <b>Inflamed or bleeding gums or loose natural teeth</b>  |
|                       | <input type="checkbox"/> | f. <b>Mouth or facial pain, discomfort or difficulty with chewing</b>   |
|                       | <input type="checkbox"/> | g. <b>None of the above were present</b>  |
|                       | <input type="checkbox"/> | h. <b>Unable to examine</b>   |

# Section M Skin Conditions

<b>M1. Current Pressure Ulcer</b>	
Enter <input type="text"/> Code	<b>Did the resident have a pressure ulcer in the last 5 days?</b> 0. <b>No</b> → Skip to M9, Healed Pressure Ulcers 1. <b>Yes</b> → Continue to M2, Stage 1 Ulcers
<b>M2. Stage 1 Ulcers</b>	
Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.	
Enter <input type="text"/> Number	<b>Number of existing pressure ulcers at Stage 1</b> —Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones only, it may appear with persistent blue or purple hues.
<b>M3. Stage 2 Ulcers</b>	
Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.	
Enter <input type="text"/> Number	<b>a. Number of existing pressure ulcers at Stage 2</b> —Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. <b>If number entered = 0 → Skip to M4, Stage 3 Ulcers.</b>
Enter <input type="text"/> Number	<b>b. Number of these Stage 2 pressure ulcers that were present on admission.</b> Of the pressure ulcers listed in M3a, how many were first noted at Stage 2 within 48 hours of admission and not acquired in the facility?
Length (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>c. Current length of largest Stage 2 pressure ulcer</b> (in centimeters).
Width (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>d. Current width of largest Stage 2 pressure ulcer</b> (in centimeters).
<b>M4. Stage 3 Ulcers</b>	
Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.	
Enter <input type="text"/> Number	<b>a. Number of existing pressure ulcers at Stage 3</b> —Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. <b>If number entered = 0 → Skip to M5, Stage 4 Ulcers.</b>
Enter <input type="text"/> Number	<b>b. Number of these Stage 3 pressure ulcers that were present on admission.</b> Of the pressure ulcers listed in M4a, how many were first noted at Stage 3 within 48 hours of admission and not acquired in the facility?
Length (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>c. Current length of largest Stage 3 pressure ulcer</b> (in centimeters).
Width (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>d. Current width of largest Stage 3 pressure ulcer</b> (in centimeters).
<b>M5. Stage 4 Ulcers</b>	
Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.	
Enter <input type="text"/> Number	<b>a. Number of existing pressure ulcers at Stage 4</b> —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. <b>If number entered = 0 → Skip to M6, Unstageable Ulcers.</b>
Enter <input type="text"/> Number	<b>b. Number of these Stage 4 pressure ulcers that were present on admission.</b> Of the pressure ulcers listed in M5a, how many were first noted at Stage 4 within 48 hours of admission and not acquired in the facility?
Length (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>c. Current length of largest Stage 4 pressure ulcer</b> (in centimeters).
Width (cm): <input type="text"/> <input type="text"/> . <input type="text"/>	<b>d. Current width of largest Stage 4 pressure ulcer</b> (in centimeters).

# Section M Skin Conditions

## M6. Unstageable Ulcers

Enter  
  
Number

**a. Number of unstageable ulcers**—Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

Enter  
  
Number

**b. Number of these unstageable pressure ulcers that were present on admission.** Of the pressure ulcers listed in M6a, how many were first noted as unstageable within 48 hours of admission and not acquired in the facility?

## M7. Tissue Type for Most Advanced Stage

Enter  
  
Code

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

1. **Epithelial Tissue**—new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.
2. **Granulation Tissue**—pink or red tissue with shiny, moist, granular appearance
3. **Slough**—yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic Tissue (Eschar)**—black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.

## M8. Worsening in Pressure Ulcer Status Since Last Assessment

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on last MDS. If no current pressure ulcer at a given stage, enter 0.

**a. Check here if N/A** (no prior MDS assessment during this stay)

Enter  
  
Number

**b. Stage 2**

Enter  
  
Number

**c. Stage 3**

Enter  
  
Number

**d. Stage 4**

## M9. Healed Pressure Ulcers — Complete on all residents

Indicate the number of pressure ulcers that were noted on last MDS that have completely closed (resurfaced with epithelium). If no healed PU at a given stage since last assessment, enter 0.

**a. Check here if N/A** (no prior MDS assessment during this stay **or** no pressure ulcers on prior assessment)

Enter  
  
Number

**b. Stage 2**

Enter  
  
Number

**c. Stage 3**

Enter  
  
Number

**d. Stage 4**

## Section M Skin Conditions

### M10. Other Ulcers, Wounds, and Skin Problems

Check all that apply in the past 5 days:

- |                       |                          |   |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. Venous or arterial ulcer(s)  |
|                       | <input type="checkbox"/> | b. Diabetic foot ulcer(s)   |
|                       | <input type="checkbox"/> | c. Other foot or lower extremity infection (cellulitis)                 |
|                       | <input type="checkbox"/> | d. Surgical wound(s)  |
|                       | <input type="checkbox"/> | e. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) |
|                       | <input type="checkbox"/> | f. Burn(s)  |
|                       | <input type="checkbox"/> | g. None of the above were present                                       |

### M11. Skin and Ulcer Treatments

Check all that apply in the past 5 days:

- |                       |                          |  |
|-----------------------|--------------------------|--|
| Check all that apply. | <input type="checkbox"/> | a. Pressure reducing device for chair  |
|                       | <input type="checkbox"/> | b. Pressure reducing device for bed  |
|                       | <input type="checkbox"/> | c. Turning/repositioning program   |
|                       | <input type="checkbox"/> | d. Nutrition or hydration intervention to manage skin problems                       |
|                       | <input type="checkbox"/> | e. Ulcer care  |
|                       | <input type="checkbox"/> | f. Surgical wound care   |
|                       | <input type="checkbox"/> | g. Application of dressings (with or without topical medications) other than to feet |
|                       | <input type="checkbox"/> | h. Applications of ointments/medications other than to feet                          |
|                       | <input type="checkbox"/> | i. Application of dressings to feet (with or without topical medications)            |
|                       | <input type="checkbox"/> | j. None of the above were provided   |

## Section N Medications

### N1. Injections

Days

Record the **number of days that injectable medications were received** during the last 5 days or since admission if less than 5 days.

### N2. Medications Received

Check all medications the resident received at any time during the last 5 days or since admission if less than 5 days:

- |                       |                          |   |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. Antipsychotic  |
|                       | <input type="checkbox"/> | b. Antianxiety  |
|                       | <input type="checkbox"/> | c. Antidepressant   |
|                       | <input type="checkbox"/> | d. Hypnotic   |
|                       | <input type="checkbox"/> | e. Anticoagulant (warfarin, heparin, or low-molecular weight heparin) |
|                       | <input type="checkbox"/> | f. None of the above were received                                    |

# Section O Special Treatments and Procedures

## O1. Special Treatments and Programs

Check treatments or programs received during the last 14 days.

Cancer Treatment		Other		
Check all that apply.	<input type="checkbox"/> a. Chemotherapy	Check all that apply.	<input type="checkbox"/> g. IV medications	
	<input type="checkbox"/> b. Radiation		<input type="checkbox"/> h. Transfusions	
	Respiratory Treatments		<input type="checkbox"/> i. Dialysis	
	<input type="checkbox"/> c. Oxygen therapy		<input type="checkbox"/> j. Hospice care	
	<input type="checkbox"/> d. Suctioning		<input type="checkbox"/> k. Respite care	
	<input type="checkbox"/> e. Tracheostomy care		<input type="checkbox"/> l. Isolation or quarantine for active infectious disease does not include standard body/fluid precautions)	
<input type="checkbox"/> f. Ventilator or respirator	<input type="checkbox"/> m. None of the above treatments or programs received			

## O2. Influenza Vaccine

Enter <input type="text"/> Code	<p>a. Did the resident receive the Influenza Vaccine <u>in this facility</u> for this year's Influenza season (October 1 through March 31)?</p> <p>0. <b>No</b> → Continue to O2b</p> <p>1. <b>Yes</b> → Skip to O3, Pneumococcal Vaccine</p> <p>9. <b>Does not apply because assessment is between July 1 and Sept 30</b> → Skip to O3, Pneumococcal Vaccine</p>
Enter <input type="text"/> Code	<p>b. <b>If Influenza Vaccine not received, state reason:</b></p> <p>1. <b>Not in facility</b> during this year's flu season</p> <p>2. <b>Received outside of this facility</b></p> <p>3. <b>Not eligible</b>—medical contraindication</p> <p>4. <b>Offered and declined</b></p> <p>5. <b>Not offered</b></p> <p>6. <b>Vaccine on order but not yet received in the facility</b></p> <p>7. <b>None of the above</b></p>

## O3. Pneumococcal Vaccine

Enter <input type="text"/> Code	<p>a. Is the resident's <b>Pneumococcal Vaccination up to date?</b></p> <p>0. <b>No</b> → Continue to O3b</p> <p>1. <b>Yes</b> → Skip to O4, Therapies</p>
Enter <input type="text"/> Code	<p>b. <b>If Pneumococcal Vaccine not received, state reason:</b></p> <p>1. <b>Not eligible</b>—medical contraindication</p> <p>2. <b>Offered and declined</b></p> <p>3. <b>Not offered</b></p>

## O4. Therapies

Record the **number of days each of the following therapies was administered** for at least 15 minutes a day in the last 7 days (column I). Enter 0 if none or less than 15 minutes daily. For Therapies a–c also record the total number of minutes (column II).

I. Days	II. Minutes	
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	a. Speech-language pathology and audiology services
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	b. Occupational Therapy
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	c. Physical Therapy
<input type="text"/>		d. Respiratory Therapy
<input type="text"/>		e. Psychological Therapy (by any licensed mental health professional)
<input type="text"/>		f. Recreational Therapy (includes recreational and music therapy)

# Section O Special Treatments and Procedures

## O5. Nursing Rehabilitation/ Restorative Care

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

Number of Days	Technique		
<input type="text"/>	a. Range of motion (passive)		
<input type="text"/>	b. Range of motion (active)		
<input type="text"/>	c. Splint or brace assistance		
Number of Days	Training and skill practice in:	Number of Days	
<input type="text"/>	d. Bed mobility	<input type="text"/>	h. Eating or swallowing
<input type="text"/>	e. Transfer	<input type="text"/>	i. Amputation/prostheses care
<input type="text"/>	f. Walking	<input type="text"/>	j. Communication
<input type="text"/>	g. Dressing or grooming		

## O6. Physician Examinations

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

## O7. Physician Orders

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

# Section P Restraints

## P1. Physical Restraints—Code for last 5 days:

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

<b>Coding:</b> 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes ↓	Enter Code <input type="text"/>	<b>Used in Bed</b>
		Enter Code <input type="text"/>	a. Bed rail (any type; e.g., full, half, one side)
		Enter Code <input type="text"/>	b. Trunk restraint
		Enter Code <input type="text"/>	c. Limb restraint
		Enter Code <input type="text"/>	d. Other
		<b>Used in Chair or Out of Bed</b>	
		Enter Code <input type="text"/>	e. Trunk restraint
		Enter Code <input type="text"/>	f. Limb restraint
		Enter Code <input type="text"/>	g. Chair prevents rising
		Enter Code <input type="text"/>	h. Other

## Section Q Participation in Assessment and Goal Setting

Q1. Participation in Assessment	
Enter <input type="text"/> Code	<b>a. Resident</b> 0. No 1. Yes
Enter <input type="text"/> Code	<b>b. Family or significant other</b> 0. No 1. Yes 9. No family or significant other
Q2. Return to Community	
Ask resident (or family or significant other if resident unable to respond): "Do you want to talk to someone about the possibility of returning to the community?"	
Enter <input type="text"/> Code	0. No 1. Yes 9. Resident unable to respond and family or significant other not available
Q3. Resident's Overall Goals—complete only on admission assessment (A10a = 01)	
Enter <input type="text"/> Code	<b>a. Select one for resident's goals established during assessment process.</b> 1. <b>Post acute care</b> —expects to return to live in community 2. <b>Post acute care</b> —expects to have continued NH needs 3. <b>Respite stay</b> —expects to return home 4. <b>Other reason for admit</b> —expects to return to live in community 5. <b>Long term care</b> for medical, functional, and/or cognitive impairments 6. <b>End-of-life care</b> (includes palliative care and hospice) 9. <b>Unknown or uncertain</b>
Enter <input type="text"/> Code	<b>b. Indicate information source for this item</b> 1. Resident 2. Family or significant other 3. Neither

## Section T Therapy Supplement for PPS

T1. Ordered Therapies	
Enter <input type="text"/> Code	<b>a.</b> Has physician ordered any of the following therapies to begin in first 14 days of stay: physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes
Enter Number <input type="text"/> <input type="text"/>	<b>b.</b> Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered
Enter Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>c.</b> Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered

