Medicaid State Plan - ICFs-MR

	State Plan Section	OAC	Description	State Plan TN #	State Plan Attachment
1	5101:3-3-01		Definitions	10-002	4.19D
2	[redacted]	5101:3-3-02	Provider agreements: NFs and ICFs-MR	03-013	4.13C
3	5101:3-3-02.2		Termination, denial of provider agreement: NFs and ICFs-MR	05-029	4.19D
4	[redacted]	5101:3-3-02.3	Eligible providers and provider types	05-029	4.13C
5	[redacted]	5101:3-3-04	Pmt. during ODJFS adm.appeals for denial/termination of provider agreement	08-005	4.28A
6	[redacted]	5101:3-3-04.1	Pmt. during survey agency adm.appeals for denial/termination of prov.agree.	08-005	4.28A
7	[redacted]	5101:3-3-16.8	Coverage of bed hold days for medically necessary absences	07-011	4.19C
8	5101:3-3-17.4		Outlier services for BRMM for ICFs-MR	06-001	4.19D
9	5101:3-3-17.5		Payment method for outlier services in ICFs-MR	08-017	4.19D
10	5101:3-3-18		Medicare Upper Payment Limit Calculation	02-008	4.19D
11	5101:3-3-19		Relationship of other covered Medicaid services	06-010	4.19D
12	5101:3-3-20		NF and ICF-MR Cost Reporting Requirements	09-029	4.19D
13	5101:3-3-21		Audits of NFs and ICFs-MR	02-010	4.19D
14	5101:3-3-22		Rate Reconsiderations	06-010	4.19D
15	[redacted]	5101:3-3-16.7	Private rooms for Medicaid residents in ICFs-MR	08-007	3.1A
16	5101:3-3-24.1		Rate adjustments for NFs and ICFs-MR: government mandates	02-010	4.19D
17	5101:3-3-26		NFs and ICFs-MR: implementation of timely rates	03-017	4.19D
18	5101:3-3-71		Medicaid Chart of Accounts (ICFs-MR)	09-029	4.19D
19	5101:3-3-71.1		Medicaid Cost Report (ICFs-MR)	06-010	4.19D
20	5101:3-3-71.2		Leased Employees (ICFs-MR)	06-010	4.19D
21	5101:3-3-71.3		Capital Asset and Depreciation Guidelines (ICFs-MR)	06-010	4.19D
22	5101:3-3-71.4		Non-Reimbursable Costs (ICFs-MR)	06-010	4.19D
23	5101:3-3-73.1		ICF-MR Case-Mix Assessment Instrument: IAF	07-011	4.19D
24	5101:3-3-73.2		Resident Assessment Classification System (RACs)	07-011	4.19D
25	5101:3-3-73.3		Calculation of quarterly & annual ICF-MR average case mix score	07-011	4.19D
26	5101:3-3-78		Method for establishing the total facility rate	03-017	4.19D
27	5101:3-3-79		Method for establishing the direct care costs component	07-011	4.19D
28	5101:3-3-81		Compensation cost limits for owners and administrators	07-011	4.19D
29	5101:3-3-81.1		Compensation cost limits for owners	07-011	4.19D
30	5101:3-3-81.2		Compensation cost limits for administrators	07-011	4.19D
31	5101:3-3-82		Method for establishing the other protected costs component	07-011	4.19D
32	5101:3-3-82.1		Method for establishing reimbursement for the franchise fee	07-011	4.19D
33	5101:3-3-83		Method for establishing the indirect care costs component	07-011	4.19D
34	5101:3-3-84		Method for establishing capital reimbursement	07-011	4.19D
35	5101:3-3-84.2		Cost of ownership and efficiency incentive	07-011	4.19D
36	5101:3-3-84.3		Nonextensive renovations	07-011	4.19D
37	5101:3-3-84.4		Return on equity	03-017	4.19D
38	5101:3-3-84.5		Notice of escrow, recovery of excess depreciation paid	07-011	4.19D
39	5101:3-3-85		Approval of Nonextensive Renovations for ICFs-MR	06-010	4.19D
40	5101:3-3-85.1		Exception Review Process (ICFs-MR)	06-010	4.19D
41	5101:3-3-86		Rates for providers new to the Medical Assistance Program	07-011	4.19D
42	5101:3-3-86.1		Change in provider agreements (ICFs-MR)	07-011	4.19D
43	5101:3-3-90		ICFs-MR, Expenditure limitation	08-017	4.19D
44	5101:3-3-96		Prospective rate reconsideration for ICFs-MR	07-011	4.19D

[redacted] Rules used soley for state plan purposes

[redacted] State plan sections contained in "non-institutional" state plan attachments processed through the Regional CMS Office in Chicago.

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 09-029 Effective Date 10/01/10

Medicaid State Plan - ICFs-MR
Attachment 4.19D - ICFs-MR Supplement 2

	State Plan Section	Description	State Plan TN #	State Plan Attachment
1	5101:3-3-01	Definitions	10-002	4.19D
2	5101:3-3-02.2	Termination, denial of provider agreement: NFs and ICFs-MR	05-029	4.19D
3	5101:3-3-17.4	Outlier services for BRMM for ICFs-MR	06-001	4.19D
4	5101:3-3-17.5	Payment method for outlier services in ICFs-MR	08-017	4.19D
5	5101:3-3-18	Medicare Upper Payment Limit Calculation	02-008	4.19D
6	5101:3-3-19	Relationship of other covered Medicaid services	06-010	4.19D
7	5101:3-3-20	NF and ICF-MR Cost Reporting Requirements	09-029	4.19D
8	5101:3-3-21	Audits of NFs and ICFs-MR	02-010	4.19D
9	5101:3-3-22	Rate Reconsiderations	06-010	4.19D
10	5101:3-3-24.1	Rate adjustments for NFs and ICFs-MR: government mandates	02-010	4.19D
11	5101:3-3-26	NFs and ICFs-MR: implementation of timely rates	03-017	4.19D
12	5101:3-3-71	Medicaid Chart of Accounts (ICFs-MR)	09-029	4.19D
13	5101:3-3-71.1	Medicaid Cost Report (ICFs-MR)	06-010	4.19D
14	5101:3-3-71.2	Leased Employees (ICFs-MR)	06-010	4.19D
15	5101:3-3-71.3	Capital Asset and Depreciation Guidelines (ICFs-MR)	06-010	4.19D
16	5101:3-3-71.4	Non-Reimbursable Costs (ICFs-MR)	06-010	4.19D
17	5101:3-3-73.1	ICF-MR Case-Mix Assessment Instrument: IAF	07-011	4.19D
18	5101:3-3-73.2	Resident Assessment Classification System (RACs)	07-011	4.19D
19	5101:3-3-73.3	Calculation of quarterly & annual ICF-MR average case mix score	07-011	4.19D
20	5101:3-3-78	Method for establishing the total facility rate	03-017	4.19D
21	5101:3-3-79	Method for establishing the direct care costs component	07-011	4.19D
22	5101:3-3-81	Compensation cost limits for owners and administrators	07-011	4.19D
23	5101:3-3-81.1	Compensation cost limits for owners	07-011	4.19D
24	5101:3-3-81.2	Compensation cost limits for administrators	07-011	4.19D
25	5101:3-3-82	Method for establishing the other protected costs component	07-011	4.19D
26	5101:3-3-82.1	Method for establishing reimbursement for the franchise fee	07-011	4.19D
27	5101:3-3-83	Method for establishing the indirect care costs component	07-011	4.19D
28	5101:3-3-84	Method for establishing capital reimbursement	07-011	4.19D
29	5101:3-3-84.2	Cost of ownership and efficiency incentive	07-011	4.19D
30	5101:3-3-84.3	Nonextensive renovations	07-011	4.19D
31	5101:3-3-84.4	Return on equity	03-017	4.19D
32	5101:3-3-84.5	Notice of escrow, recovery of excess depreciation paid	07-011	4.19D
33	5101:3-3-85	Approval of Nonextensive Renovations for ICFs-MR	06-010	4.19D
34	5101:3-3-85.1	Exception Review Process (ICFs-MR)	06-010	4.19D
35	5101:3-3-86	Rates for providers new to the Medical Assistance Program	07-011	4.19D
36	5101:3-3-86.1	Change in provider agreements (ICFs-MR)	07-011	4.19D
37	5101:3-3-90	ICFs-MR: Expenditure limitation	08-017	4.19D
38	5101:3-3-96	Prospective rate reconsideration for ICFs-MR	07-011	4.19D

☐ Rules used solely for state plan purposes

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 09-029 Effective Date 10/01/10

5101:3-3-01 **Definitions.**

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

(A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the Ohio department of job and family services (ODJFS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62, 5111.683, and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

(1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (10/1/2005);

(2) The provider reimbursement manual (CMS Publication 15-1, www.cms.hhs.gov/manuals); or

(3) Generally accepted accounting principles in accordance with standards prescribed by the "American Institute of Certified Public Accountants" (AICPA) as in effect on the effective date of this rule. These standards can be obtained at www.aicpa.org.

(B) "Ancillary and support costs" means costs for NFs other than the costs listed under the direct care, tax, or capital components in the NF chart of accounts. Ancillary and support costs include, but are not limited to, the following: dietary payroll taxes, fringe benefits, staff development; medical/habilitation, pharmaceutical and incontinence supplies; activity and habilitation/rehabilitation; medical minor equipment; utility expenses; administrative and general services; home office costs; maintenance and minor equipment; equipment acquired by operating lease; ancillary/support payroll taxes, fringe benefits, and staff development; and non-reimbursable expenses.

(C) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit.

(D) "Capital costs" means costs of ownership and nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any items capitalized including the following:

(i) Buildings;

(ii) Building improvements;

(iii) Equipment;

(iv) Extensive renovation;

(v) Transportation equipment;

(vi) Replacement beds;

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided under paragraph (M) of this rule, lease and rent of land, building, and equipment.

(2) "Costs of nonextensive renovation" means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.

(E) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(F) "Case mix score" means the measure of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).

(G) "Cost of construction" means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.

(H) "Cost per case mix unit" Cost per case mix unit for ICFs-MR is determined annually. The "cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year preceding the fiscal year in which the rate will be paid by the facility's annual average case mix score for the applicable calendar year.

(I) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds. For a facility originally licensed as a residential facility, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

(1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

(2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.

(J) "Desk reviewed" means that costs as reported on a cost report have been subjected to a desk review and preliminarily determined to be allowable costs.

(K) "Direct care costs" means costs as defined under rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code.

(L) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(M) "Indirect care costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(N) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(O) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."

(P) "Maintenance and repair expenses" means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a

normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.

(Q) "Minimum data set" (MDS) is the resident assessment instrument approved by the centers for medicare and medicaid services (CMS). The MDS provides the resident assessment data which is used to classify the resident into a resource utilization group in the RUG case-mix classification system, is the foundation for planning and delivering care to nursing facility residents, and is used in the calculation of nursing facility reimbursement rates.

(R) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."

(S) "Other protected costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(T) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-17 of the Administrative Code.

(U) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.

(V) "Patient" includes resident or individual.

(W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.

(X) "Provider agreement" means a contract between ODJFS and an operator of a NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator or the operator's authorized agent binds the operator to the terms of the agreement.

(Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.

(Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter.

(AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:

(a) A supplier is a separate bona fide organization;

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;

(c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").

(6) If a provider transfers an interest or leases an interest in a facility to another provider who is a related party, the capital cost basis shall be adjusted for a sale of a facility to or a lease to a provider that is not a related party if all of the following conditions are met:

(a) For a NF transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year, plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the

actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(b) For a NF lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the

same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(c) For an ICF-MR transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(d) For an ICF-MR lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(e) The provider shall notify ODJFS in writing and shall supply sufficient documentation demonstrating compliance with the provisions of this rule no less than ninety days before the anticipated date of completion of the transfer or lease. In the case of a transaction completed before December 28, 2000 and subject to CMS approval the provider shall supply sufficient documentation demonstrating compliance with the provisions of this rule within thirty days of the effective date of this rule. If the provider does not supply any of the required information, the provider shall not qualify for a rate adjustment. ODJFS shall issue a written decision determining whether the transfer meets the requirements of this rule within sixty days after receiving complete information as determined by ODJFS.

(f) Subject to approval by CMS of a state plan amendment authorizing such, the provisions of paragraph (BB)(6) of this rule shall apply to any transfer or lease that meets the requirements specified in paragraph (BB)(6) of this rule that occurred prior to December 28, 2000. Any rate adjustments which result from the provisions contained in paragraph (BB)(6) of this rule shall take effect as specified in rule 5101:3-3-24 of the Administrative Code, following a determination by ODJFS that the requirements of paragraph (BB)(6) of this rule are met. A provider seeking a determination from ODJFS that a transaction occurring prior to December 28, 2000, meets the requirements of this rule shall submit the necessary documentation under paragraph (BB)(6)(e) of this rule no later than thirty days after the effective date of this rule.

(CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster parent, foster child, foster brother, or foster sister.

(DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (D)of this rule.

(1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(2) ODJFS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODJFS determines that the renovation is more prudent than construction of new beds.

(EE) "Nonextensive renovation" means the betterment, improvement, or restoration of an ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (D) of this rule.

(FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODJFS on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the

rules of ODJFS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODJFS, "construction is started" means the date in which the actual construction work begins at the facility site.

(GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR. Replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling which corresponds to the period the beds were replaced.

(HH) "RUGs" is the resource utilization groups system of classifying NF residents into case-mix groups.

Medicaid State Plan - Nursing Facilities

	State Plan Section	OAC	Description	TN #	State Plan Attachment	Vol.
1	**309.30.20.000**		Fiscal Year 2008 Medicaid Reimbursement System for Nursing Facilities	07-010A	4.19D	25
2	**309.30.20.001**	5101:3-3-68	FY2008 NF Rate Change Limitation (stop gain)	07-010A	4.19D	25
3	**309.30.30.000**		Fiscal Year 2009 and Forward Medicaid Reimbursement System for Nursing Facilities	08-016	4.19D	25
4	**5111.02.000**		Rule making authority	06-010	4.19D	24
5	**5111.02.001**	5101:3-3-19	Relationship of Other Covered Medicaid Services	08-019	4.19D	26
6	**5111.02.002**	5101:3-3-22	Rate Recalculations, Interest on Overpayments, Penalties, etc	06-010	4.19D	24
7	[redacted]	5101:3-3-16.3	Private rooms for Medicaid residents in NFs	08-007	3.1A	25
8	**5111.20.000**		Definitions	06-010	4.19D	24
9	**5111.20.001**	5101:3-3-01	Definitions	10-002	4.19D	28
10	**5111.21.000**		Requirements for Medicaid Payments under Provider Agreement with ODJFS	06-010	4.19D	24
11	**5111.21.001**	5101:3-3-17.3	Outlers: Out of State TBI	06-010	4.19D	24
12	**5111.22.000**		Provider Agreement with ODJFS	06-010	4.19D	24
13	[redacted]	5101:3-3-02	Provider Agreements: NFs and ICFs-MR	03-013	4.13B	22
14	**5111.22.001**	5101:3-3-02.2	Termination and Denial of Provider Agreement: NFs and ICFs-MR	06-010	4.19D	24
15	[redacted]	5101:3-3-02.3	Eligible providers and provider types	05-029	4.13B	23
16	[redacted]	5101:3-3-04	Pmt.during ODJFS Adm.appeals for denial/termination of provider agreement	06-005	4.28A	25
17	[redacted]	5101:3-3-04.1	Pmt.during survey agency adm. appeals for denial/termination of provider agreement	06-005	4.28A	25
18	**5111.221.000**		Timely Vendor Payments	06-010	4.19D	24
19	**5111.222.000**		Total Facility Rate	08-016	4.19D	24
20	**5111.222.001**	5101:3-3-41	Nursing Facilities (NFs) Placement into Peer Groups	06-010	4.19D	24
21	**5111.231.000**		NF Direct Care	06-010	4.19D	24
22	**5111.231.001**	5101:3-3-43.3	Calc. of Qtrly., Semi-Annual, and Annual NF Avg. Case Mix Scores	10-002	4.19D	28
23	**5111.232.000**		Medicaid Only Case-Mix	09-024	4.19D	26
24	**5111.232.001**	5101:3-3-43.1	NF Case-Mix Instrument: MDS Version 2.0	10-002	4.19D	28
25	**5111.232.002**	5101:3-3-43.2	RUGs III: NF Case-Mix Payment System	10-002	4.19D	28
26	**5111.24.000**		NF Ancillary and Support	06-010	4.19D	24
27	**5111.242.000**		NF Property Taxes	06-010	4.19D	24
28	**5111.242.001**	5101:3-3-57	Tax Cost Add-On for NFs	06-010	4.19D	24
29	**5111.243.000**		NF Franchise Fee Payment	06-010	4.19D	24
30	**5111.244.000**		Quality Add-On	06-010	4.19D	24
31	**5111.244.001**	5101:3-3-58	Quality Incentive Payment for NFs	06-010	4.19D	24
32	**5111.25.000**		NF Capital	06-010	4.19D	24
33	**5111.25.001**	5101:3-3-42.3	Capital Asset and Depreciation Guidelines - NFs	06-010	4.19D	24
34	**5111.254.000**		NF New Facility	06-010	4.19D	24
35	**5111.254.001**	5101:3-3-65	Rates for Providers with an Initial Date of Certification on or after 07/01/06	06-010	4.19D	24
36	**5111.257.000**		NF Bed Additions	06-010	4.19D	24
37	**5111.258.000**		Outliers - Special Populations	06-010	4.19D	24
38	**5111.258.001**	5101:3-3-17	Payment Methodology for the Provision of Outlier Services in NFs	06-010	4.19D	24
39	**5111.258.002**	5101:3-3-54.1	Outlier Care in Nursing Facilities for Individuals with TBI (NF - TBI Services)	06-010	4.19D	24
40	**5111.258.003**	5101:3-3-54.5	Pediatric Outlier Care in Nursing Facilities (NF - PED Services)	06-010	4.19D	24
41	**5111.26.000**		Annual Cost Report	06-010	4.19D	24
42	**5111.26.001**	5101:3-3-20	Medicaid Cost Report Filing, Record Retention, and Disclosure Requirement	08-019	4.19D	26
43	**5111.26.002**	5101:3-3-42	NFs Chart of Accounts	06-010	4.19D	24
44	**5111.26.003**	5101:3-3-42.1	NFs Annual Cost Report	06-010	4.19D	24
45	**5111.26.004**	5101:3-3-42.2	NFs Leased Employees	06-010	4.19D	24
46	**5111.26.005**	5101:3-3-42.4	NFs: Non-Reimbursable Costs	06-010	4.19D	24
47	**5111.263.000**		NF Therapies	06-010	4.19D	24
48	****5111.263.001**	5101:3-3-46.1	Skilled therapy and related services for nursing facilities (NFs): coverage and limitations	07-010A	4.19D	25
49	[redacted]	5101:3-3-46	Physical Therapy and Related Services (fee-for-service NF therapies)	07-010B	4.19B	25
50	**5111.264.000**		Related Party	06-010	4.19D	24
51	**5111.265.000**		CHOPs/Operating Rights	06-010	4.19D	24
52	**5111.266.000**		NF Franchise Fee Reporting	06-010	4.19D	24
53	**5111.27.000**		Desk Reviews	06-010	4.19D	24
54	**5111.27.001**	5101:3-3-21	Audits of NFs	06-010	4.19D	24
55	**5111.27.002**	5101:3-3-43.4	Exception Review Process for NFs	10-002	4.19D	28
56	**5111.28.000**		Amended Cost Reports	06-010	4.19D	24
57	**5111.29.000**		Rate Reconsiderations	06-010	4.19D	24
58	**5111.29.001**	5101:3-3-24	Prospective Rate Reconsideration for NFs for Prospective Rate Calc. Errors	06-010	4.19D	24
59	[redacted]	5101:3-3-16.4	Coverage of bed-hold days for medically necessary absences	07-010A	4.19C	25
60	**5111.676.000**		Adjustments to Medicaid Reimbursement for NFs and ICFs-MR that Change Operator	06-010	4.19D	24
61	**5111.676.001**	5101:3-3-65.1	Rates for Providers that Change Provider Agreements	06-015	4.19D	25

[redacted] Rules used solely for state plan purposes

[redacted] State plan sections contained in "non-institutional" state plan attachments processed through the Regional CMS Office in Chicago

* As referenced on the CMS-179 form. CMS approved the move of 5111.33.001 (5101:3-3-16.4) to Attachment 4.19C on 04/10/08

** Consider both locations when updating state plan

TN 10-002 Approval Date **AUG 18 2011**
Supersedes
TN 09-024 Effective Date 10/01/10

Medicaid State Plan - Nursing Facilities
Attachment 4.19D - NF Supplement 1

	State Plan Sect/o	OAC	Description	TN #	State Plan Attachment	Vol.
1	**309.30.20.000**		Fiscal Year 2008 Medicaid Reimbursement System for Nursing Facilities	07-010A	4.19D	25
2	**309.30.20.001**	5101:3-3-68	FY2008 NF Rate Change Limitation (stop gain)	07-010A	4.19D	25
3	**309.30.30.000**		Fiscal Year 2009 and Forward Medicaid Reimbursement System for Nursing Facilitie	08-016	4.19D	25
4	**5111.02.000**		Rule making authority	06-010	4.19D	24
5	**5111.02.001**	5101:3-3-19	Relationship of Other Covered Medicaid Services	08-019	4.19D	26
6	**5111.02.002**	5101:3-3-22	Rate Recalculations, Interest on Overpayments, Penalties, etc.*	06-010	4.19D	24
7	**5111.20.000**		Definitions	06-010	4.19D	24
8	**5111.20.001**	5101:3-3-01	Definitions	10-002	4.19D	28
9	**5111.21.000**		Requirements for Medicaid Payments under Provider Agreement with ODJFS	06-010	4.19D	24
10	**5111.21.001**	5101:3-3-17.3	Outliers: Out of State TBI	06-010	4.19D	24
11	**5111.22.000**		Provider Agreement with ODJFS	06-010	4.19D	24
12	**5111.22.001**	5101:3-3-02.2	Termination and Denial of Provider Agreement: NFs and ICFs-MR	06-010	4.19D	24
13	**5111.221.000**		Timely Vendor Payments	06-010	4.19D	24
14	**5111.222.000**		Total Facility Rate	08-016	4.19D	25
15	**5111.222.001**	5101:3-3-41	Nursing Facilities (NFs) Placement into Peer Groups	06-010	4.19D	24
16	**5111.231.000**		NF Direct Care	06-010	4.19D	24
17	**5111.231.001**	5101:3-3-43.3	Calc. of Qtrly., Semi-Annual, and Annual NF Avg. Case Mix Scores	10-002	4.19D	28
18	**5111.232.000**		Medicaid Only Case-Mix	09-024	4.19D	26
19	**5111.232.001**	5101:3-3-43.1	NF Case-Mix Instrument: MDS Version 3.0	10-002	4.19D	28
20	**5111.232.002**	5101:3-3-43.2	RUGs III: NF Case-Mix Payment System	10-002	4.19D	28
21	**5111.24.000**		NF Ancillary and Support	06-010	4.19D	24
22	**5111.242.000**		NF Property Taxes	06-010	4.19D	24
23	**5111.242.001**	5101:3-3-57	Tax Cost Add-On for NFs	06-010	4.19D	24
24	**5111.243.000**		NF Franchise Fee Payment	06-010	4.19D	24
25	**5111.244.000**		Quality Add-On	06-010	4.19D	24
26	**5111.244.001**	5101:3-3-58	Quality Incentive Payment for NFs	06-010	4.19D	24
27	**5111.25.000**		NF Capital	06-010	4.19D	24
28	**5111.25.001**	5101:3-3-42.3	Capital Asset and Depreciation Guidelines - NFs	06-010	4.19D	24
29	**5111.254.000**		NF New Facility	06-010	4.19D	24
30	**5111.254.001**	5101:3-3-65	Rates for Providers with an Initial Date of Certification on or after 07/01/06	06-010	4.19D	24
31	**5111.257.000**		NF Bed Additions	06-010	4.19D	24
32	**5111.258.000**		Outliers - Special Populations	06-010	4.19D	24
33	**5111.258.001**	5101:3-3-17	Payment Methodology for the Provision of Outlier Services in NFs	06-010	4.19D	24
34	**5111.258.002**	5101:3-3-54.1	Outlier Care in Nursing Facilities for Individuals with TBI (NF - TBI Services)	06-010	4.19D	24
35	**5111.258.003**	5101:3-3-54.5	Pediatric Outlier Care in Nursing Facilities (NF - PED Services)	06-010	4.19D	24
36	**5111.26.000**		Annual Cost Report	06-010	4.19D	24
37	**5111.26.001**	5101:3-3-20	Medicaid Cost Report Filing, Record Retention, and Disclosure Requirement	06-010	4.19D	24
38	**5111.26.002**	5101:3-3-42	NFs Chart of Accounts	08-019	4.19D	26
39	**5111.26.003**	5101:3-3-42.1	NFs Annual Cost Report	06-010	4.19D	24
40	**5111.26.004**	5101:3-3-42.2	NFs Leased Employees	06-010	4.19D	24
41	**5111.26.005**	5101:3-3-42.4	NFs: Non-Reimbursable Costs	06-010	4.19D	24
42	**5111.263.000**		NF Therapies	06-010	4.19D	24
43	**5111.263.001**	5101:3-3-46.1	Skilled therapy and related services for nursing facilities (NFs); coverage and limitati	07-010A	4.19D	25
44	**5111.264.000**		Related Party	06-010	4.19D	24
45	**5111.265.000**		CHOPs/Operating Rights	06-010	4.19D	24
46	**5111.266.000**		NF Franchise Fee Reporting	06-010	4.19D	24
47	**5111.27.000**		Desk Reviews	06-010	4.19D	24
48	**5111.27.001**	5101:3-3-21	Audits of NFs	06-010	4.19D	24
49	**5111.27.002**	5101:3-3-43.4	Exception Review Process for NFs	10-002	4.19D	28
50	**5111.28.000**		Amended Cost Reports	06-010	4.19D	24
51	**5111.29.000**		Rate Reconsiderations	06-010	4.19D	24
52	**5111.29.001**	5101:3-3-24	Prospective Rate Reconsideration for NFs for Prospective Rate Calc. Errors	06-010	4.19D	24
53	**5111.676.000**		Adjustments to Medicaid Reimbursement for NFs and ICFs-MR that Change Operati	06-010	4.19D	24
54	**5111.676.001**	5101:3-3-65.1	Rates for Providers that Change Provider Agreements	06-015	4.19D	25

Rules used solely for state plan purposes

TN 10-002 Approval Date **AUG 18 2011**
Supersedes
TN 09-024 Effective Date 10/01/10

5101:3-3-01 **Definitions.**

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

(A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the Ohio department of job and family services (ODJFS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62, 5111.683, and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

(1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (10/1/2005);

(2) The provider reimbursement manual (CMS Publication 15-1, www.cms.hhs.gov/manuals); or

(3) Generally accepted accounting principles in accordance with standards prescribed by the "American Institute of Certified Public Accountants" (AICPA) as in effect on the effective date of this rule. These standards can be obtained at www.aicpa.org.

(B) "Ancillary and support costs" means costs for NFs other than the costs listed under the direct care, tax, or capital components in the NF chart of accounts. Ancillary and support costs include, but are not limited to, the following: dietary payroll taxes, fringe benefits, staff development; medical/habilitation, pharmaceutical and incontinence supplies; activity and habilitation/rehabilitation; medical minor equipment; utility expenses; administrative and general services; home office costs; maintenance and minor equipment; equipment acquired by operating lease; ancillary/support payroll taxes, fringe benefits, and staff development; and non-reimbursable expenses.

(C) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit.

(D) "Capital costs" means costs of ownership and nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any items capitalized including the following:

(i) Buildings;

(ii) Building improvements;

(iii) Equipment;

(iv) Extensive renovation;

(v) Transportation equipment;

(vi) Replacement beds;

(b) Amortization and interest on land improvements and leasehold improvements;

(c) Amortization of financing costs;

(d) Except as provided under paragraph (M) of this rule, lease and rent of land, building, and equipment.

(2) "Costs of nonextensive renovation" means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.

(E) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.

(F) "Case mix score" means the measure of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).

(G) "Cost of construction" means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.

(H) "Cost per case mix unit" for NFs is determined at least once every ten years for a peer group and shall be used for subsequent years until the department redetermines it. The "cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year preceding the fiscal year in which the rate will be paid by the facility's annual average case mix score for the applicable calendar year.

(I) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds. For a facility originally licensed as a residential

facility, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

(1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.

(2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.

(J) "Desk reviewed" means that costs as reported on a cost report have been subjected to a desk review and preliminarily determined to be allowable costs.

(K) "Direct care costs" means costs as defined under rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code.

(L) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.

(M) "Indirect care costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(N) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.

(O) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."

(P) "Maintenance and repair expenses" means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.

(Q) "Minimum data set" (MDS) is the resident assessment instrument approved by the centers for medicare and medicaid services (CMS). The MDS provides the resident assessment data which is used to classify the resident into a resource utilization group in the RUG case-mix classification system, is the foundation for planning and delivering care to nursing facility residents, and is used in the calculation of nursing facility reimbursement rates.

(R) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."

(S) "Other protected costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.

(T) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-17 of the Administrative Code.

(U) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.

(V) "Patient" includes resident or individual.

(W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.

(X) "Provider agreement" means a contract between ODJFS and an operator of a NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator or the operator's authorized agent binds the operator to the terms of the agreement.

(Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.

(Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter.

(AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.

(BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

(1) An individual who is a relative of an owner is a related party.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

(4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:

(a) A supplier is a separate bona fide organization;

(b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;

(c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;

(d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").

(6) If a provider transfers an interest or leases an interest in a facility to another provider who is a related party, the capital cost basis shall be adjusted for a sale of a facility to or a lease to a provider that is not a related party if all of the following conditions are met:

(a) For a NF transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year, plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the

actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(b) For a NF lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the

same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(c) For an ICF-MR transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(d) For an ICF-MR lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(e) The provider shall notify ODJFS in writing and shall supply sufficient documentation demonstrating compliance with the provisions of this rule no less than ninety days before the anticipated date of completion of the transfer or lease. In the case of a transaction completed before December 28, 2000 and subject to CMS approval the provider shall supply sufficient documentation demonstrating compliance with the provisions of this rule within thirty days of the effective date of this rule. If the provider does not supply any of the required information, the provider shall not qualify for a rate adjustment. ODJFS shall issue a written decision determining whether the transfer meets the requirements of this rule within sixty days after receiving complete information as determined by ODJFS.

(f) Subject to approval by CMS of a state plan amendment authorizing such, the provisions of paragraph (BB)(6) of this rule shall apply to any transfer or lease that meets the requirements specified in paragraph (BB)(6) of this rule that occurred prior to December 28, 2000. Any rate adjustments which result from the provisions contained in paragraph (BB)(6) of this rule shall take effect as specified in rule 5101:3-3-24 of the Administrative Code, following a determination by ODJFS that the requirements of paragraph (BB)(6) of this rule are met. A provider seeking a determination from ODJFS that a transaction occurring prior to December 28, 2000, meets the requirements of this rule shall submit the necessary documentation under paragraph (BB)(6)(e) of this rule no later than thirty days after the effective date of this rule.

(CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:

(1) Spouse;

(2) Natural parent, child, or sibling;

(3) Adopted parent, child, or sibling;

(4) Stepparent, stepchild, stepbrother, or stepsister;

(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;

(6) Grandparent or grandchild;

(7) Foster parent, foster child, foster brother, or foster sister.

(DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (D)of this rule.

(1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(2) ODJFS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODJFS determines that the renovation is more prudent than construction of new beds.

(EE) "Nonextensive renovation" means the betterment, improvement, or restoration of an ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (D) of this rule.

(FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODJFS on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the

rules of ODJFS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODJFS, "construction is started" means the date in which the actual construction work begins at the facility site.

(GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR. Replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling which corresponds to the period the beds were replaced.

(HH) "RUGs" is the resource utilization groups system of classifying NF residents into case-mix groups.

5101:3-3-43.4 **Exception review process for nursing facilities (NFs).**

(A) The definitions of all terms not defined in this rule are the same as set forth in rules 5101:3-3-01 and 5101:3-3-43.1 of the Administrative Code.

(1) "Combination review" is a type of exception review where the Ohio department of job and family services (ODJFS) reviews records selected in one of the following ways:

(a) A combination of records selected pursuant to random and targeted criteria; or

(b) Records initially selected for a targeted review, but insufficient records were available to meet the targeted review sample size requirements, are combined with randomly selected records to complete the sample size.

(c) Records initially selected for a random review combined with records selected for a targeted review as a result of findings of the random review.

(2) "Exception review" is a review of minimum data set (MDS) assessment data. It is conducted at a selected nursing facility (NF) by registered nurses and other appropriate licensed or certified health professionals employed by or under contract with ODJFS for purposes of identifying any patterns or trends related to resident assessments submitted in accordance with rule 5101:3-3-43.1 of the Administrative Code, which could result in inaccurate case mix scores used to calculate the direct care rate.

(3) "Effective date of the rate" is either the first day of July or January for a given fiscal year.

(4) "Exception review tolerance level" is the level of variance between the facility and ODJFS in MDS assessment item responses affecting the resource utilization groups, version III (RUG III) classification of a facility's residents. Two kinds of tolerance levels have been established for exception reviews: initial sample tolerance level, and expanded review tolerance level.

(a) "Initial sample tolerance level" is the percentage of unverifiable records found during the initial sample of an exception review, below which no further review will be pursued for the same six month period. The initial sample tolerance level shall be less than fifteen per cent of the entire sample.

(b) "Expanded review tolerance level" is an acceptable level of variance in the calculation of a provider's quarterly facility average medicaid case mix score or an acceptable per cent of the records sampled at exception review that were unverifiable.

(5) "Random review" is a type of exception review that examines randomly selected records from any of the RUG III major categories identified in rule 5101:3-3-43.2 of the Administrative Code.

(6) "Record" is an MDS assessment identified as a medicaid record as set forth in paragraph (D)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(7) "Targeted review" is a type of exception review that targets records in restorative nursing programs, current toileting program or trial, and/or bowel toileting program, clinically complex with symptoms of depression, or one or more of the seven mutually exclusive RUG III major categories identified in rule 5101:3-3-43.2 of the Administrative Code. Nursing rehabilitation/restorative care includes records grouped in the following RUG III classifications: RLB, RLA, IB2, IA2, BB2, BA2, PE2, PD2, PC2, PB2, and PA2 as identified in rule 5101:3-3-43.2 of the Administrative Code. Clinically complex with depression includes records grouped in the following RUG III classification: CC2, CB2, and CA2 as identified in rule 5101:3-3-43.2 of the Administrative Code.

(8) The "variance" is the percentage difference between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records.

(a) The exception review tolerance level shall be either less than a two per cent variance between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records or less than twenty per cent of the medicaid records sampled at exception review were unverifiable.

(b) The variance calculation will not recognize modifications to MDS assessments and new assessments following an inactivation, submitted by the facility after notification of the exception review.

(9) A "verifiable MDS record" is a provider's completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter, which upon examination by ODJFS during an exception review, has been determined to accurately represent the

aspects of the resident's condition, during the specified assessment time frame, that affect the correct RUG III classification of that record.

(10) An "unverifiable MDS record" is a provider's completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter which, upon examination by ODJFS, has been determined to inaccurately represent the aspects of the resident's condition, during the specified assessment time frame, that affect the RUG III classification of that record. MDS coding may be deemed unsupported if inconsistencies are found in the sources of information through verification activities.

(B) All exception reviews will comply with the applicable provisions of the medicare and medicaid programs.

(C) Providers may be selected for an exception review by ODJFS based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health that may indicate that the facility is not accurately assessing residents, which may result in the resident's inaccurate classification into the RUG III system;

(2) A risk analysis profile that may include, but is not limited to, one or more of the following:

(a) A change in the frequency distribution of their residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression; or

(b) The frequency distribution of residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression that exceeds statewide averages; or

(c) A sudden or drastic change in the facility average case mix score; or

(d) A change in the frequency distribution of coded responses to a MDS item.

(3) Prior resident assessment performance of the provider, may include but is not limited to, ongoing problems with assessment submission deadlines, error rates, incorrect assessment dates, and apparent unchanged assessment practice(s) following a previous exception review.

(D) Exception reviews shall be conducted at the facility by registered nurses and other licensed or certified health professionals under contract with or employed by ODJFS. When a team of ODJFS reviewers conducts an on-site exception review, the team

shall be led by a registered nurse. Persons conducting exception reviews on behalf of ODJFS shall meet the following conditions:

(1) During the period of their professional employment with ODJFS, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a NF which they review in Ohio.

(2) Reviewers shall not review any provider where a member of their family is a current resident.

(3) Reviewers shall not review any provider that has been a client of the reviewer within the past twenty-four months.

(4) Employment of a member of a health professional's family by a provider that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of a NF.

(5) Reviewers shall not review any provider that has been an employer of the reviewer within the past twenty-four months.

(E) Prior notice: ODJFS shall notify the provider by telephone at least two working days prior to the review.

(F) Providers selected for exception reviews must provide ODJFS reviewers with reasonable access to residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments and supporting documentation regarding the residents' care needs and treatments. Providers must also provide ODJFS with sufficient information to be able to contact the resident's attending or consulting physicians, other professionals from all disciplines who have observed, evaluated or treated the resident, such as contracted therapists, and the resident's family/significant others. These sources of information may help to validate information provided on the resident assessment instrument submitted to the state. Verification activities may include reviewing resident assessment forms and supporting documentation, conducting interviews with staff knowledgeable about the resident during the observation period for the MDS, and observing residents.

(G) An exception review shall be conducted of a random, targeted, or a combination of random and targeted samples of completed resident assessment instruments. The initial sample size shall be greater than or equal to the minimum sample size presented in appendix A to this rule. The expanded sample is based on the initial sample findings. The expanded sample size is presented in appendix B to this rule.

(H) Results from review of the initial sample shall be used to decide if further action by ODJFS is warranted. If the initial sample is to be expanded for further review,

ODJFS reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(4)(a) of this rule, ODJFS:

(1) May subsequently expand the exception review process to review MDS assessments as follows:

(a) If the initial sample was a targeted review, the expanded sample size shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(b) If the initial sample was a random review that became a targeted review, the expanded sample shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(c) If the initial sample was a random review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule.

(d) If the initial sample was a combination review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule. The expanded sample may consist of the remaining records in the targeted and random categories.

(e) If the expanded review tolerance level is exceeded, ODJFS may subsequently expand the sample size for the same reporting quarter up to and including one hundred per cent of the records and continue the review process.

(I) At the conclusion of the on-site portion of the exception review process, ODJFS reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify RUG III classification for reviewed records. Reviewers will give provider representatives one written preliminary copy of the exception review findings indicating whether the facility was under or over the established tolerance levels.

(J) All exception reviews shall include a final written summary of the exception review findings including the final facility tolerance level calculations and revised quarterly facility average total case mix score and revised quarterly facility average medicaid case mix score. ODJFS shall mail a copy of the final written summary to the provider.

(K) All exception review reports shall be retained by ODJFS for at least six years.

(L) If the expanded review tolerance level is exceeded, ODJFS shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly, semiannual, and annual facility average case mix scores. Calculations or recalculations shall apply only to records actually reviewed by ODJFS and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODJFS shall recalculate quarterly facility average case mix scores by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

(M) ODJFS shall use the quarterly, semiannual, and annual facility average case mix scores based on exception review findings which exceed the exception review tolerance level to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period(s). However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average case mix score or a peer group cost per case mix unit made in accordance with rule 5101:3-3-43.3 of the Administrative Code as a result of the facility's failure to submit, or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly or semiannual facility average case mix score or peer group cost per case mix unit than the one to be assigned.

(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding six month period, and the review results in findings that exceed the tolerance level, ODJFS shall use the recalculated quarterly facility average case mix scores to calculate the facility's semiannual average case mix score for the facility's direct care rate for that six month period. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility's submission of assessment information.

(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODJFS shall increase the direct care rate prospectively for the remainder of the six month period, beginning one month after the first day of the month after the exception review is completed.

(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODJFS shall

reduce the direct care rate and apply it to the six month periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule 5101:3-3-22 of the Administrative Code.

(N) Except for additional information submitted to ODJFS as part of the processes set forth in paragraphs (O) and (P) of this rule, the ODJFS exception review determination for any resident case mix score shall be considered final. A provider may submit corrections for individual records in accordance with rule 5101:3-3-43.1 of the Administrative Code; however, the exception review determination for any resident assessment case mix score will be used to establish the facility average case mix score.

(O) The provider may seek reconsideration of any prospective direct care rate which was established by recalculating the direct care rate as a result of an exception review of resident assessment information conducted before the effective date of the rate. Requests for rate reconsideration related to exception review findings must be submitted in accordance with the following procedures:

(1) A reconsideration of a prospective direct care rate on the basis of a dispute with ODJFS exception review findings shall be submitted to ODJFS no more than thirty days after receipt of exception review findings.

(2) The request for a reconsideration of a prospective rate on the basis of a dispute with exception review findings shall be filed in accordance with the following procedures:

(a) The request shall be in writing; and

(b) The request shall be addressed to "Ohio Department of Job and Family Services, Ohio Health Plans, Bureau of Long Term Care Services and Supports, Disability and Aging Policy Section"; and

(c) The request shall indicate that it is a request for rate reconsideration due to a dispute with exception review findings; and

(d) The request shall include a detailed explanation of the items on the resident assessment records under dispute as well as copies of relevant, supporting documentation from specific individual records. The request shall also include the provider's proposed resolution.

(3) ODJFS shall respond in writing within sixty days of receiving each written request for a rate reconsideration related to disputed exception review findings. If ODJFS requests additional information to determine if the rate adjustment is

warranted, the provider shall respond in writing and shall provide additional supporting documentation no more than thirty days after the receipt of the request for additional information. ODJFS shall respond in writing within sixty days of receiving the additional information to the request for a rate reconsideration due to disputed exception review findings.

(4) If the rate is increased pursuant to a rate reconsideration due to disputed exception review findings, the rate adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(5) When calculating the annual and semiannual facility average case mix scores in accordance with rule 5101:3-3-43.3 of the Administrative Code, ODJFS shall use any resident case mix scores adjusted as a result of a rate reconsideration determination in lieu of the resident case mix scores from the exception review findings.

(P) The findings of an exception review conducted after the effective date of the rate may be appealed under provisions of the Administrative Procedure Act, Chapter 119. of the Revised Code. ODJFS shall not withhold from the facility's current payments any amounts ODJFS claims to be due from the facility as a result of the exception review findings while the provider is pursuing administrative or judicial remedies in good faith.

5101:3-3-43.3 **Calculation of quarterly, semiannual and annual nursing facility (NF) average case mix scores.**

(A) The definitions of all terms used in this rule are the same as set forth in rules 5101:3-3-01, 5101:3-3-43.1 and 5101:3-3-43.4 of the Administrative Code.

(B) The Ohio department of job and family services (ODJFS) shall process resident assessment data submitted by NFs in accordance with rule 5101:3-3-43.1 of the Administrative Code and shall classify residents using the resource utilization groups, version III (RUG III) classification system to determine resident case mix scores in accordance with rule 5101:3-3-43.2 of the Administrative Code. These resident case mix scores, based on relative resource weights as set forth in appendix E of rule 5101:3-3-43.2 of the Administrative Code, are used to establish two quarterly facility average case mix scores each quarter.

(1) The first quarterly facility average case mix score shall be calculated using all records selected for the quarter and shall be the quarterly facility average total case mix score.

(2) The second quarterly facility average case mix score shall be calculated using only the records selected for the quarter that ODJFS identifies as medicaid records and shall be the quarterly facility average medicaid case mix score.

(C) ODJFS shall calculate a quarterly facility average total case mix score for all providers meeting the following requirements:

(1) In accordance with rule 5101:3-3-43.1 of the Administrative Code, the provider submitted resident assessment information by the filing date, and the data included resident assessments for all residents in medicaid certified beds as of the reporting period end date, and

(a) The provider's resident assessment data submitted timely for that reporting quarter provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four, or

(b) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedures outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four; and

(c) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average total case mix score.

(2) The quarterly facility average total case mix score for providers that submitted their minimum data set version 3.0 (MDS 3.0) data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) All resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of resident case mix scores is divided by the total number of residents.

(3) If a provider does not comply with paragraph (C)(1) of this rule, ODJFS shall assign the NF a penalty score. The penalty score for the quarterly facility average total case mix score shall be a score that is five per cent less than the quarterly facility average total case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly total facility average case mix score shall be the score that is five per cent less than the score determined by the exception review.

(b) If the facility was assigned a quarterly facility average total case mix score for the preceding calendar quarter, the assigned quarterly facility average total case mix score shall be the score that is five per cent less than the score assigned for the preceding quarter.

(D) ODJFS shall calculate a quarterly facility average medicaid case mix score for all providers meeting the following requirements:

(1) The provider's resident assessment data submitted timely for that reporting quarter provide sufficient information for classifying at least ninety per cent of records identified as medicaid records into RUG III groups one through forty-four, or

(a) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedure outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for

accurately classifying at least ninety per cent of all residents into RUG III groups one through forty-four; and

(b) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average medicaid case mix score.

(2) ODJFS shall identify a MDS 3.0 as a medicaid record if the MDS 3.0 meets the following requirements:

(a) The MDS 3.0 is not completed to meet the requirements for a medicare part A stay.

(b) The social security number (SSN) on the MDS 3.0 matches a SSN on the medicaid recipient master file (RMF) and

(c) The assessment reference date (ARD) on the MDS 3.0 falls within the recipient's medicaid eligibility span.

(3) The quarterly facility average medicaid case mix score for providers that submitted their MDS 3.0 data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) Medicaid resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of medicaid resident case mix scores is divided by the total number of medicaid residents.

(4) If a provider does not comply with paragraph (D)(1) of this rule, ODJFS shall assign the NF a penalty score. The penalty score for the quarterly facility average medicaid case mix score shall be a score that is five per cent less than the quarterly facility average medicaid case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly facility average medicaid case mix score shall be the score that is five per cent less than the score determined by the exception review.

(b) If the facility was assigned a quarterly facility average medicaid case mix score for the preceding calendar quarter, the assigned quarterly facility average medicaid case mix score shall be the score that is five per cent less than the score assigned for the preceding quarter.

(5) ODJFS shall use a facility's assigned penalty score to calculate the semiannual facility average medicaid case mix score.

(E) This paragraph describes the method for calculating the semiannual facility average medicaid case mix score.

(1) The semiannual facility average medicaid case mix score for the payment period beginning the first day of July for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding December and March reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the December and March reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(2) The semiannual facility average medicaid case mix score for the payment period beginning the first day of January for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding June and September reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the June and September reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(F) ODJFS shall calculate the annual facility average case mix score as follows. The PPS other medicare required assessments (OMRAs) may not be selected for calculating case mix scores due to the inability to assign the record to a RUG III classification.

(1) The annual facility average case mix score shall be calculated only for facilities with at least two quarterly facility average total case mix scores meeting the requirements of paragraphs (C)(1) and (C)(2) of this rule. In addition for any score meeting the requirements of paragraphs (C)(1) and (C)(2) that was adjusted, the adjusted score will be substituted according to the following hierarchy:

(a) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted before the effective date of the rate; or

(b) Adjusted quarterly facility average total case mix scores as a result of exception review findings.

(2) If ODJFS assigned a facility a quarterly facility average total case mix score in accordance with paragraph (C)(3) of this rule, said assigned score will not be used to calculate the provider's annual facility average case mix score.

(3) The qualifying case mix scores shall be summed and divided by the total number of quarters of qualifying scores to arrive at the annual facility average case mix score.

(G) For each provider that submits MDS 3.0 data in a given week, ODJFS shall send the "Case Mix Report" containing the following four components:

(1) The "Provider Detail Listing of Successfully Grouped Records," identifies records that were successfully grouped by ODJFS. The report will include all records received, even if the records will not be used in the quarterly score calculation;

(2) The "Critical Error Summary," that identifies the provider's records that will be assigned into the default group forty-five unless they are corrected before the end of the reporting quarter in accordance with rule 5101:3-3-43.1 of the Administrative Code.

(3) The "Provider Detail Listing of Records with Critical Errors," provides detail for each record listed on the "Critical Error Summary" identifying the failed edits.

(4) The "Discharge and Reentry Tracking Form Summary," that identifies all discharge and reentry tracking forms that were received by ODJFS.

(H) ODJFS shall provide two preliminary "Calculation of Facility Case Mix Scores" reports. The first report will reflect records submitted up to the quarterly filing date. The second report will reflect records submitted up to approximately two weeks prior to the quarterly corrections deadline. Both reports will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score. Providers may file corrections to the extent permitted by rule 5101:3-3-43.1 of the Administrative Code.

(I) After the quarterly corrections deadline specified in rule 5101:3-3-43.1 of the Administrative Code, ODJFS shall provide a final "Calculation of Facility Case Mix Scores" report. The report will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score.

(J) Following the determination of the two quarterly facility average medicaid case mix scores used to calculate the semiannual medicaid case mix scores effective July first and January first of the fiscal year, ODJFS shall provide a "Semiannual Medicaid Case Mix Score Calculation Report" to each provider.

(K) Following the calculation of the annual facility average case mix score, ODJFS shall provide an "Annual Facility Average Case Mix Score Calculation Report" to each provider.

5111.232.002

APPENDIX A
MDS 3.0 DATA ELEMENTS USED IN THE RUG III CLASSIFICATION SYSTEM

Attachment 4.19D
Supplement 1

ITEM #	DESCRIPTION	IMACT ON RUG III CATEGORY
B0100	Comatose	Clinically Complex, Impaired Cognition
C0700	Short term memory	Impaired Cognition
C1000	Cognitive Skills for Daily Decision Making	Impaired Cognition
B0700	Makes self understood	Impaired Cognition
D0200A2	Little interest or pleasure in doing things	Clinically Complex
D0200B2	Feeling down, depressed, or hopeless	Clinically Complex
D0200C2	Trouble falling or staying asleep, or sleeping too much	Clinically Complex
D0200D2	Feeling tired or having little energy	Clinically Complex
D0200E2	Poor appetite or overeating	Clinically Complex
D0200F2	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	Clinically Complex
D0200G2	Trouble concentrating on things, such as reading the newspaper or watching television	Clinically Complex
D0200H2	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	Clinically Complex
D0200I2	Thoughts that you would be better off dead, or of hurting yourself in some way	Clinically Complex
D0300	Total Severity Score	Clinically Complex
D0500A	Little interest or pleasure in doing things	Clinically Complex
D0500B	Feeling or appearing down, depressed, or hopeless	Clinically Complex
D0500C	Trouble falling or staying asleep, or sleeping too much	Clinically Complex
D0500D	Feeling tired or having little energy	Clinically Complex
D0500E	Poor appetite or overeating	Clinically Complex
D0500F	Indicating that s/he feels bad about self, is a failure, or has let self or family down	Clinically Complex
D0500G	Trouble concentrating on things, such as reading the newspaper or watching television	Clinically Complex
D0500H	Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he have been moving around a lot more than usual	Clinically Complex
D0500I	States that life isn't worth living, wishes for death, or attempts to harm self	Clinically Complex
D0500J	Being short - tempered, easily annoyed	Clinically Complex
D0600	Total Severity Score	Clinically Complex
C0200	Repetition of three words	Impaired Cognition
C0300A	Able to report correct year	Impaired Cognition
C0300B	Able to report correct month	Impaired Cognition
C0300C	Able to report correct day of the week	Impaired Cognition
C0400A	Able to recall "sock"	Impaired Cognition
C0400B	Able to recall "blue"	Impaired Cognition
C0400C	Able to recall "bed"	Impaired Cognition
C0500	Summary Score	Impaired Cognition
E0900	Wandering	Behavior Problems
E0200B	Verbal behavioral symptoms directed toward others	Behavior Problems
E0200A	Physical behavioral symptoms directed toward others	Behavior Problems
E0200C	Other behavioral symptoms not directed toward others	Behavior Problems
E0800	Rejection of care	Behavior Problems
G0110A1	Bed Mobility - Self Performance	ADL Index
G0110A2	Bed Mobility - Support	ADL Index
G0110B1	Transfer - Self Performance	ADL Index
G0110B2	Transfer - Support	ADL Index
G0110H1	Eating - Self Performance	ADL Index
G0110I1	Toilet Use - Self Performance	ADL Index
G0110I2	Toilet Use - Support	ADL Index
H0200C	Current toileting program or trial	Impaired Cognition, Behavior Problems, Reduced Physical Function, Rehabilitation
H0500	Bowel toileting program	Impaired Cognition, Behavior Problems, Reduced Physical Function, Rehabilitation
I2900	Diabetes Mellitus	Clinically Complex
I4300	Aphasia	Special Care
I4400	Cerebral palsy	Special Care
I4900	Hemiplegia or Hemiparesis	Clinically Complex
I5200	Multiple Sclerosis	Special Care
I5100	Quadriplegia	Special Care
I2000	Pneumonia	Special Care, Clinically Complex
I2100	Septicemia	Clinically Complex
J1550C	Dehydrated	Special Care, Clinically Complex
E0100B	Delusions	Behavior Problems
J1550A	Fever	Special Care
E0100A	Hallucinations	Behavior Problems
J1550D	Internal bleeding	Clinically Complex
J1550B	Vomiting	Special Care

5111.232.002

APPENDIX A

MDS 3.0 DATA ELEMENTS USED IN THE RUG III CLASSIFICATION SYSTEM

Attachment 4.19D
Supplement 1

K0300	Weight Loss	Special Care
K0500A	Parenteral/IV feeding	Extensive Care
K0500B	Feeding tube	Special Care, Clinically Complex
K0700A	Proportion of total calories	Special Care, Clinically Complex
K0700B	Average fluid intake	Special Care, Clinically Complex
M0300A	Stage 1 pressure ulcers	Special Care
M0300B1	Stage 2 pressure ulcers	Special Care
M0300C1	Stage 3 pressure ulcers	Special Care
M0300D1	Stage 4 pressure ulcers	Special Care
M0300F1	Unstageable pressure ulcers - slough and/or eschar	Special Care
M1040F	Burn(s) (second or third degree)	Clinically Complex
M1040D	Open lesion(s) other than ulcers, rashes, cuts	Special Care
M1040E	Surgical wound(s)	Special Care
M1200A	Pressure reducing device for chair	Special Care
M1200B	Pressure reducing device for bed	Special Care
M1200C	Turning/repositioning program	Special Care
M1030	Number of venous and arterial ulcers	Special Care
M1200D	Nutrition or hydration intervention to manage skin problems	Special Care
M1200E	Ulcer care	Special Care
M1200F	Surgical wound care	Special Care
M1200G	Application of nonsurgical dressings other than to feet	Special Care
M1200H	Application of ointments/medications other than to feet	Special Care
M1040A	Infection of the foot	Clinically Complex
M1040C	Other open lesion(s) on the foot	Clinically Complex
M1200I	Application of dressings to feet	Clinically Complex
M1040B	Diabetic foot ulcer(s)	Clinically Complex
N0300	Injections	Clinically Complex
O0100A(1,2)	Chemotherapy	Extensive
O0100J(1,2)	Dialysis	Clinically Complex
O0100H(1,2)	IV medications	Special Care
O0100C(1,2)	Oxygen therapy	Extensive
O0100B(1,2)	Radiation	Extensive
O0100D(1,2)	Suctioning	Rehabilitation
O0100E(1,2)	Tracheostomy care	Rehabilitation
O0100I(1,2)	Transfusions	Rehabilitation
O0100F(1,2)	Ventilator or respirator	Rehabilitation
O0400A4	Speech-language pathology & audiology services days	Rehabilitation
O0400A1,2,3	Speech-language pathology & audiology services minutes	Rehabilitation
O0400B4	Occupational therapy days	Rehabilitation
O0400B1,2,3	Occupational therapy minutes	Rehabilitation
O0400C4	Physical therapy days	Rehabilitation
O0400C1,2,3	Physical therapy minutes	Rehabilitation
O0400D2	Respiratory therapy days	Special Care
O0500A	Range of motion (passive)	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500B	Range of motion (active)	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500C	Splint or brace assistance	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500D	Bed mobility	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500E	Transfer	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500F	Walking	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500G	Dressing and/or grooming	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500H	Eating and/or swallowing	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500I	Amputation/prostheses care	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500J	Communication	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0600	Physician Examinations	Clinically Complex
O0700	Physician Orders	Clinically Complex

5111.232.002

Attachment 4.19D
Supplement 1

APPENDIX B
RUG III ADL SCORE INDEXING WEIGHTS

MDS 3.0 REFERENCE	ACTIVITY OF DAILY LIVING	SCORE
Items G0110A, G0110I,and G0110B: Self perf = "-", 0, 1, 7	**Bed mobility, Toileting, and Transfer:** Unknown, Independent, Supervision, or Activity occurred only once or twice	1
Self perf = 2	Limited Assistance	3
Self perf. = 3, 4, 8 Staff support = "-", 0 ,1 ,2	Extensive Assistance or Total Dependence: With 1 person physical assistance	4
Self perf. = 3, 4, 8 Staff support = 3, 8	Extensive Assistance or Total Dependence or Activity did not occur With 2+ person physical assistance or Activity did not occur	5
Item G0110H: Self perf. = "-", 0, 1, 7	**Eating**: Unknown, Independent, Supervision, or Activity occurred only once or twice	1
Self perf. = 2	Limited Assistance	2
Self perf. = 3, 4, 8 Parenteral/IV feeding: Item K0500A Feeding tube: Item K0500B with Percent intake by artificial route: Item K0700A and K0700B	Extensive Assistance or Total Dependence or Activity did not occur Parenteral IV/ feeding, or feeding tube with 51% or more of total calories, or 26-50% of total calories and fluid intake of 501cc or more	3

Self perf. means " ADL self performance" as used in MDS 3.0, item G01101.
Staff support means " ADL support provided" as used in MDS 3.0, item G01102.

To determine the RUG III ADL Index:
Add the scores for the four ADL variables
The index ranges from 4-18 point

5111.232.002

Attachment 4.19D
Supplement 1

APPENDIX C

DESCRIPTION OF RUG-III CLASSIFICATION BRANCHES

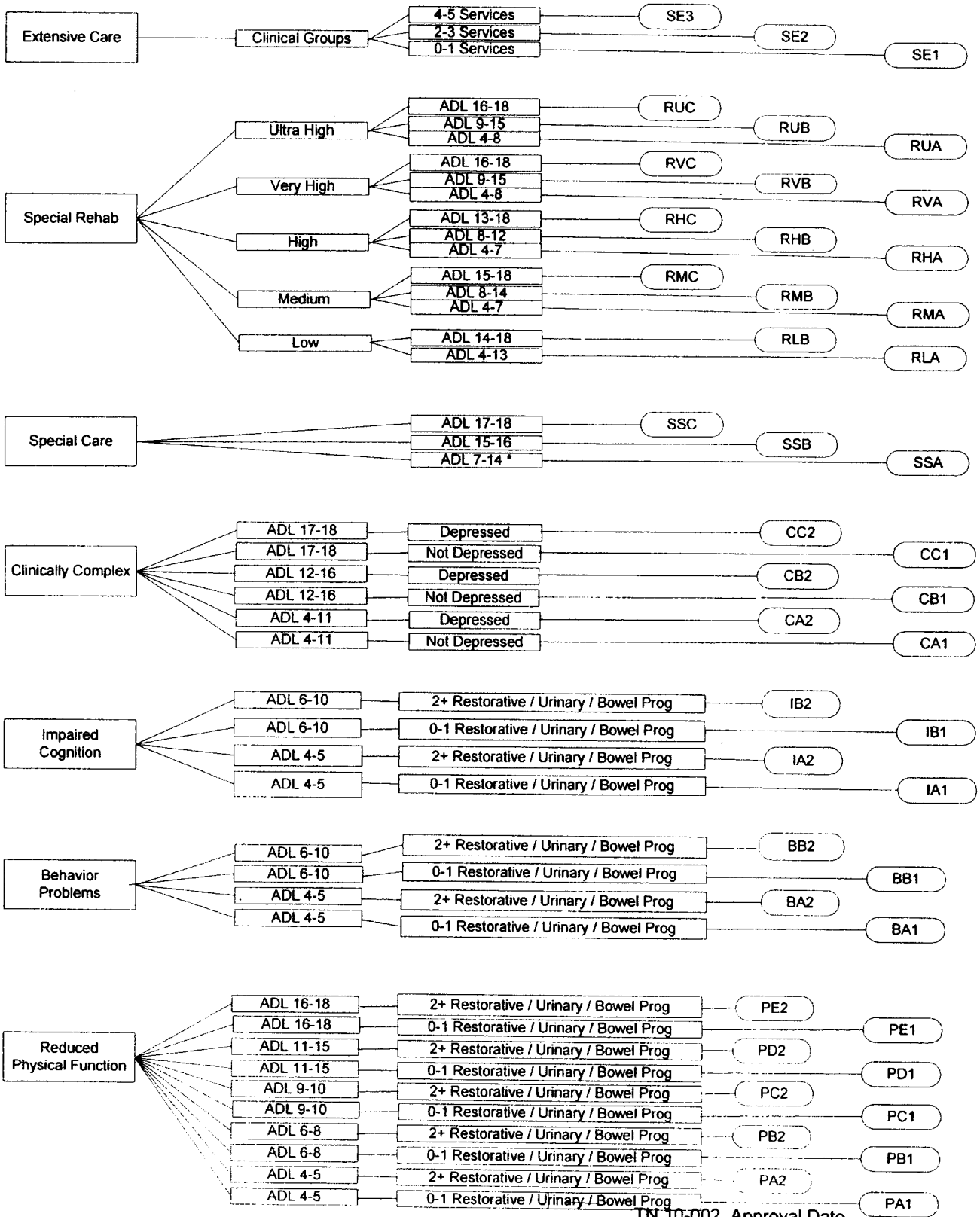
HIERARCHY CATEGORY (First Level)	ACTIVITIES OF DAILY LIVING (Second Level)	PROBLEM/ SERVICE SPLIT (Third Level)
EXTENSIVE CARE	Not Used	COUNT OF TWO SETS OF QUALIFIERS
REHABILITATION: ULTRA HIGH VERY HIGH HIGH MEDIUM LOW	 3 LEVELS 3 LEVELS 3 LEVELS 3 LEVELS 2 LEVELS	Not Used
SPECIAL CARE	3 LEVELS	Not Used
CLINICALLY COMPLEX	3 LEVELS	SYMPTOMS OF DEPRESSION
IMPAIRED COGNITION	2 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count
BEHAVIOR PROBLEMS	2 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count
REDUCED PHYSICAL FUNCTIONING	5 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count

5111.232.002

Appendix D

Rug III Classification System

Attachment 4.19D
Supplement 1



* Also includes those which meet the criteria for Extensive Care but have an ADL Index score of 4, 5, or 6.

APPENDIX E

5111.232.002

RUGIII CLASSIFICATION SYSTEM RESOURCE UTILIZATION GROUPS

Attachment 4.19D
Supplement 1

	RUGIII GROUP	ADL	RUGS CLASS	RELATIVE WEIGHTS
1	Extensive Special Care 3	>6	SE3	3.6037
2	Extensive Special Care 2	>6	SE2	2.9532
3	Extensive Special Care 1	>6	SE1	2.5253
4	Rehabilitation Ultra High	16-18	RUC	2.7812
5	Rehabilitation Ultra High	9-15	RUB	2.0327
6	Rehabilitation Ultra High	4-8	RUA	1.6546
7	Rehabilitation Very High	16-18	RVC	2.4192
8	Rehabilitation Very High	9-15	RVB	2.2206
9	Rehabilitation Very High	4-8	RVA	1.7320
10	Rehabilitation High	13-18	RHC	2.6820
11	Rehabilitation High	8-12	RHB	2.2565
12	Rehabilitation High	4-7	RHA	1.8480
13	Rehabilitation Medium	15-18	RMC	2.8835
14	Rehabilitation Medium	8-14	RMB	2.3328
15	Rehabilitation Medium	4-7	RMA	2.0480
16	Rehabilitation Low	14-18	RLB	2.4124
17	Rehabilitation Low	4-13	RLA	1.7119
18	Special Care	17-18	SSC	2.4449
19	Special Care	15-16	SSB	2.2715
20	Special Care	7-14*	SSA	2.1546
21	Clinically Complex with Symptoms of Depression	17-18	CC2	2.4231
22	Clinically Complex	17-18	CC1	2.1474
23	Clinically Complex with Symptoms of Depression	12-16	CB2	1.9681
24	Clinically Complex	12-16	CB1	1.8232
25	Clinically Complex with Symptoms of Depression	4-11	CA2	1.7925
26	Clinically Complex	4-11	CA1	1.6009
27	Cognitive Impairment with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-10	IB2	1.5112
28	Cognitive Impairment	6-10	IB1	1.4600
29	Cognitive Impairment with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	IA2	1.2366
30	Cognitive Impairment	4-5	IA1	1.1481
31	Behavior Problem with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-10	BB2	1.4861
32	Behavior Problem	6-10	BB1	1.4116
33	Behavior Problem with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	BA2	1.2090
34	Behavior Problem	4-5	BA1	1.0259
35	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	16-18	PE2	1.7400
36	Physical Function	16-18	PE1	1.6983
37	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	11-15	PD2	1.5821
38	Physical Function	11-15	PD1	1.5509
39	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	9-10	PC2	1.4489
40	Physical Function	9-10	PC1	1.3925
41	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-8	PB2	1.1054
42	Physical Function	6-8	PB1	1.0892
43	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	PA2	1.0503
44	Physical Function	4-5	PA1	1.0000
45	Default		BC1	1.0000

* Also includes those which meet the criteria for Extensive Care but have an ADL Index Score of 4, 5, or 6.

5101:3-3-43.1 **Nursing facility (NF) case mix assessment instrument: minimum data set version 3.0 (MDS 3.0).**

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case-mix unit.

(2) "Assessment reference date (ARD)" is the last day of the observation (or "look back") period that the MDS 3.0 assessment covers for the resident.

(3) "Care area assessment (CAA) process" is the mechanism to facilitate care planning decisions and includes care area triggers (CATs), assessment of a triggered care area to facilitate care planning decision making and completion of the CAA summary (on the MDS 3.0, section V, item V0200) titled CAAs and care planning.

(4) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the provider on the status of all MDS 3.0 assessment data that pertains to the calculation of a quarterly, semiannual or annual facility average case mix score.

(5) "Comprehensive assessment" means an assessment that includes completion of not only the appropriate MDS 3.0 assessment type listed in paragraph (B)(2) of this rule and designated for use in Ohio but also completion of the care area assessment (CAA) process.

(6) "Critical elements" are data items from a resident's MDS 3.0 that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(7) "Critical errors" are errors in the MDS 3.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(8) "Default group" is RUG III group forty-five, the case mix group assigned to residents with MDS 3.0 records with inconsistent date fields, missing, incomplete, out of range or inaccurate data, including inaccurate resident identifiers any of which precludes grouping the record into RUG III groups one through forty-four.

(9) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with

the United States centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(10) "Filing date" is the deadline for submission of the NF's MDS 3.0 assessment data that will be used to calculate the preliminary facility quarterly average case mix score. The filing date is the fifteenth calendar day following the reporting period end date (RPED).

(11) "Medicare required assessment" means the MDS 3.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the CAA process.

(12) "Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)" is the statutory authority for the RAI which specifies the a minimum data set (MDS) of core elements for use in conducting assessments of nursing home residents. Assessments are federally mandated and must be performed for all residents of medicare and/or medicaid certified nursing homes.

(13) "Other medicare required assessment (OMRA)" is an unscheduled MDS 3.0 PPS assessment required to be completed during a resident's medicare Part A SNF covered stay based on the start or cessation of rehabilitation services.

(14) "PPS assessment" is the tool that skilled nursing facilities (SNFs) use to assess the clinical condition for each medicare resident receiving Part A SNF level care for reimbursement under the SNF PPS.

(15) "Quarterly facility average total case mix score" is the facility average case mix score based on both medicaid and non-medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(1) of rule 5101:3-3-43.3 of the Administrative Code.

(16) "Quarterly facility average medicaid case mix score" is the facility average case mix score based on only medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(17) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 3.0 designated for use in Ohio that does not include the CAA process.

(18) "Record" means a resident's encoded MDS 3.0 assessment as described in paragraphs (B)(1) to (B)(4) of this rule.

(19) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in paragraph (H) of rule 5101:3-3-43.2 of the Administrative Code.

(20) "Reporting period end date" (RPED) is the last day of each calendar quarter.

(21) "Reporting quarter" is the calendar quarter in which the MDS 3.0 is completed, as indicated by the assessment reference date in MDS 3.0 section A, item - A2300, except as specified in paragraphs (C)(7) and (C)(8) of this rule.

(22) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 code of federal regulations (CFR) section 483.20 (effective 8/11/09 http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=2e0cc442b567f836691e8d460522a8a3 & c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio specified and federally approved instrument is composed of the MDS 3.0, and CAA process.

(23) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 3.0 assessment.

(24) "Resident identifier code" is an alternative resident identifier if the resident does not have a social security number. The resident identifier code shall be reported in MDS 3.0 item S0150. The following method must be used to construct the identifier code. In the first three boxes, enter the first three letters of the resident's last name. In the next six boxes, enter the six digits of the resident's date of birth. Omit the century in the birth date.

(25) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in paragraph (B) of rule 5101:3-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that correlate with resource use.

(26) "Semiannual facility average medicaid case mix score" is the average of a facility's two quarterly facility average medicaid case mix scores. It is used to establish the direct care rate and is calculated pursuant to paragraph (E) of rule 5101:3-3-43.3 of the Administrative Code.

(B) For the purpose of assigning a RUG III classification determining medicaid payment rates for NFs, ODJFS shall utilize the data from the MDS 3.0 as specified by the state and approved by CMS. Each NF shall assess all residents of medicaid-certified beds using the appropriate MDS 3.0 for assessment reference dates (ARDs) on or after October 1, 2010 as set forth in appendix A to this rule for a comprehensive assessment, or appendix D to this rule for a quarterly assessment, or appendix E to this rule for a PPS assessment. When the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) assessment (admission assessment, annual assessment, quarterly assessment, or significant change in status or a significant correction to a prior assessment) and medicare assessment time frames coincide, one assessment shall be used to satisfy both assessments. Admission assessments must be combined with either the medicare five day or medicare fourteen day assessment. For a resident who is not a new admission to the facility, the quarterly, the annual, and significant change in status assessments must be combined with any medicare assessment if the assessment reference date (ARD) is within the assigned medicare observation period. When combining the OBRA and medicare assessments, the most stringent requirement for MDS completion must be met. ODJFS shall not utilize the data in the other medicare required assessments (OMRAs) for calculating case mix scores or determining medicaid payment rates.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20.

(2) For a comprehensive assessment, NFs must use the Ohio specified MDS 3.0, including section S. The comprehensive assessment, as set forth in appendix A to this rule is completed upon admission, annually, and when a significant change in the resident's status has occurred or a significant correction to a prior comprehensive assessment is required. NFs must use either the Ohio specified nursing home quarterly MDS 3.0 as set forth in appendix D to this rule including section S or the nursing home PPS assessment set forth in appendix E to this rule for the quarterly review assessment or a significant correction to a prior quarterly assessment. The nursing home PPS assessment must be used for all medicare required assessments.

(3) NFs must use the MDS 3.0 discharge assessment as set forth in appendix B to this rule for any residents who transfer, or are discharged and the MDS 3.0 tracking record as set forth in appendix C to this rule for any residents entering or reentering or who died in the facility in accordance with 42 CFR section 483.20.

(4) NFs must use the MDS correction request in section X of the MDS 3.0 for modification or inactivation of MDS records that have been accepted into the national MDS database.

(C) All NFs must submit to the national database encoded, accurate, and complete MDS - 3.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 3.0 data completed in accordance with paragraphs (B)(1) to (B)(4) of this rule must be encoded in accordance with 42 CFR section 483.20, CMS' uniform data submission document, and state record layout specifications.

(2) MDS 3.0 data must be submitted in an electronic format and in accordance with the frequency schedule found in 42 CFR section 483.20. The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state. Except as provided in paragraph (D) of this rule, all records used in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score must be submitted by the filing date.

(3) If a NF submits MDS 3.0 data needed for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score after the forty-fifth day after the RPED, ODJFS may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) MDS 3.0 data submitted by a provider that can not be timely extracted by ODJFS from the CMS data server may result in assignment of a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(5) The annual, semiannual, and quarterly facility average total case mix score and quarterly facility average medicaid case mix score will be calculated using the MDS 3.0 record in effect on the RPED for:

(a) Residents who were admitted to the medicaid certified NF prior to the RPED and continue to be physically present in the NF on the RPED; and

(b) Residents who were admitted to the medicaid certified NF on the RPED; and

(c) Residents who were temporarily absent on the RPED but are considered residents and for whom a return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the RPED will not be used for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score.

(7) For a resident admitted within fourteen days prior to the RPED, and whose initial assessment is not due until after the RPED, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0" issued by CMS (November 2009 http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp) and in 42 CFR 483.20.

(b) The initial assessment, if completed and submitted timely in accordance with paragraphs (C)(1) and (C)(2) of this rule, shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score in the quarter the resident entered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(8) For a resident who had at least one MDS 3.0 assessment completed before being transferred to a hospital, who then reenters the NF within fourteen days prior to the RPED, and has experienced a significant change in status that requires a comprehensive assessment upon reentry, the following shall apply:

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 3.0 assessment reference date (MDS 3.0, item A2300).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score for the quarter in which the resident reentered the facility even if the assessment

reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(D) Corrections to MDS 2.0 data with an ARD on or before September 30, 2010 must be made in accordance with the requirements in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0", and the "State Operations Manual" issued by CMS (http://www.cms.gov/Manuals/IOM/). Corrections to MDS 3.0 data with an ARD on or after October 1, 2010 must be made in accordance with the requirements in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0", and the "State Operations Manual" issued by CMS (Rev.1, May 21, 2004 http://www.cms.gov/Manuals/IOM/) and,

(1) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, the facility must transmit the corrections to the state no later than forty-five days after the RPED.

(2) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, all significant correction assessments must contain an assessment reference date within the reporting quarter.

(3) The provider shall submit an accurate, encoded MDS 3.0 record for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS 3.0 assessments that were completed timely but omitted from the previous transmissions and ODJFS shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score, if the assessments are transmitted no later than forty-five days after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code. If the assessments are not transmitted within forty-five days after the RPED, ODJFS may assign a default group for those records.

(b) The provider shall notify ODJFS within forty-five days of the RPED of any records for residents in medicaid certified beds on the RPED that were not completed timely and were not transmitted to the state. ODJFS may assign default scores to those records as described in paragraph (F) of rule 5101:3-3-43.2 of the Administrative Code.

(c) The provider has forty-five days after the RPED to transmit the appropriate discharge assessment to the national database, if more residents are determined as being in the facility on the RPED than the number of its medicaid certified beds. If the facility does not correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(d) The provider shall notify ODJFS within forty-five days of the RPED of any residents who were reported to be residents of the facility on the RPED, but who had actually been discharged prior to the RPED. If the provider fails to correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(e) The provider has forty-five days after the RPED to submit appropriate modifications or discharge assessments to rectify any discrepancy between the records selected for determining the quarterly facility average total case mix score and the facility census on the RPED. If the facility does not correct the error(s) within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(3)(a) and (D)(3)(b) of this rule is greater than ten per cent, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

5101:3-3-43.2 **Resource utilization groups, version III (RUG III): the nursing facility case mix payment system.**

The Ohio department of job and family services (ODJFS) shall pay each eligible nursing facility (NF) provider a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each provider's rate for direct care costs semiannually. Each provider's rate for direct care costs shall be based on a case mix payment system.

(A) The Ohio medicaid case mix payment system for direct care contains the following core components:

(1) As set forth in rule 5101:3-3-43.1 of the Administrative Code, a uniform resident assessment instrument (the minimum data set version 3.0, (MDS 3.0) including - section S) and as set forth in appendix A to this rule, a database which provides the core data elements that are used to group residents into case mix categories;

(2) A methodology for grouping residents into case mix groups in a way that is clinically meaningful and uses criteria that sufficiently differentiates one group from another, as outlined in paragraphs (B) to (F) of this rule;

(3) The identification of those specific costs within the direct care cost category which will be affected by changes in case mix, as described in paragraph (G) of this rule.

(4) A means of measuring the relative costliness of caring for residents in one group versus another, known as "relative resource weights", as described in paragraph (H) of this rule.

(B) The medicaid provider case mix payment system shall use the methodology for grouping residents known as RUG III developed through the United States centers for medicare and medicaid services (CMS) multistate nursing home case-mix and quality demonstration project and described in this rule. Residents in each RUG III group utilize similar quantities and patterns of resources. The RUG III classification system includes the following seven mutually exclusive major categories of resident types from which forty-four RUG III groups are classified:

(1) Extensive care, which includes three groups;

(2) Special rehabilitation, which includes five resident subtypes and fourteen groups;

(3) Special care, which includes three groups;

(4) Clinically complex, which includes six groups;

(5) Impaired cognition, which includes four groups;

(6) Behavior problems, which includes four groups; and

(7) Reduced physical functioning, which includes ten groups. The RUG III categories are listed in descending order of hierarchy. Based on the items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group within the highest major category of resident types according to the hierarchy unless the activities of daily living (ADL) index score is not met for placement within the highest major category of resident types. Residents without any of the characteristics which result in assignment to the higher categories comprise the last resident type. Rehabilitation is the highest category in the national RUG III version; however, it is ranked second to extensive services in Ohio.

(C) The RUG III classification system defines the criteria that are used to assign residents into one of the seven major categories of resident types. These criteria are summarized in paragraph (D) of this rule. Assignment of a resident to one of the RUG III groups within the major category is then based upon either or both of the following additional dimensions described below: resident functionality as measured by an ADL index score outlined in paragraph (C)(1) of this rule and additional problems or services required, outlined in paragraphs (C)(2) and (C)(3) of this rule.

(1) With the exception of the extensive care category, each group within a major category of resident types is identified by an ADL index score, which is computed using a special scoring technique. The ADL index score is based on four ADL variables (bed mobility, toileting, transfer and eating) and is calculated by assigning a score for the resident on each ADL variable and summing the scores. A resident's ADL index score may range from four to eighteen.

(a) The ADL scores for bed mobility, toileting, and transfer are as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one for each ADL activity.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "2" for limited assistance are assigned an ADL score of three in each ADL activity.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for extensive assistance, "4" for total dependence or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of four in each ADL activity if they are coded on MDS 3.0 item (G0110A2), (G0110B2), or (G0110I2), respectively, as "-" for unknown, "0" for no set up or physical help from staff, "1" for setup help only, or "2" for "one person physical assist".

(iv) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for "extensive assistance," "4" for "total dependence," or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of five in each ADL activity if they are coded on ADL support provided item (G0110A2), (G0110B2), or (G0110I2), respectively, as "3" for "two+ persons physical assist" or "8" for "ADL activity itself did not occur during entire period".

(b) The ADL score for eating is as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "2" for limited assistance are assigned an ADL score of two.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "3" for "extensive assistance", "4" for "total dependence" or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of three. This score is also assigned if section K: swallowing/nutritional status, item (K0500A) for "parenteral/IV feeding" is checked or item (K0500B) for "feeding tube" is checked and if fifty-one per cent or more of total calories are received through parenteral or tube feeding, item (K0700A) is coded "3", or twenty-six per cent to fifty per cent of total calories received

through parenteral or tube feeding item (K0700A) is coded "2", and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2".

(2) Symptoms of depression are used to determine groupings for those who qualify for the clinically complex category using the criteria outlined in paragraph (D)(6) of this rule.

(a) On the MDS 3.0 at section D: mood, Should Resident Mood Interview be Conducted, item (D0100), for residents coding yes "1", the assessor will attempt to complete the interview. If the assessor is unable to complete the interview or if item D0100 is coded "0" no, the assessor will complete the Staff Assessment of Resident Mood (PHQ-9-OV), item (D0500).

(b) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to 10 coded on the MDS 3.0 at section D: mood, total severity score, item (D0300).

(c) The total severity score is the sum of the frequency of the following symptoms on the MDS 3.0 section D: mood, resident mood interview (PHQ-9), item (D0200):

(i) Little interest or pleasure in doing things (on MDS 3.0 at section D: mood, item (D0200A2)).

(ii) Feeling down, depressed, or hopeless (on MDS 3.0 at section D: mood, item (D0200B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on MDS 3.0 at section D: mood, item (D0200C2)).

(iv) Feeling tired or having little energy (on MDS 3.0 at section D: mood, item (D0200D2)).

(v) Poor appetite or overeating (on MDS 3.0 at section D: mood, item (D0200E2)).

(vi) Feeling bad about yourself-or that you are a failure or have let yourself or your family down (on MDS 3.0 at section D: mood, item (D0200F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on MDS 3.0 at section D: mood, item (D0200G2)).

(viii) 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 (on MDS 3.0 at section D: mood, item (D0200H2)).

(ix) Thoughts that you would be better off dead, or of hurting yourself in some way (on MDS 3.0 at section D: mood, item (D0200I2)).

(d) If the Resident Mood Interview (PHQ-9) is not successfully completed, the staff assessment of resident mood (PHQ-9-OV) on the MDS 3.0 section D: mood, item (D0500) is used to determine grouping for those who qualify for the clinically complex resource utilization group using the criteria outlined in paragraph (D)(6) of this rule.

(e) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to 10 coded (on the MDS 3.0 at section D: mood, item (D0600)). The total severity score is the sum of the frequency of the following symptoms:

(i) Little interest or pleasure in doing things (on the MDS 3.0 section D: mood, item (D0500A2)).

(ii) Feeling or appearing down, depressed, or hopeless (on the MDS 3.0 section D: mood, item (D0500B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on the MDS 3.0 section D: mood, item (D0500C2)).

(iv) Feeling tired or having little energy (on the MDS 3.0 section D: mood, item (D0500D2)).

(v) Poor appetite or overeating (on the MDS 3.0 section D: mood, item (D0500E2)).

(vi) Indicating that s/he feels bad about self, is a failure, or has let self or family down (on the MDS 3.0 section D: mood, item (D0500F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on the MDS 3.0 section D: mood, item (D0500G2)).

(viii) 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 (on the MDS 3.0 section D: mood, item (D0500H2)).

(ix) States that life isn't worth living, wishes for death, or attempts to harm self (on the MDS 3.0 section D: mood, item (D0500I2)).

(x) Being short-tempered, easily annoyed (on the MDS 3.0 section D: mood, item (D0500J2)).

(3) Restorative nursing programs, current toileting program or trial, and/or bowel toileting program are used to determine grouping within three categories of resident types and in classifying residents into the low intensity resident subtype of the rehabilitation category.

(a) Two or more of the following activities, each occurring within the timeframes described in paragraph (C)(3)(b) of this rule places an individual in a higher resource use group within the impaired cognition, behavior problems, or reduced physical functioning categories:

(i) Passive range of motion and/or active range of motion (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500A) or (O0500B));

(ii) Splint or brace assistance (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500C));

(iii) Training and skill practice in any of the following:

(a) Walking and/or bed mobility (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500F) or (O0500D)),

(b) Transfer (on the MDS 3.0, at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500E)),

(c) Dressing and/or grooming (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500G)),

(d) Eating and/or swallowing (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500H)),

(e) Amputation/prostheses care (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500I)),

(f) Communication (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500J)),

(iv) Current toileting program or trial, and/or bowel toileting program (on the MDS 3.0 at section H: bladder and bowel, item (H0200C) or (H0500)). The current toileting program or trial at item (H0200C) must be managed 4 or more days of the 7 day look back period.

(b) Restorative nursing programs that are used to determine grouping within the rehabilitation category, low intensity subtype, are listed in paragraphs (C)(3)(a)(i) to (C)(3)(a)(iv) of this rule. Each restorative nursing program must be performed at least six days a week for at least fifteen minutes a day to be counted. The current toileting program or trial at item (H0200C) must be managed 4 or more days of the 7 day look back period.

(D) The RUG III criteria for classification into the seven major categories and the forty-four groups is listed below:

(1) The extensive care category includes residents who have a RUG III ADL index score of seven through eighteen and is determined by the two sets of qualifiers set forth in paragraphs (D)(1)(a) and (D)(1)(b) of this rule.

(a) The presence of extensive treatments received are the initial qualifiers for the extensive care category. The following clinical indicators are the initial qualifiers. If the initial qualifiers are met but the ADL index score is four, five or six the record shall be placed in the special care category SSA.

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) Suctioning, including nasopharyngeal or tracheal aspiration (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100D1 "while NOT a resident") and/or (O0100D2 "while a resident")),

(iii) Tracheostomy care (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100E1 "while NOT a resident") and/or (O0100E2 "while a resident")),

(iv) Ventilator or respirator (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100F1 "while NOT a resident") and/or (O0100F2 "while a resident")), and

(v) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident") and/or (O0100H2 "while a resident")).

(b) Once the resident has qualified for the extensive care category, a secondary set of qualifiers determines the RUG III grouping. The qualifiers are:

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident) and/or (O0100H2 "while a resident")),

(iii) Eligible for special care (as described in paragraph (D)(4) of this rule,

(iv) Eligible for clinically complex (as described in paragraph (D)(6) of this rule) or

(v) Eligible for impaired cognition (as described in paragraph (D)(8) of this rule.

(2) The extensive care category has three groups of residents who meet one or more of the secondary extensive qualifiers listed in paragraph (D)(1) of this rule:

(a) Class "SE3" residents are in RUG III group one and meet four or five of the secondary qualifiers.

(b) Class "SE2" residents are in RUG III group two and meet two or three of the secondary qualifiers.

(c) Class "SE1" residents are in RUG III group three and meet zero or one of the secondary qualifiers.

(3) The special rehabilitation category is split into five resident subtypes and has fourteen groups. Therapies refers to any combination of physical therapy, occupational therapy, or speech-language pathology and audiology services. On the MDS3.0, at section O: special treatments, procedures, and programs, items (O0400A4), (O0400B4), and (O0400C4), the number of days each type of therapy is administered for fifteen minutes or more in the last seven calendar days is recorded. On the MDS 3.0, at section O: special treatments, procedures, and programs, items (O0400A1 through O0400A3), (O0400B1 through O0400B3), and (O0400C1 through O0400C3), the total number of minutes each type of therapy is provided for individual, concurrent, and group therapy in the last seven days is recorded.

(a) Ultra high intensity multidisciplinary rehabilitation is the first subtype for residents who receive:

(i) Seven hundred twenty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day; and

(iii) At least one type of therapy three or more days per week and at least fifteen minutes per day.

(b) The ultra high intensity rehabilitation subtype has three groups:

(i) Class "RUC" residents are in RUG III group four and have an ADL index score of sixteen to eighteen.

(ii) Class "RUB" residents are in RUG III group five and have an ADL index score of nine through fifteen.

(iii) Class "RUA" residents are in RUG III group six and have an ADL index score of four through eight.

(c) Very high intensity rehabilitation is the second subtype for residents who receive:

(i) Five hundred minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(d) The very high intensity rehabilitation subtype has three groups.

(i) Class "RVC" residents are in RUG III group seven and have an ADL index score of sixteen through eighteen.

(ii) Class "RVB" residents are in RUG III group eight and have an ADL index score of nine through fifteen.

(iii) Class "RVA" residents are in RUG III group nine and have an ADL index score of four through eight.

(e) High intensity rehabilitation is the third subtype for residents who receive:

(i) Three hundred twenty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(f) The high intensity rehabilitation subtype has three groups.

(i) Class "RHC" residents in RUG III group ten have an ADL index score of thirteen through eighteen.

(ii) Class "RHB" residents in RUG III group eleven have an ADL index score of eight through twelve.

(iii) Class "RHA" residents in RUG III group twelve have an ADL index score of four through seven.

(g) Medium intensity rehabilitation is the fourth subtype for residents who receive:

(i) One hundred fifty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least five days per week of any combination of rehabilitation therapy.

(h) The medium intensity rehabilitation subtype has three groups.

(i) Class "RMC" residents in RUG III group thirteen have an ADL index score of fifteen through eighteen.

(ii) Class "RMB" residents in RUG III group fourteen have an ADL index score of eight through fourteen.

(iii) Class "RMA" residents in RUG III group fifteen have an ADL index score of four through seven.

(i) Low intensity rehabilitation is the fifth subtype for residents who receive the following:

(i) Forty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least three days per week of any combination of rehabilitation therapy; and

(iii) At least two types of restorative nursing programs each provided at least six days per week, current toileting program or trial managed for 4 or more days of the 7 days, or bowel toileting program. Programs counted for the rehabilitation category are listed in paragraphs (C)(3)(a)(i) to (C)(3)(a)(iv) of this rule.

(j) The low intensity rehabilitation subtype has two groups.

(i) Class "RLB" residents in RUG III group sixteen have an ADL index score of fourteen through eighteen.

(ii) Class "RLA" residents in RUG III group seventeen have an ADL index score of four through thirteen.

(4) Except as set forth in paragraph (D)(4)(d) of this rule, the special care category includes residents who have a RUG III ADL index score of seven through eighteen and either:

(a) Have one or more of the following conditions:

(i) Cerebral palsy (on the MDS 3.0 at section I: active diagnoses, item (I4400)), with an ADL index score greater than or equal to ten;

(ii) Surgical wound(s) or open lesion(s) other than ulcers, rashes, cuts (on the MDS 3.0 at section M: skin conditions, item (M1040E) or (M1040D)) and surgical wound care (on the MDS 3.0 at section M: skin conditions, item (M1200F)) or application of nonsurgical dressings with or without topical medications other than to feet or application of ointments/medications other than to feet (on the MDS 3.0 section M: skin conditions, items (M1200G or M1200H));

(iii) Fever with vomiting, pneumonia, weight loss, dehydrated, or feeding tube with percent intake by artificial route qualifiers (on the MDS 3.0 at section J: health conditions, item (J1550A) is checked and at least one of the following: At section J: item (J1550B) is checked, or at section I: active diagnoses item (I2000) is checked, or at section K: weight - loss, item (K0300) is scored "1" or "2", or at section J: health conditions item (J1550C) is checked) or at section K: swallowing/nutritional status, item (K0500B) is checked and fifty-one per cent or more of total calories are received through parenteral or tube feeding intake (item (K0700A) is coded "3") or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding intake (item (K0700A) is coded "2") and fluid intake is five hundred one or more cubic centimeters (CCs) per day (item (K0700B) is coded "2";

(iv) Multiple sclerosis (on the MDS 3.0 at section I: active diagnoses, item (I5200)) with an ADL index score greater than or equal to ten;

(v) Stage three or four pressure ulcer or unstageable pressure ulcer-slough and/or eschar (on the MDS 3.0 at section M: skin conditions, items (M0300C1), (M0300D1), or (M0300F1)) and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, items (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C) turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet) or two or more ulcers of any type (on the MDS 3.0 at section M: skin conditions, item (M0300A), (M0300B1), (M0300C1), (M0300D1), (M0300F1), or (M1030) number of venous and arterial ulcers and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, item (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C)

turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet);

(vi) Quadriplegia (on the MDS 3.0 at section I: active diagnoses, item (I5100)), with an ADL index score greater than or equal to ten; or

(b) Receive one or more of the following types of special care:

(i) Seven days of respiratory therapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0400D2)),

(ii) Radiation treatment (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100B1 "while NOT a resident") and/or (O0100B2 "while a resident)), or

(iii) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) with parenteral or tube feeding intake (on the MDS 3.0 at section K: parenteral or tube feeding intake item (K0700A) is coded "3" or item (K0700A) is coded "2" and item (K0700B) is coded "2" and aphasia (on the MDS 3.0 section I, active diagnoses, item (4300)).

(c) Meet the conditions for the extensive care category but have a RUG III ADL index score of four, five, or six.

(d) If the ADL index score is four, five or six the record shall be placed in the clinically complex category CA1.

(5) The special care category has three groups.

(a) Class "SSC" residents in RUG III group eighteen have an ADL index score of seventeen through eighteen.

(b) Class "SSB" residents in RUG III group nineteen have an ADL index score of fifteen through sixteen.

(c) Class "SSA" residents in RUG III group twenty have an ADL index score of seven through fourteen.

(6) The clinically complex category includes residents who have at least one of the following conditions or are receiving at least one of the following treatments:

(a) Burns (on the MDS 3.0 at section M; skin conditions, item (M1040F)),

(b) Comatose (on the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) is scored "1", and at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days).

(c) Diabetes mellitus (on the MDS 3.0 at section I: active diagnoses, item (I2900)) and injections on seven days (on the MDS 3.0 at section N: medications, item (N0300)) and physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)).

(d) Dehydrated (on the MDS 3.0 at section J: health conditions, item (J1550C)),

(e) Hemiplegia or hemiparesis (on the MDS 3.0 at section I: active diagnoses, item (I4900)), with an ADL index score greater than or equal to ten,

(f) Internal bleeding (on the MDS 3.0 at section J: health conditions, item (J1550D)),

(g) Pneumonia (on the MDS 3.0 at section I: active diagnoses, item (I2000)),

(h) Infection of the foot, diabetic foot ulcer(s) or other open lesion(s) on the foot (on the MDS 3.0 at section M: skin conditions, items (M1040A), (M1040B) or (M1040C)) and application of dressings to feet (with or without topical medications) (on the MDS 3.0 at section M: skin conditions, item (M1200I-)),

(i) Septicemia (on the MDS 3.0 at section I: active diagnoses, item (I2100)),

(j) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) and fifty-one per cent or more of total calories are received through parenteral or tube feeding intake, item (K0700A) is coded "3" or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding, item (K0700A) is coded "2" and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2",

(k) Chemotherapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100A1 "while NOT a resident") and/or (O0100A2 "while a resident")),

(l) Dialysis (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100J1 "while NOT a resident") and/or (O0100J2 "while a resident")),

(m) Physician order changes on four or more days in the last fourteen days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations of one or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0600) or physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations on two or more days (on the MDS 3.0 section O: special treatments, procedures, and programs, item (O0600)),

(n) Oxygen therapy (on the MDS at section O: special treatments, procedures, and programs, items (O0100C1 "while NOT a resident") and/or (O0100C2 "while a resident")),

(o) Transfusions (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100I1 "while NOT a resident") and/or (O0100I2 "while a resident")),

(p) Meet the conditions for the special care categories but have a RUG III ADL index score of four, five or six.

(7) The clinically complex category has six groups.

(a) Class "CC2" residents in RUG III group twenty-one have an ADL index score of seventeen through eighteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(b) Class "CC1" residents in RUG III group twenty-two have an ADL index score of seventeen through eighteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(c) Class "CB2" residents in RUG III group twenty-three have an ADL index score of twelve through sixteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(d) Class "CB1" residents in RUG III group twenty-four have an ADL index score of twelve through sixteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(e) Class "CA2" residents in RUG III group twenty-five have an ADL index score of four through eleven and have symptoms of depression as described in paragraph (C)(2) of this rule.

(f) Class "CA1" residents in RUG III group twenty-six have an ADL index score of four through eleven and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(8) The impaired cognition category includes residents with a RUG III ADL index score of four through ten, and a Brief Interview for Mental Status (BIMS) score less than or equal to 9 or a cognitive performance scale of three through six. The BIMS score ranges from 0 to 15 and is based on resident responses to 7 questions. On the MDS 3.0 at section C: cognitive patterns, Should Brief Interview for Mental Status be conducted, item (C0100), for residents coding yes "1", the assessor will attempt to complete the BIMS. If coded "0" no, the cognitive performance scale described in paragraph (D)(8)(b) of this rule is computed to determine impaired cognition.

(a) The BIMS is based on 3 qualifiers: repetition of three words, temporal orientation, and recall. The summation of the following qualifiers on the MDS 3.0 at section C: cognitive patterns, summary score, item (C0500) determine the BIMS score for the impaired cognition category:

(i) Repetition of three words (on the MDS 3.0 at section C: cognitive patterns, item (C0200)),

(ii) Able to report correct year (on the MDS 3.0 at section C: cognitive patterns, item (C0300A)),

(iii) Able to report correct month (on the MDS 3.0 at section C: cognitive patterns, item (C0300B)),

(iv) Able to report correct day of week (on the MDS 3.0 at section C: cognitive patterns, item (C0300C)),

(v) Able to recall "sock" (on the MDS 3.0 at section C: cognitive patterns, item (C0400A)),

(vi) Able to recall "blue" (on the MDS 3.0 at section C: cognitive patterns, item (C0400B)),

(vii) Able to recall "bed" (on the MDS 3.0 at section C: cognitive patterns, item (C0400C)).

(b) If the BIMS cannot be completed, the cognitive performance scale is computed to determine impaired cognition. The cognitive performance scale values range from zero to six and are based on three qualifiers: the presence or absence of coma, self-performance in eating and the summation of an impairment count and a severity count which evaluates the resident using the MDS 3.0 variables. These three qualifiers, evaluated in the following manner, determine the resident's cognitive performance scale for the impaired cognition category:

(i) On the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) residents coded with a "one" for comatose, section G: functional status-ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days, and in section C: cognitive patterns, cognitive skills for daily decision making item (C1000) is not coded "-", "0", "1" or "2", the cognitive performance scale is assigned a score of six.

(ii) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making item (C1000), residents coded with a "3" for severely impaired and section G: functional status, ADL self-performance, eating item (G0110H1), is coded "4" for total dependence or "8" for activity did not occur during entire seven days, the cognitive performance scale is assigned a score of six. If section G, eating item (G0110H1) is coded "-" for unknown, "0" for independent, "1" for supervision, "2" for limited assistance, or "3" for extensive assistance, the cognitive performance scale is assigned a score of five.

(iii) The summation of the impairment count and severity count are used in assigning values of one through four on the cognitive performance scale and are calculated as follows:

(*a*) The impairment count identifies deficits in three key cognitive areas and is determined by summing the scores for the following variables:

(*i*) Short term memory, on the MDS 3.0 at section C: cognitive patterns, item (C0700) residents coded "1" for a memory problem are assigned a score of one.

(ii) Cognitive skills for daily decision making, on the MDS 3.0 at section C: cognitive patterns, item (C1000), residents coded with a "1" for modified independence or "2" for moderately impaired are assigned a score of one.

(iii) Makes self understood, on the MDS 3.0 at section B: hearing, speech, and vision, item (B0700), residents coded "1" for usually understood, "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(b) The severity count identifies the deficit level of residents with moderate to severe impairment in cognitive skills for daily decision making (C1000) and in makes self understood (B0700). This count is determined by summing the scores for the following variables:

(*i*) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making, item (C1000), residents coded with a "2" for moderately impaired are assigned a score of one.

(ii) On the MDS 3.0 at section B: hearing, speech, and vision, makes self understood, item (B0700), residents coded with "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(c) If the total for the impairment count is two or three and the total for the severity count is two, the cognitive performance scale is assigned a score of four.

(d) If the total for the impairment count is two or three and the total for the severity count is one, the cognitive performance scale is assigned a score of three.

(e) If the total for the impairment count is two or three and the total of the severity count is zero, the cognitive performance scale is assigned a score of two. Residents would not qualify for the impaired cognition category.

(f) If the total of the impairment count is one, the cognitive performance scale is assigned a score of one. Residents would not qualify for the impaired cognition category.

(9) The impaired cognition category has four groups.

(a) Class "IB2" residents in RUG III group twenty-seven have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "IB1" residents in RUG III group twenty-eight have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "IA2" residents in RUG III group twenty-nine, have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "IA1" residents in RUG III group thirty have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(10) The behavior problems category includes residents with a RUG III ADL index score of four through ten, and

(a) Have hallucinations and/or delusions (on the MDS 3.0 at section E: behavior, items (E0100A) or (E0100B)), or

(b) Problem displayed in any one of the following on four or more days per week:

(i) Wandering (on the MDS 3.0 at section E: behavior, item (E0900)), or

(ii) Verbal behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200B)), or

(iii) Physical behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200A)), or

(iv) Other behavioral symptoms not directed toward others (on the MDS 3.0 at section E: behavior, item (E0200C)), or

(v) Rejection of care (on the MDS 3.0 at section E: behavior, item (E0800)).

(11) The behavior problems category has four groups.

(a) Class "BB2" residents in RUG III group thirty-one have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "BB1" residents in RUG III group thirty-two have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "BA2" residents in RUG III group thirty-three have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "BA1" residents in RUG III group thirty-four have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(12) The reduced physical function category has ten groups and includes residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the impaired cognition or behavior problems categories but have a RUG III ADL index score of more than ten.

(a) Class "PE2" residents in RUG III group thirty-five have an ADL index score of sixteen through eighteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial

managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "PE1" residents in RUG III group thirty-six have an ADL index score of sixteen through eighteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "PD2" residents in RUG III group thirty-seven have an ADL index score of eleven through fifteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "PD1" residents in RUG III group thirty-eight have an ADL index score of eleven through fifteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(e) Class "PC2" residents in RUG III group thirty-nine have an ADL index score of nine or ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(f) Class "PC1" residents in RUG III group forty have an ADL index score of nine or ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(g) Class "PB2" residents in RUG III group forty-one have an ADL index score of six through eight and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(h) Class "PB1" residents in RUG III group forty-two have an ADL index score of six through eight and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or

more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(i) Class "PA2" residents in RUG III group forty-three have an ADL index score of four or five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(j) Class "PA1" residents in RUG III group forty-four have an ADL index score of four or five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(E) A list of the MDS 3.0 data elements used to group residents in the RUG III classification system is set forth in appendix A to this rule. The ADL index scoring system is set forth in a table in appendix B to this rule. A description of classification branches in the RUG III system is summarized in the table set forth in appendix C to this rule. A graphic description of the RUG III classification system is set forth in appendix D to this rule.

(F) The RUG III classification system has forty-four different groups. All MDS 3.0 data elements related to the RUG III classification system must be completed before a resident can be classified. Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the RUG III classification shall be assigned by default into a forty-fifth group. Corrections to MDS 3.0 data can be made only as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code.

(G) The relationship between resident characteristics and resource utilization, as measured by staff time for the registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides (NAs) worker classifications, was analyzed for the RUG III system to identify characteristics which differentiate resource use among residents. Staff time and assessment data were collected by the federal multistate nursing home case-mix and quality demonstration project for the purpose of establishing common nursing staff times associated with all resident categories that are standard across residents, nursing staff, facilities, units and states. Resident specific and resident non-specific time for each worker classification (RN, LPN, and NA) was averaged for each of the forty-four RUG III groups.

(H) Each of the forty-four RUG III groups is assigned a relative resource weight. This weight indicates the relative amount of staff time required on average for all three

worker classifications listed in paragraph (G) of this rule to deliver care to residents in that RUG III group.

(1) The relative resource weight is calculated as follows using the average minutes per worker classification per RUG III group provided by the United States department of health and human services, and three-year averages, beginning with calendar year 1989, of RN, LPN, and NA wages in Ohio medicaid certified NFs as reported to ODJFS.

(a) By setting the NA wage weight at one, wage weights for RNs and LPNs are calculated by dividing the NA wage into the RN or LPN wage.

(b) To calculate the total weighted minutes for each RUG III group, the wage weight for each worker classification is multiplied by the average number of minutes that classification of workers spends caring for a resident in the RUG III group and the products are summed.

(c) The RUG III group with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the lowest group's total weighted minutes into each group's total weighted minutes. Weight calculations are rounded to the fourth decimal place.

(2) The lowest weight for the forty-four RUG III groups is used as the weight for the forty-fifth default group.

(3) Relative resource weights for the forty-five NF case-mix RUG III groups are set forth in appendix E to this rule.

(4) Except as provided in paragraph (H)(4)(b) of this rule, relative resource weights may be recalibrated using wage weights based on three-year statewide averages of RN, LPN, and NA wages in Ohio NFs as reported on the long term care facility medicaid cost report for NFs, and minutes per worker classification per RUG III group as follows:

(a) Upon receipt of revised worker classification minutes from the United States department of health and human services, ODJFS shall recalibrate the relative resource weights based on the revised minutes and the averages of RN, LPN, and NA wages from cost report data from the most recent three calendar years, to be effective at the beginning of the next state fiscal year.

(b) ODJFS may recalibrate the relative resource weights at least once every ten years, using the most current worker classification minutes from the United

States department of health and human services and the average worker classification wages, to be effective at the beginning of the next state fiscal year. When recalibrating the relative resource weights, as permitted by paragraph (H)(4)(b) of this rule ODJFS shall use cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year.

(c) ODJFS may recalibrate relative resource weights more frequently if significant variances in wage ratios between worker classifications occur.

(d) After recalibrating relative resource weights under paragraph (H)(4)(a), (H)(4)(b), or (H)(4)(c) of this rule, ODJFS shall use the recalibrated relative resource weights to calculate the semiannual NF case mix score effective for the start of the fiscal year and to recalculate the annual NF case mix score for the calendar year preceding the fiscal year.

Resident _____ Identifier _____ Date _____

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

Section A Identification Information

A0100. Facility Provider Numbers

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

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

C. **State Provider Number:**

A0200. Type of Provider

Enter Code

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

A0310. Type of Assessment

Enter Code

A. **Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. **PPS Assessment**
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. **PPS Other Medicare Required Assessment - OMRA**
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. **Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

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

Enter Code

F. **Entry/discharge reporting**
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

B. Medicare number (or comparable railroad insurance number): ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

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

A1100. Language

Enter Code ☐

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

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

B. Preferred language: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

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

A1300. Optional Resident Items

A. Medical record number: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number: ☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

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

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

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

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

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

MR/DD With Organic Condition

☐ A. Down syndrome

☐ B. Autism

☐ C. Epilepsy

☐ D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐ E. MR/DD with no organic condition

No MR/DD

☐ Z. None of the above

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

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code ☐☐

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

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

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2400. Medicare Stay

Enter Code ☐

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

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

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Resident _____ Identifier _____ Date _____

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

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

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

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

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐
Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*
Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**
After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

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

Ask resident: "*Please tell me what year it is right now.*"
Enter Code ☐
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

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**

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. Summary Score

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

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code ☐

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

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

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

Delirium

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

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

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

↓ **Enter Codes in Boxes**

- ☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- ☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- ☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

Enter Code ☐

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

D0200. Resident Mood Interview (PHQ-9©)

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

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

D0300. Total Severity Score

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

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?**
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

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

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

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

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

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

D0600. Total Severity Score

☐☐ Enter Score

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

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. 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 Codes in Boxes

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

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

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/or 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**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

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

E1000. Wandering - Impact

Enter Code ☐

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

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

Enter Code ☐

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

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

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

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

Enter Code ☐

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

F0400. Interview for Daily Preferences

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

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

↓ **Enter Codes in Boxes**

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

F0500. Interview for Activity Preferences

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

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

↓ **Enter Codes in Boxes**

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

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

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

Enter Code ☐

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

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

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

Resident _____ Identifier _____ Date _____

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

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
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)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
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	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

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

G0300. Balance During Transitions and Walking

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

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

↓ **Enter Codes in Boxes**

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

G0400. Functional Limitation in Range of Motion

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

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

↓ **Enter Codes in Boxes**

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

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

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code ☐

A. Resident believes he or she is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Direct care staff believe resident is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

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

H0200. Urinary Toileting Program

Enter Code ☐

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

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

Enter Code ☐

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

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

Enter Code ☐

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

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

H0300. Urinary Continence

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary 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 the entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

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

H0500. Bowel Toileting Program

Enter Code ☐

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

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

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

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

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Cancer

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

Heart/Circulation

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

Gastrointestinal

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

Genitourinary

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

Infections

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

Metabolic

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

Musculoskeletal

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

Neurological

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

Neurological Diagnoses continued on next page

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Neurological - Continued

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

Nutritional

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

Psychiatric/Mood Disorder

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

Pulmonary

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

Vision

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

None of Above

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

Other

- ☐ **I8000. Additional active diagnoses**

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

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

Resident _____ Identifier _____ Date _____

Section J Health Conditions

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

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted?

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

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

Pain Assessment Interview

J0300. Pain Presence

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

J0400. Pain Frequency

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

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

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

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -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**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

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

Staff Assessment for Pain

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

↓ **Check all that apply**

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

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

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain
1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1300. Current Tobacco Use

Enter Code ☐

Tobacco use
0. **No**
1. **Yes**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

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

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

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

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

Enter Code ☐

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

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

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

↓ **Enter Codes in Boxes**

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

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

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

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

Check all that apply

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

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

☐☐ inches

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

☐☐☐ pounds

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

K0300. Weight Loss

Enter Code ☐

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

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

K0500. Nutritional Approaches

Check all that apply

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

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

Enter Code ☐

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

Section L Oral/Dental Status

L0200. Dental

Check all that apply

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

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ Check all that apply

- ☐ A. **Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ B. **Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ C. **Clinical assessment**
- ☐ Z. **None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐

Is this resident at risk of developing pressure ulcers?

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

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

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

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

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers

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

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** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐

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

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐

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

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** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐

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

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

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

Enter Number ☐
1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐
1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

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

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0

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

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

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 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. Ulcer 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

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

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

N0350. Insulin

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

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

N0400. Medications Received

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

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

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

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

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

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

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

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

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 O0400B, Occupational Therapy

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 O0400C, Physical Therapy

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 O0400D, Respiratory Therapy

Enter Number of Days

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

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

Month – Day – Year

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

Month – Day – Year

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

D. Respiratory Therapy

Enter Number of Minutes ☐☐☐☐

Enter Number of Days ☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

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

Enter Number of Minutes ☐☐☐☐

Enter Number of Days ☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400F, Recreational Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes ☐☐☐☐

Enter Number of Days ☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0500, Restorative Nursing Programs
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

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?**

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

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

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

↓ Enter Codes in Boxes	
	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

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

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

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

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐

A. Is there an active discharge plan in place for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐

B. What determination was made by the resident and the care planning team regarding discharge to the community?
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to next active section (V or X)

Q0500. Return to Community

Enter Code ☐

A. Has the resident been asked about returning to the community?
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐

B. Ask the resident (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐

Has a referral been made to the local contact agency?
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section V Care Area Assessment (CAA) Summary

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

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

Enter Code ☐☐

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

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

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

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. **Not PPS** assessment

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Score ☐☐

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

Enter Score ☐☐

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

Enter Score ☐☐

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section V Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

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

A. CAA Results

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

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

1. Signature

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

C. Signature of Person Completing Care Plan and Date Signed

1. Signature

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

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

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

Enter Code ☐

Type of provider

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

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

A. First name:

☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

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

Enter Code ☐☐

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

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

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA

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

X0600 continued on next page

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0200 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

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

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 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 (X0100 = 3)

Check all that apply

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

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. **No**
1. **Yes**

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG Case Mix group:**

B. **RUG version code:**

Resident _____ Identifier _____ Date _____

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 ☐☐☐☐

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Discharge (ND) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

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

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

C. **State Provider Number:**

A0200. Type of Provider

Enter Code ☐

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

A0310. Type of Assessment

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code ☐

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

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name:

B. Middle initial: ☐

C. Last name:

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

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

B. Medicare number (or comparable railroad insurance number):

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

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

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

A1100. Language

Enter Code ☐

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

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

B. Preferred language:

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

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

A1300. Optional Resident Items

A. Medical record number: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number: ☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

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

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

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

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

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

MR/DD With Organic Condition

☐ A. Down syndrome

☐ B. Autism

☐ C. Epilepsy

☐ D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐ E. MR/DD with no organic condition

No MR/DD

☐ Z. None of the above

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

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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

A2300. Assessment Reference Date

Observation end date:

Month – Day – Year

A2400. Medicare Stay

Enter Code

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

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

B. Start date of most recent Medicare stay:

Month – Day – Year

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

Month – Day – Year

AUG 18 2011
TN 10-002 Approval Date _____
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

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

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

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

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐
Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*
Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

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

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

Ask resident: "*Please tell me what year it is right now.*"
Enter Code ☐
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

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**

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. Summary Score

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

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code ☐

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

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

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

Delirium

C1300. Signs and Symptoms of Delirium (from CAMe)

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

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

↓ **Enter Codes in Boxes**

- ☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- ☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- ☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

Enter Code ☐

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

D0200. Resident Mood Interview (PHQ-9©)

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

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

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

D0300. Total Severity Score

Enter Score ☐☐

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

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

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

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

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

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

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

D0600. Total Severity Score

☐☐ Enter Score

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

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Section E Behavior

E0100. 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**

Resident _____ Identifier _____ Date _____

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

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
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)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
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	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

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

G0300. Balance During Transitions and Walking

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

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

↓ **Enter Codes in Boxes**

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

G0400. Functional Limitation in Range of Motion

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

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

↓ **Enter Codes in Boxes**

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

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

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

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

H0300. Urinary Continence

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary 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 the entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Heart/Circulation

- ☐ I0200. **Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ I0600. **Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ I0700. **Hypertension**
- ☐ I0800. **Orthostatic Hypotension**

Genitourinary

- ☐ I1550. **Neurogenic Bladder**
- ☐ I1650. **Obstructive Uropathy**

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)**
- ☐ I2000. **Pneumonia**
- ☐ I2100. **Septicemia**
- ☐ I2200. **Tuberculosis**
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ I2500. **Wound Infection** (other than foot)

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)

Musculoskeletal

- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I4000. **Other Fracture**

Neurological

- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ I4900. **Hemiplegia or Hemiparesis**
- ☐ I5000. **Paraplegia**
- ☐ I5100. **Quadriplegia**
- ☐ I5200. **Multiple Sclerosis (MS)**
- ☐ I5250. **Huntington's Disease**
- ☐ I5300. **Parkinson's Disease**
- ☐ I5400. **Seizure Disorder or Epilepsy**
- ☐ I5500. **Traumatic Brain Injury (TBI)**

Nutritional

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

Psychiatric/Mood Disorder

- ☐ I5700. **Anxiety Disorder**
- ☐ I5800. **Depression** (other than bipolar)
- ☐ I5900. **Manic Depression** (bipolar disease)
- ☐ I5950. **Psychotic Disorder** (other than schizophrenia)
- ☐ I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)

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**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Other

☐ **I8000. Additional active diagnoses**

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

A. _____ | | | | | | | | |

B. _____ | | | | | | | | |

C. _____ | | | | | | | | |

D. _____ | | | | | | | | |

E. _____ | | | | | | | | |

F. _____ | | | | | | | | |

G. _____ | | | | | | | | |

H. _____ | | | | | | | | |

I. _____ | | | | | | | | |

J. _____ | | | | | | | | |

Resident _____ Identifier _____ Date _____

Section J Health Conditions

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

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted?

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

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

Pain Assessment Interview

J0300. Pain Presence

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

J0400. Pain Frequency

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

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

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

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -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**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

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

Staff Assessment for Pain

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

↓ **Check all that apply**

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

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

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain
1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

☐	**A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	**B. Shortness of breath** or trouble breathing **when sitting at rest**
☐	**C. Shortness of breath** or trouble breathing **when lying flat**
☐	**Z. None of the above**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

☐	**A. Fever**
☐	**B. Vomiting**
☐	**C. Dehydrated**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

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

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

Enter Code ☐

Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0200, Height and Weight
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

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

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

↓ **Enter Codes in Boxes**

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

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

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

Section K Swallowing/Nutritional Status

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

☐☐ inches

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

☐☐☐ pounds

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

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ **Check all that apply**

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

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ Check all that apply

- ☐ **A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐ **Is this resident at risk of developing pressure ulcers?**

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

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

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

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐ **A. Number of Stage 1 pressure ulcers**

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

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** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ **2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐ **2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐ **2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

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

Enter Number ☐
1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐
1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm — **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm — **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm — **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

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

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0

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

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

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 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. Ulcer 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

Resident _____ Identifier _____ Date _____

Section N Medications

N0400. Medications Received

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

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

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 ↓	
E. Tracheostomy care		☐
F. Ventilator or respirator		☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

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

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
- 0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
- 1. **Yes** → Continue to O0250B, Date vaccine received

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
- 0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
- 1. **Yes** → Skip to O0600, Physical Examinations

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

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 P Restraints

P0100. Physical Restraints

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

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

↓ Enter Codes in Boxes	
	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

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

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

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

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0300, Insurance Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

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

Enter Code ☐

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

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

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

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

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

AUG 18 2011
TN 10-002 Approval Date _____
Supersedes
~~TN 06-010 Effective Date 10-01-10~~

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

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

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 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 (X0100 = 3)

Check all that apply

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0300. Insurance Billing

A. RUG Case Mix group: | | | | | | | | | | |

B. RUG version code: | | | | | | | | | | |

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 | | | | |

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home and Swing Bed Tracking (NT/ST) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

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

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

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

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

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

B. Medicare number (or comparable railroad insurance number): ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

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

A1200. Marital Status

Enter Code ☐

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

Resident _____ Identifier _____ Date _____

Section A Identification Information

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:

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

Month – Day – Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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

Resident _____ Identifier _____ Date _____

Section A Identification Information

A2400. Medicare Stay

Enter Code ☐

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

0. **No** → Skip to X0100, Type of Record
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

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

Enter Code ☐

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

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

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

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

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

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

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 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 (X0100 = 3)

Check all that apply

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

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

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.			

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Quarterly (NQ) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

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

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

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

A0200. Type of Provider

Enter Code ☐

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

A0310. Type of Assessment

Enter Code ☐☐

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code ☐

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

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

AUG 18 2011

TN 10-002 Approval Date _____
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

B. Medicare number (or comparable railroad insurance number): ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

Check all that apply

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

A1100. Language

Enter Code ☐

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

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

B. Preferred language: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

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

A1300. Optional Resident Items

A. Medical record number:

☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number:

☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

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

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

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

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

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

MR/DD With Organic Condition

☐ **A. Down syndrome**

☐ **B. Autism**

☐ **C. Epilepsy**

☐ **D. Other organic condition related to MR/DD**

MR/DD Without Organic Condition

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

No MR/DD

☐ **Z. None of the above**

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

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

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

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code ☐☐

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

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

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2400. Medicare Stay

Enter Code ☐

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

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

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Resident _____ Identifier _____ Date _____

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

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

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

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

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Attempt to conduct interview with all residents

Enter Code ☐

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

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

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

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. Summary Score

Enter Score ☐☐

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

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code ☐

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

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

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

Delirium

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

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

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

↓ **Enter Codes in Boxes**

- ☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- ☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- ☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

Enter Code ☐

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

D0200. Resident Mood Interview (PHQ-9©)

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

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

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

D0300. Total Severity Score

☐☐ Enter score

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

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

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

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

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

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

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

D0600. Total Severity Score

☐☐ Enter Score

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

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. 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 Codes in Boxes

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

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

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

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

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited**
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**

Resident _____ Identifier _____ Date _____

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

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
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)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
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	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

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

G0300. Balance During Transitions and Walking

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

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

↓ **Enter Codes in Boxes**

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

G0400. Functional Limitation in Range of Motion

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

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

↓ **Enter Codes in Boxes**

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

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

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

Check all that apply

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

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**

H0300. Urinary Continence

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary 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 the entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

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

H0500. Bowel Toileting Program

Enter Code ☐

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
	Genitourinary
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**
	Infections
☐	**I1700. Multidrug-Resistant Organism (MDRO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☐	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100. Hyponatremia**
☐	**I3200. Hyperkalemia**
☐	**I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
	Musculoskeletal
☐	**I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐	**I4000. Other Fracture**
	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5100. Quadriplegia**
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5400. Seizure Disorder or Epilepsy**
☐	**I5500. Traumatic Brain Injury (TBI)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Psychiatric/Mood Disorder

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

Pulmonary

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

Other

- ☐ **I8000. Additional active diagnoses**

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section J Health Conditions

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

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted?

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

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

Pain Assessment Interview

J0300. Pain Presence

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

J0400. Pain Frequency

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

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

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

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -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**

AUG 18 2011

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

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

Staff Assessment for Pain

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

↓ Check all that apply

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

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

Enter Code ☐

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

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

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- ☐ A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ B. **Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ C. **Shortness of breath** or trouble breathing **when lying flat**
- ☐ Z. **None of the above**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

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

J1550. Problem Conditions

↓ Check all that apply

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

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

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

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

Enter Code ☐

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

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

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

↓ **Enter Codes in Boxes**

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

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

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

AUG 18 2011

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

Check all that apply

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

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

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

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

K0300. Weight Loss

Enter Code ☐

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

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

K0500. Nutritional Approaches

Check all that apply

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

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

Enter Code ☐

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

Section L Oral/Dental Status

L0200. Dental

Check all that apply

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

Check all that apply

- ☐ A. **Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ B. **Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ C. **Clinical assessment**
- ☐ Z. **None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐ **Is this resident at risk of developing pressure ulcers?**

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

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

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

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐ **A. Number of Stage 1 pressure ulcers**

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

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** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ **2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

Enter Number ☐ **1. Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐ **2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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

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

Enter Number ☐ **2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

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

Enter Number ☐
1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

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** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐
1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐
2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

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

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0

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

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

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

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 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. Ulcer 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

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

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

N0350. Insulin

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

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

N0400. Medications Received

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

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

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

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

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	[redacted]	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	[redacted]	☐

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

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

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

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Resident _____ Identifier _____ Date _____

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 O0400B, Occupational Therapy

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 O0400C, Physical Therapy

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 O0400D, Respiratory Therapy

Enter Number of Days ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

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

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?**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

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

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

↓ **Enter Codes in Boxes**

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

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

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

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

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

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐

A. Is there an active discharge plan in place for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐

B. What determination was made by the resident and the care planning team regarding discharge to the community?
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code ☐

A. Has the resident been asked about returning to the community?
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐

B. Ask the resident (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐

Has a referral been made to the local contact agency?
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

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

Enter Code ☐

Type of provider

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

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

A. First name:

☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

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

Enter Code ☐☐

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

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

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA

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

X0600 continued on next page

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

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

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 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 (X0100 = 3)

↓ **Check all that apply**

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. No
1. Yes

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG Case Mix group:**

B. **RUG version code:**

Resident _____ Identifier _____ Date _____

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 ____

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home PPS (NP) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

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

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

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

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

AUG 18 2011

TN 10-002 Approval Date _____
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

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

B. Medicare number (or comparable railroad insurance number): ☐☐☐☐☐☐☐☐☐☐☐☐

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

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

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

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

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

A1100. Language

Enter Code ☐

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

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

B. Preferred language: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

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

A1300. Optional Resident Items

A. Medical record number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number: ☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

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

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

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

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

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

MR/DD With Organic Condition

☐ A. Down syndrome

☐ B. Autism

☐ C. Epilepsy

☐ D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐ E. MR/DD with no organic condition

No MR/DD

☐ Z. None of the above

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

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code ☐☐

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

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code ☐☐

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

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2300. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2400. Medicare Stay

Enter Code ☐

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

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

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Resident _____ Identifier _____ Date _____

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

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

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

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

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

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

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

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

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

Number of words repeated after first attempt

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

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

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

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

Enter Code ☐

A. Able to report correct year

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

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**

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. Summary Score

Enter Score ☐☐

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

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

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

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter Code ☐

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

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

☐ **A. Current season**
☐ **B. Location of own room**
☐ **C. Staff names and faces**
☐ **D. That he or she is in a nursing home**
☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

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

Delirium

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

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

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

↓ **Enter Codes in Boxes**

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

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

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

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

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

Enter Code ☐

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

D0200. Resident Mood Interview (PHQ-9©)

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

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

D0300. Total Severity Score

☐☐ Enter Score

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

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

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

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

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

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

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

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

D0600. Total Severity Score

☐☐ Enter Score

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

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. 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 Codes in Boxes**

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

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

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

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

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited**
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**

Resident _____ Identifier _____ Date _____

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

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
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)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
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	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

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

G0300. Balance During Transitions and Walking

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

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

↓ **Enter Codes in Boxes**

☐ **A. Moving from seated to standing position**

☐ **B. Walking** (with assistive device if used)

☐ **C. Turning around** and facing the opposite direction while walking

☐ **D. Moving on and off toilet**

☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

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

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

↓ **Enter Codes in Boxes**

☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)

☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

☐ **A. Cane/crutch**

☐ **B. Walker**

☐ **C. Wheelchair** (manual or electric)

☐ **D. Limb prosthesis**

☐ **Z. None of the above** were used

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

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

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**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary 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 the entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

H0500. Bowel Toileting Program

Enter Code ☐

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
	Genitourinary
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**
	Infections
☐	**I1700. Multidrug-Resistant Organism (MDRO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☐	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100. Hyponatremia**
☐	**I3200. Hyperkalemia**
☐	**I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
	Musculoskeletal
☐	**I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐	**I4000. Other Fracture**
	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5100. Quadriplegia**
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5400. Seizure Disorder or Epilepsy**
☐	**I5500. Traumatic Brain Injury (TBI)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

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

Psychiatric/Mood Disorder

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

Pulmonary

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

Other

- ☐ **I8000. Additional active diagnoses**

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

A. _____ | | | | | | | | | |

B. _____ | | | | | | | | | |

C. _____ | | | | | | | | | |

D. _____ | | | | | | | | | |

E. _____ | | | | | | | | | |

F. _____ | | | | | | | | | |

G. _____ | | | | | | | | | |

H. _____ | | | | | | | | | |

I. _____ | | | | | | | | | |

J. _____ | | | | | | | | | |

Resident _____ Identifier _____ Date _____

Section J Health Conditions

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

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted?

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

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

Pain Assessment Interview

J0300. Pain Presence

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

J0400. Pain Frequency

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

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

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

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -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**

AUG 18 2011

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

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

Staff Assessment for Pain

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

↓ **Check all that apply**

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

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

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain
1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

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

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

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

Enter Code ☐

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

Enter Code ☐

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

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

Enter Code ☐

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

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

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

↓ **Enter Codes in Boxes**

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

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

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

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

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

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

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

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ **Check all that apply**

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

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

Enter Code ☐

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

Section L Oral/Dental Status

L0200. Dental

↓ **Check all that apply**

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ Check all that apply

- ☐ A. **Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ B. **Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ C. **Clinical assessment**
- ☐ Z. **None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐

Is this resident at risk of developing pressure ulcers?
0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐

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

Enter Number ☐

Enter Number ☐

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

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

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

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Number ☐

Enter Number ☐

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

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

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

Enter Number ☐

Enter Number ☐

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

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

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

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

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

Enter Number ☐

1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐

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

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** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐

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

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐

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

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

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

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

Complete only if A0310E = 0

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

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

TN 10-002 Approval Date AUG 18 2011

Supersedes

~~TN 06-010 Effective Date 10-01-10~~

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐ **A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?**
0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

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 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. Ulcer 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

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

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

N0350. Insulin

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

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

N0400. Medications Received

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

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

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

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

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

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

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

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

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Resident _____ Identifier _____ Date _____

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 O0400B, Occupational Therapy

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 O0400C, Physical Therapy

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 O0400D, Respiratory Therapy

Enter Number of Days ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

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

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?**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

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

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

↓ **Enter Codes in Boxes**

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

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

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

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

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐

A. Is there an active discharge plan in place for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐

B. What determination was made by the resident and the care planning team regarding discharge to the community?
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code ☐

A. Has the resident been asked about returning to the community?
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐

B. Ask the resident (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐

Has a referral been made to the local contact agency?
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

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

Enter Code ☐

Type of provider

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

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

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

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

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

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

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

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

☐☐☐ – ☐☐ – ☐☐☐☐

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

Enter Code ☐☐

A. **Federal OBRA Reason for Assessment**

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. **PPS Assessment**

PPS Scheduled Assessments for a Medicare Part A Stay

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

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code ☐

C. **PPS Other Medicare Required Assessment - OMRA**

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

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

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

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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

X0800. Correction Number

Enter Number ☐☐

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

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 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 (X0100 = 3)

Check all that apply

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

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. **No**
1. **Yes**

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

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

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG Case Mix group:**

B. **RUG version code:**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

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 ☐☐☐☐

OS Notification

State/Title/Plan Number:	**Ohio 10-002**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**September 1, 2011**
Fiscal Impact:	**FY 2011 $ 0** **FY 2012 $ 0**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: **Effective for services on or after October 1, 2010, this amendment implements the Minimum Data Set (MDS) Version 3.0 resident assessment instrument, used by CMS, for purposes of calculating reimbursement for NF services.**

Ohio pays each eligible NF provider a per resident per day rate for direct care costs established prospectively for each facility. Each provider's rate for direct care costs is based on a case mix payment system. The State processes resident assessment data, using the minimum data set system (MDS) Version2.0, submitted by NFs and classifies residents using the resource utilization groups, version III (RUG III) classification system to determine resident case mix scores. This amendment implements the MDS Version 3.0 System for measuring resident assessment data.

Other Considerations: **This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.**

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact: **Todd McMillion (608) 441-5344**
National Institutional Reimbursement Team