User Guide Addenda

The information that was included in the LTC Community Services Waiver Programs User Guide in the “Inactivations” section has been updated to reflect a new requirement to enter a note when inactivating MN/LOC Assessments 2.0 and 3.0. The updated information is included in the addendum, which immediately follows the User Guide and can be accessed by using the bookmarks.

Click the link to view the following addendum: Enter a Note When Inactivating MN/LOC Assessments.
Addendum added 08/03/2012.

For more information, contact the LTC Help Desk at 1-800-626-4117, Option 1.

The information included in the LTC Community Services Waiver Programs Workshop User Guide in the “Appendix C: Medical Necessity and Level of Care (MN/LOC) Assessment – Version 3.0” section has been updated to reflect new requirements for fields G0110 and G0120. The updated information is included in the addendum, which immediately follows the User Guide and can be accessed by using the bookmarks.

Click the link to view the following addendum: MN/LOC Assessment 3.0 Field Updates.
Addendum added 10/25/2012.

For more information, contact the LTC Help Desk at 1-800-626-4117, Option 1.

The information that was included in the LTC Community Services Waiver Program User Guide in the “Medical Necessity and Level of Care 3.0 Assessment” section has been updated to reflect a change to the MN/LOC 3.0 criteria. The updated information is included in the addendum, which immediately follows the User Guide and can be accessed by using the bookmarks.

Click the link to view the following addendum: MDS and MN/LOC 3.0 Updates.
Addendum added 10/01/2013.

For more information, contact the LTC Help Desk at 1-800-626-4117, Option 1.
Long Term Care Community Services
Waiver Programs Workshop

— User Guide —
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Learning Objectives

After attending the Long Term Care Community Services Waiver Programs Workshop, you will be able to:

- Understand the Medicaid team roles.
- Identify National Provider Identifier (NPI) requirements.
- Obtain an LTC Online Portal administrator account.
- Understand basic LTC Online Portal features.
- Understand Medical Necessity (MN) and the MN determination process.
- Submit Medical Necessity and Level of Care (MN/LOC) Assessments.
- Understand and complete the Long Term Care Medicaid Information (LTCMI) section, field by field.
- Understand the provider workflow process.
- Understand how to correct or inactivate assessments—and the consequences of doing so.
- Understand how to print completed and blank assessments.
- Identify assessment statuses and how to resolve issues.
- Understand Resource Utilization Group (RUG) training requirements.
- Report Medicaid waste, abuse and fraud.
- Understand Health Insurance Portability and Accountability Act (HIPAA) of 1996 guidelines and provider responsibilities.
- Identify additional resources.
Medicaid Team

The following groups and individuals make up the Medicaid Team. Together, they make it possible to deliver Medicaid services to Texans.

• **Centers for Medicare & Medicaid Services (CMS)** – Federal agency that oversees Medicaid on a federal level—guidelines, rules, and regulations.

• **Individuals** – Those served by Texas Medicaid.

• **Managed Care Organization (MCO)** – State-contracted entity that has been given delegated authority to provide acute and long term services to support enrolled managed care members.

• **Providers** – The crucial players in a quality health-care program. The focus is on providing the best care possible while being reimbursed for allowed services rendered.

• **Texas Department of Aging and Disability Services (DADS)** – Administers a comprehensive array of services for persons who are aging or disabled and for persons who have Intellectual and Developmental Disabilities (IDD). Additionally, DADS licenses and regulates providers of these services.

• **Texas Health and Human Services Commission (HHSC)** – Oversees operations of the entire health and human services system in Texas. It operates the Medicaid acute care program, Children's Health Insurance Plan (CHIP), State of Texas Access Reform (STAR)+PLUS, and several other related programs. HHSC’s Office of Eligibility Services (OES) determines eligibility for Medicaid.

• **Texas Medicaid & Healthcare Partnership (TMHP)** – Contracted by the State as the claims administrator to process claims for providers under traditional Medicaid. TMHP processes and approves claims for traditional Long Term Care (LTC). TMHP does not pay LTC claims; this is done by the comptroller. Responsibilities also include the following:
  - Determination of MN
  - Provider Education
  - Provide timely processing of claims (except for services covered by the STAR+PLUS premium) and represents DADS at Fair Hearings
  - Provide yearly manuals, quarterly LTC Bulletins, and Remittance and Status (R&S) Reports
  - Maintain the TMHP Call Center/Help Desk, Monday through Friday, 7:00 a.m.–7:00 p.m., Central Time
  - Provide training sessions for providers, which includes technical assistance to the TexMedConnect online application
  - Conduct training sessions for providers, which includes technical assistance on the TexMedConnect online application

• **Texas State Legislature** – The state legislature allocates budgetary dollars for Texas Medicaid.
National Provider Identifier/Atypical Provider Identifier Requirements

HIPAA established the NPI as the 10-digit standard unique identifier for health-care providers and requires covered health-care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

NPI is required on all claims submitted electronically, through third-party software, or through TexMedConnect. On the LTC Online Portal, NPI is used for security purposes, and links providers to their assessments so that only those associated with that NPI are viewable. Without an NPI, providers would not be able to locate their assessments on the LTC Online Portal.

Note: DADS Medically Dependant Children Program (MDCP) nurses are not required to apply for an NPI. They enter an Atypical Provider Identifier (API) which is assigned by the appropriate region.

To obtain an NPI, go to https://nppes.cms.hhs.gov/NPPES.

It is important the NPI be included in MN/LOC Assessment submissions field S2d. NPI is required on claims and assessment submissions using the following methods:

- LTC Online Portal
- TexMedConnect
- Third-party software vendor
The LTC Online Portal

The LTC Online Portal is used to submit, monitor, and manage MN/LOC Assessments.

Benefits of Using the LTC Online Portal

- Web-based application.
- 24/7 system availability.
- TMHP provides LTC Online Portal technical support by telephone at **1-800-626-4117**, Option 3, from 7:00 a.m.–7:00 p.m., Central Time, Monday through Friday–excluding holidays.
- Edits are in place to verify the validity of data entered.
- Provides error messages that must be resolved before submission.
- Providers have the ability to monitor the status of their assessments by using Form Status Inquiry (FSI) or Current Activity.
- Allows providers to submit additional information.

LTC Online Portal Security

In order to utilize the LTC Online Portal, providers must request access to the LTC Online Portal. Your agency may already have an account. You may need to contact your agency’s administrator for user access. An administrator account is required for LTC Online Portal access, but it is strongly recommended to have multiple administrator accounts, in case one administrator is unavailable.

The administrator account is the primary user account for a provider/contract number.

The administrator account provides the ability to add/remove permissions (access to LTC Online Portal features) for other user accounts on the same provider/contract number.

A user account can be created by an administrator. User account permissions and limitations are set by the holder of an administrator account. This allows administrators to set the level of access according to employees’ responsibilities.

**Note:** MDCP nurses obtain LTC Online Portal access directly from HHSC ([www.hhsc.state.tx.us](http://www.hhsc.state.tx.us)).

If you already have either an administrator or user account, go to [www.tmhp.com/Pages/LTC/Ltc_home.aspx](http://www.tmhp.com/Pages/LTC/Ltc_home.aspx). Click the “Log In to LTC Online Portal” button.
If you do not have an account, you can create one by following the steps below. To do so, you will need to have your:

- **Provider contract number** – assigned by DADS when the provider signs the contract to provide Medicaid services.
- **Vendor number** – four-digit number assigned by DADS when the provider signs the contract to submit assessments on the LTC Online Portal.
- **Vendor password** – provider must call the Electronic Data Interchange (EDI) Help Desk at **1-888-863-3638** to obtain their vendor password. Please note that it may take three to five business days to receive the password, which is randomly generated by TMHP.

**How to Create an LTC Online Portal Administrator Account**

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click “providers” in the green bar located at the top of the screen.
3. Click “Long Term Care” in the yellow bar.
4. Click “I would like to...” in the blue bar located at the top of the screen.

5. Click the **Activate my account** link.

6. From here you have two choices:
   a. To create a new TMHP User Account without an existing provider/vendor account, click the **New Username and Enroll** link.
      - if selected, go to step 8. (Provider Type step)
   b. To create a new TMHP User Account with an existing provider/vendor account, click the **New Username and Activate Existing Provider** link.
      - if selected, go to step 7.
7. The following page will appear. Follow the instructions listed at the top of the page and click the Create a Provider/Vendor Administrator Account link at the bottom of the page.
8. Select a Provider Type from the drop-down box.

   **Note:** The Provider Types listed immediately below are the only two choices in the drop-down box that are applicable for this guide.

   - Use **NF/Waiver Programs** to submit MN/LOC Assessments on the LTC Online Portal. If you already use TexMedConnect, you are still required to create an NF/Waiver Programs account to submit MN/LOC Assessments on the LTC Online Portal.
   - Use **Long Term Care** to access TexMedConnect (for submitting claims, accessing R&S Reports, and performing Medicaid Eligibility and Service Authorization Verifications [MESAVs]).

9. Enter your provider number, vendor number, and vendor password.

10. Click the “Next” button.
11. Check the “I agree to these terms” box at the bottom of the screen, under the General Terms and Conditions section, to indicate agreement.

12. Click the “Create Provider Administrator” button to create your User name and Password.

**My Account**

My Account is used to perform various maintenance activities for your account, such as: setting up user accounts, changing passwords, and other administrative tasks.

To access My Account:

1. Go to [www.tmhp.com](http://www.tmhp.com).
2. Click “providers” in the green bar located at the top of the screen.
3. Click the “Log in to My Account” button in the blue bar located at the top of the screen.

**Note:** You may be prompted to enter your LTC Online Portal User ID and Password.
4. The “My Account” page will appear.

Log In to the LTC Online Portal


2. Click “providers” in the green bar located at the top of the screen.
3. Click “Long Term Care” in the yellow bar.

4. Click the “Log In to LTC Online Portal” button.

5. Enter your User name and Password.

6. Click the “OK” button. After log in, Form Status Inquiry (FSI) will display by default:
LTC Online Portal Basics

Blue Navigational Bar Links

All portal features based on your security level will be found in the blue navigational bar located at the top of the portal screen.

Options found in the blue navigational bar may include: Home, Submit Form, Form Status Inquiry, Current Activity, Drafts, Printable Forms, and Help.

Home

When the blue navigational bar above is displayed, the Home feature at the far left will take you to My Account. From the My Account page, providers can perform various maintenance activities for an account such as: setting up user accounts, changing passwords, and other administrative tasks. Providers may click the TMHP.com link located on the far left side of the “My Account” page, to go back to the www.tmhp.com home page.

Using the TMHP home page providers may:

- Access the LTC Online Portal.
- Access TexMedConnect.
- Submit a prior authorization.
- Access provider manuals and guides.
- Access bulletins and banner messages.
Submit Form

The Submit Form feature allows providers to submit *Waiver 3.0: Medical Necessity and Level of Care Assessments*.
Note: The steps to submit MN/LOC Assessments are covered in the “Medical Necessity and Level of Care Assessment” section.
Form Status Inquiry (FSI)

The FSI feature provides a query tool for monitoring the status of assessments that have been successfully submitted.

Providers may use FSI to search for either Type of Form: Waiver 2.0: Medical Necessity and Level of Care Assessments or Type of Form: Waiver 3.0: Medical Necessity and Level of Care Assessments. The search does not have the capability to return both 2.0 and 3.0 Assessments with one search. Searches must be performed separately for 2.0 and 3.0 Assessments.

FSI allows providers to retrieve assessments in order to:

- Access assessments to research and review statuses.
- Provide additional information to an assessment.
- Retrieve assessments to make corrections or perform inactivations.
- Resolve any assessments set to “Provider Action Required.”

Note: FSI can retrieve information from the previous seven years. The search is based on the TMHP Received Date. There is a 50-record line limit for search results; therefore, you may need to narrow your search to retrieve specific records.

1. Click the **Form Status Inquiry** link in the blue navigational bar.

2. Type of Form: Choose **Waiver 2.0: Medical Necessity and Level of Care Assessment** or **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Medicaid Number,” “Last Name,” “First Name,” “SSN,” “Form Status,” “From” and “To” Dates, and “Reason for Assessment.” Dates are searched against the TMHP Received Date (date of successful submission).

4. Click the “Search” button, and the LTC Online Portal will return any matching submissions (records).

Note: FSI search results will only display the Type of Form selected.
5. Click the View Detail link of the requested assessment to open and view the assessment.

<table>
<thead>
<tr>
<th>DLN</th>
<th>TMHP Received Date</th>
<th>SSN</th>
<th>Medicaid #</th>
<th>Medicare #</th>
<th>First Name and Last Name</th>
<th>Status</th>
<th>RUG</th>
<th>Purpose Code</th>
<th>Contract Number</th>
<th>Vendor Number</th>
<th>Reason for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>01510016</td>
<td>10/9/2012</td>
<td>16/07/0000</td>
<td>Provider ID Pending</td>
<td>CA2</td>
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</tbody>
</table>

Descriptions of the column headings seen above are:

- **View Detail**: The hyperlink used to open the assessment.
- **DLN**: The unique document locator number (DLN) assigned to each successfully submitted assessment.
- **TMHP Received Date**: The actual date the assessment was successfully submitted on the LTC Online Portal.
- **SSN**: (2.0: AA5a, 3.0: A0600A), Medicaid # (2.0: AA7, 3.0: A0700), Medicare # (2.0: AA5b, 3.0: A0600B), First Name and Last Name (2.0: AA1a and AA1c, 3.0: A0500A and A0500C): Information used to identify the individual associated with the assessment.
- **Status**: The status of the assessment at the time of the search.
- **RUG**: The assigned Resource Utilization Group (RUG) value.
- **RN Signature Date**: Date the assessment was completed as identified in field R2b for 2.0 Assessments and field Z0500B for 3.0 Assessments.
- **Purpose Code**:
  - Purpose Code 1: Utilization Review Assessment submitted by DADS.
  - Purpose Code L: Lookback Review Assessment submitted by DADS.
- **Contract Number**: The nine-digit provider number.
- **Vendor Number**: The four-digit site identification number.
- **Reason for Assessment**: (2.0: AA8a, 3.0: A0310A):

<table>
<thead>
<tr>
<th>Waiver 2.0: MN/LOC Assessment</th>
<th>Waiver 3.0: MN/LOC Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA8a = 01. Initial Assessment</td>
<td>A0310A = 01. Initial Assessment</td>
</tr>
<tr>
<td>AA8a = 02. Annual Assessment</td>
<td>A0310A = 03. Annual Assessment</td>
</tr>
<tr>
<td>AA8a = 03. Significant change in status assessment (SCSA)</td>
<td>A0310A = 04. Significant change in status assessment (SCSA)</td>
</tr>
</tbody>
</table>

**Current Activity**

The Current Activity feature allows providers to view assessment submissions or status changes that have occurred within the last 14 calendar days. After 14 days, providers must utilize the FSI query tool to locate an assessment. Current Activity will display MN/LOC 3.0 and MN/LOC 2.0 Assessments.

1. Click the Current Activity link in the blue navigational bar.
2. Click the appropriate vendor number (if applicable).

3. The results will display a summary of all assessment submissions or status changes within the last 14 calendar days.

   **Note:** 2.0 Assessments will be grouped together by form type under column headings Waiver 2.0 and 3.0 Assessments will be grouped together by form type under column headings Waiver 3.0.

   ![Screen capture of Current Activity page]

   Descriptions of the column headings seen above:
   - **Waiver 2.0/ Waiver 3.0:** The unique DLN assigned to each successfully submitted assessment.
   - **Received:** The actual date the assessment was successfully submitted on the LTC Online Portal.
   - **SSN:** (A0600A), **Medicaid** (A0700), **Medicare** (A0600B), **First Name and Last Name** (A0500A and A0500C): Information used to identify the individual associated with the assessment.
   - **Status:** The status of the assessment.

4. Click the DLN link to display the details of the requested assessment.

   Providers are able to sort the Current Activity results in a variety of ways. By clicking on the heading of a column, the provider can choose to sort results by DLN, Received Date, SSN, Medicaid Number, Medicare Number, Name, or Status. When the provider clicks on a column heading the first time, it is sorted in ascending order. By clicking on the column heading a second time, the sort will change to descending order.
Drafts

The Drafts feature allows access to all drafts saved under the vendor/contract number to which the user is linked.

To access a saved draft:

1. Click the Drafts link in the blue navigational bar.

2. Click the appropriate vendor number hyperlink under Vendor Numbers. A list of drafts saved for the selected vendor/contract number will display.

3. From here you have two choices:
   a. Click the Open link to open the draft to edit and submit.

   **Note:** Providers will not be able to perform an original submission of a 2.0 draft after October 1, 2010. If a provider attempts to open a draft MN/LOC 2.0 Assessment (i.e., Form Type Waiver 2.0) after October 1, 2010, the following error message will display:

   - As of 10/1/2010, MN and LOC 2.0 Assessments are no longer accepted. Please submit an MN and LOC 2.0 Assessment MN and LOC 2.0 Corrections are accepted if within 14 days of the original parent assessment TMHP received date. If a 2.0 correction is necessary after 14 days, an MN and LOC 3.0 Assessment must be submitted.
b. Click the **Remove** link to permanently delete the draft.

**Note:** The following confirmation prompt message will appear:

- Click the “OK” button to delete the draft.
  - or
- Click the “Cancel” button to keep the draft.

**Note:** Once a draft has been removed, it cannot be retrieved.
Printable Forms

The Printable Forms feature allows the provider to view blank assessments, print blank assessments, or interactively complete assessments by saving to the provider's desktop:

1. Click the **Printable Forms** link in the blue navigational bar.

2. Choose an assessment by clicking the corresponding link. Adobe Reader® will open in a new window and will display the blank assessment in Portable Document Format (PDF).

   **Note:** To type information into an assessment, click on the appropriate link. Once open, save the document to your desktop and begin entering information.

![Printable Forms](image-url)
3. Click the “Print” Icon.

   To print the entire document:
   a. Printer: Choose the appropriate printer name from drop-down box.
   b. Print Range: Click the “All” radio button.
   c. Click the “OK” button.

   To print certain pages, instead of the entire document:
   a. Printer: Choose the appropriate printer name from drop-down box.
   b. Print Range: Click the “Pages” radio button.
   c. Enter the pages to print. (Example: 1-5 will print all pages 1 through 5; 1, 3, 7 will print only pages 1, 3, and 7.) This is useful for printing only the LTCMI, instead of the entire MN/LOC Assessment.
   d. Click the “OK” button.
Help

The Help feature at the far right in the blue navigational bar will display a Help page consisting of links to online guides that will assist with questions you may have about the LTC Online Portal. The Medical Necessity and Level of Care Assessment 3.0 Instructions link provides section-by-section instructions to guide the registered nurses (RNs) in completing the MN/LOC Assessment.

Note: Providers may access an electronic version of the LTC User Guide by clicking the Long Term Care Community Services Waiver Programs Workshop User Guide link within the Help page.

Yellow Form Actions Bar

Options found in the yellow Form Actions bar may include: Print, Print Physician’s Signature, Use as template, Correct this form, Add Note, or Inactivate Form. Options will vary depending on your security level as well as the document status. The yellow Form Actions bar is available when an individual document is being viewed in detail.

Print

The Print feature allows the provider to print completed MN/LOC Assessments. Click the “Print” button to print completed assessments.

Note: To only print specific sections of the assessment, click the “Pages” radio button and enter the page range for the desired pages only. When printing the MN/LOC 3.0 Assessment, the individual’s name will appear on the top left corner of each page. The name will be auto populated based on the information entered in field A0500.
Print Physician’s Signature

The Print Physician’s Signature feature allows a provider to generate and print a Physician’s Signature page at any time. Initial Assessments require a physician’s signature on the certification statement. The certification statement is found on the Physician's Signature page. A physician’s signature is optional on Annual Assessments and Significant Change in Status Assessments.

To print the Physician’s Signature page (required for an Initial Assessment):

1. Complete all designated fields of the assessment on the LTC Online Portal.
2. Before submitting the assessment, click the “Print Physician’s Signature” button located in the yellow Form Actions bar. The diagnoses listed on the printed Physician's Signature page are pulled from the information entered in Section I and the Primary Diagnosis listed in field S3a of the LTCMI section.
3. Click the “Save as Draft” button to save the assessment until the physician’s signature is obtained.
4. Once the physician’s signature is obtained, retrieve the assessment from Drafts.
5. Check the box labeled “Physician’s Signature on File” found in the LTCMI section under S7e to indicate that the physician’s signature is on file.
6. Click the “Submit Form” button to submit the Assessment.

Physician’s Signature page for Annual Assessments and Significant Change in Status Assessments (optional):

1. Once the physician’s signature is obtained on the Initial Assessment, the Physician’s Signature box can be checked on the Annual Assessments and Significant Change in Status Assessments.
2. Click the “Submit Form” button to submit the assessment.

Use as template

The Use as template feature allows a provider to complete a new assessment by using the information in a previously submitted assessment as a template. Various fields will auto populate; be sure to check for accuracy. Be careful not to confuse this feature with a similarly-named feature in TexMedConnect.

Once you have found and are displaying the assessment using FSI or Current Activity:

1. Click the “Use as template” button; the data in this assessment will be used to create a new assessment.
Note: Modify assessment data to reflect the current status of the individual. Also, adjust the Reason for Assessment if necessary (e.g., if you chose to use an Initial Assessment as a template for the Annual Assessment, don’t forget to change the Reason for Assessment from Initial to Annual).

2. Enter data into remaining fields that are not auto populated.

Note: Fields not auto populated in the 3.0 Assessment are: Assessment Date (A2300), Date Assessment was Completed (Z0500B), and Medication Certification Checkbox (S9).

3. Click the “Print” button located in the yellow Form Actions bar to print the assessment in progress, if you want a hard copy for your records.

From here you have two choices:

a. Click the “Submit Form” button located at the bottom right of the screen, if you are ready to submit for processing.

or

b. Click the “Save as Draft” button located in the yellow Form Actions bar to save an assessment as a draft until you are ready to submit.
Correct this form

The Correct this form feature allows providers to perform corrections to the MN/LOC Assessment within 14 calendar days of the original submission (i.e., TMHP received date). However, corrections are not allowed if an assessment is set to status “Form Inactivated,” “Invalid/Complete,” “SAS Request Pending,” or “Corrected.”

Note: A parent assessment is the original assessment that is being corrected and will be set to status “Corrected.” The child assessment is the new assessment that will be processed through the LTC Online Portal.

Note: The steps to correct an assessment are covered in the “Corrections” section.

Add Note

The Add Note feature located in the yellow Form Actions bar is always available unless the assessment is locked by another user. It may be used to add additional MN information that was not captured upon original submission. Information is added to the History trail of the assessment, not to the assessment itself (i.e., not added to Comments in the LTCMI section of the assessment).

If the status is set to “Pending Denial (need more information)” and a note is added, the assessment will be set to status “Pending Review.” The additional information entered will then be reviewed by a TMHP nurse.

To add a note to a submitted assessment:

1. Locate the assessment using FSI or Current Activity.
2. Click the “Add Note” button, a text box will open.
3. Enter additional information (up to 500 characters).
4. Click the “Save” button to save your note or the “Cancel” button to erase your note, located under the text box.
Note: If unsure why an assessment is set to status “Pending Denial (need more information),” call the TMHP Help Desk (1-800-626-4117, Option 2) to speak with a nurse. If “Add Note” is chosen for any assessment set to status “Pending Denial (need more information),” the assessment will be reviewed again for MN. If the nurse is unable to approve the assessment with the additional information provided, the assessment will be sent to the TMHP Medical Director for review and determination of MN. Notes added in any status other than “Pending Denial (need more information)” are added to the history of the assessment but are not reviewed by TMHP.

Note: State staff are able to add notes to an MN/LOC Assessment to assist a provider in resolving their assessment-related issue(s) for those assessments set to status “Provider Action Required” or “Submitted to CS.” Providers should look for these notes in the History trail of the MN/LOC Assessment.

Inactivate Form

The Inactivate Form feature allows providers to inactivate an MN/LOC Assessment. Once inactivated, the assessment will not be available for further processing. Inactivations are not allowed if an assessment is set to status “Corrected,” “Form Inactivated,” or “SAS Request Pending.” Inactivated assessments may be used as templates via the “Use as template” feature.

Save as Draft

The Save as Draft feature allows users to save unfinished assessments on the LTC Online Portal. Once saved, these drafts will be accessible by all users under the vendor/contract number to which the draft is linked. The user may access the draft by clicking the Drafts link located on the blue navigational bar.

Note: The “Save as Draft” button will only display in the yellow Form Actions bar until the assessment being entered has been successfully submitted on the portal.
Other Basic Information

Required Fields

Within the LTC Online Portal, red dots indicate required fields. Fields without the red dot are optional.

History

An assessment's history can be found by scrolling down on an open assessment. This History trail shows the different statuses the assessment has held. The most recent status will appear at the bottom.

<table>
<thead>
<tr>
<th>History</th>
<th>Date/Time</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form</td>
<td>5/10/2010 2:33:41 PM</td>
<td>Form Submitted</td>
</tr>
<tr>
<td>Approved</td>
<td>5/10/2010 2:33:42 PM</td>
<td>TMHP: The Form has passed Auto Mn Approval</td>
</tr>
<tr>
<td>Medicaid ID</td>
<td>5/10/2010 2:33:43 PM</td>
<td>Pending</td>
</tr>
<tr>
<td>SAS Request</td>
<td>5/10/2010 2:33:44 PM</td>
<td>SAS Request submitted</td>
</tr>
<tr>
<td>ID Confirmed</td>
<td>5/18/2010 2:02:14 PM</td>
<td>TMHP: Medicaid ID confirmed for this client</td>
</tr>
<tr>
<td>Rejected by</td>
<td>5/18/2010 2:02:37 PM</td>
<td>Rejected by</td>
</tr>
<tr>
<td>SAS</td>
<td>5/18/2010 2:02:38 PM</td>
<td>SAS</td>
</tr>
<tr>
<td>Submitted to</td>
<td>5/18/2010 2:02:39 PM</td>
<td>Submitted to manual workflow</td>
</tr>
<tr>
<td>Processed/Complete</td>
<td>5/18/2010 2:02:41 PM</td>
<td>Processed/Complete</td>
</tr>
<tr>
<td>Escalated</td>
<td>5/18/2010 2:13:13 PM</td>
<td>Escalated</td>
</tr>
<tr>
<td>Rejected</td>
<td>5/18/2010 2:13:14 PM</td>
<td>Rejected to manual workflow</td>
</tr>
<tr>
<td>Processed/Complete</td>
<td>5/18/2010 4:35:07 PM</td>
<td>Processed/Complete</td>
</tr>
</tbody>
</table>
UnLock Form

Upon opening, the assessment becomes automatically locked by the viewer and will remain locked for 20 minutes of no activity or until the viewer clicks the “UnLock Form” button. The UnLock Form button will unlock the assessment so that a different user can make changes. If an assessment is locked, others will not be able to make changes or add additional information. You may be asked to unlock an assessment if you are seeking assistance from TMHP or DADS.

To unlock an assessment, click the “UnLock Form” button located at the top right corner of the screen.

Error Messages

If required information is missing or information is invalid, an error message(s) will display, and you will not be able to continue to the next step until the error is resolved. You may need to scroll to the top of the screen to find the error message(s) since the error message(s) will be displayed at the top. If you click an error message hyperlink, you will automatically go to the field containing the error.
Entering Dates

To enter dates, you have the option to click on the calendar icon next to any of the date fields to activate the dynamic calendar. Choose the date desired. Or, you may manually enter the date using the mm/dd/yyyy format.

Timeout

The LTC Online Portal will timeout after 20 minutes of no activity. To prevent this timeout from occurring, complete and submit the assessment within 20 minutes or click on a different tab (e.g., Section A) to reset the timer, then return to the previous tab.

RUG Value

Resource Utilization Group (RUG) is used to classify relative direct care resource requirements for nursing facility (NF) residents and to establish the cost limit for community services consumers in the Community Based Alternatives (CBA), MDCP Waivers, STAR+PLUS, and Program of All-Inclusive Care for the Elderly (PACE). Once an individual assessment is open, the RUG value can be found next to the DLN, as seen in the screen shot below.
Medical Necessity and Level of Care 3.0 Assessment

MN/LOC Assessments are submitted to determine MN for individuals in the community and for Medicaid reimbursement.

There are three reasons to submit an MN/LOC 3.0 Assessment:

- A0310A = 01. Initial Assessment
- A0310A = 03. Annual Assessment
- A0310A = 04. Significant Change in Status Assessment (SCSA), submitted when authorized by the DADS case manager due to changes in the medical condition of the individual.

**Significant Change in Status Assessment Submission Guidelines**

The LTC Online Portal will accept SCSA submissions only when there is a record of previously approved MN found within the past 365 calendar days for the individual.

If there is no approved MN within the past 365 calendar days, the SCSA will not be accepted onto the LTC Online Portal and the following error message will display:

- The SCSA cannot be accepted. No previous MN on file for client within past 365 days. Please submit Initial or Annual Assessment.

The LTC Online Portal will not accept SCSA submissions if the latest approved MN Assessment found for an individual is within the 365 calendar day limit and is set to one of the following pending statuses:

- Pending Nurse Review
- Pending Denial
- Denial Inventory
- Pending Doctor Review

In the above circumstance the following error message will display:

- The SCSA cannot be accepted. The final decision has not been made on your previously submitted Initial or Annual assessment for this client. You may save this SCSA as a draft for submission at a later date.

**Note:** Health Maintenance Organizations (HMOs) complete the SCSA but do not submit on the LTC Online Portal. Print and keep in the individual’s records.

All assessments must be submitted through the LTC Online Portal.

**Note:** The DADS Regional Nurse acts as a provider when submitting the MN/LOC Assessment.
How to Submit a Medical Necessity and Level of Care Assessment

1. Log in to the LTC Online Portal.
2. Click the **Submit Form** link located in the blue navigational bar.
3. Type of Form: Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

4. To auto populate an individual’s information in the MN/LOC Assessment, enter one of the following combinations of information:
   - Medicaid/Children with Special Health Care Needs (CSHCN) ID
   - Social Security number (SSN) and Last Name
   - SSN and Date of Birth
   - Date of Birth and Last Name and First Name

   **Note:** All demographic information (except gender) is auto populated when one of the aforementioned data items is entered. Refer to the demographic information located in Section A and section LTCMI of the MN/LOC Assessment.

5. Click the “Enter Form” button.
6. Click the tabs (“Section A,” “Section B,” etc.) and enter the assessment information.

   For Initial Assessments only, the following is required:
   a. Click the “Print Physician’s Signature” button and print the signature page and obtain the MD/DO signature.
   b. Click the “Save as Draft” button to save the MN/LOC Assessment to be recalled later.
c. Once the physician’s signature has been obtained, click the **Drafts** link in the blue navigational bar.

d. Click the **Open** link.

![Drafts](image)

<table>
<thead>
<tr>
<th>Date Created</th>
<th>Form Type</th>
<th>Description</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/8/2010 5:29:35 PM</td>
<td>Waiver 3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/8/2010 4:13:04 PM</td>
<td>Waiver 3.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

e. Click the “Section LTCMI” tab. Check the box indicating the physician’s signature is on file.

![Section LTCMI](image)

7. Click the “Submit Form” button.

a. If the assessment is submitted successfully, a DLN will be assigned and the following message will be displayed:

![Submit Form](image)

b. If an assessment is not successfully submitted, an error message will appear at the top of the screen. The provider must resolve the error(s) to ensure the assessment will be submitted successfully. The error message will prompt the provider as to how to resolve the error or save to draft for research and correction at a later date. If the provider is unable to resolve the error, they may contact TMHP for assistance.

![Error Message](image)
MN/LOC 3.0 Assessment Sections

- Section A: Identification Information
- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section D: Mood
- Section E: Behavior
- Section G: Functional Status
- Section H: Bladder and Bowel
- Section I: Active Diagnoses
- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section L: Oral/Dental Status
- Section M: Skin Conditions
- Section N: Medications
- Section O: Special Treatments, Procedures, and Programs
- Section P: Restraints
- Section Q: Participation in Assessment and Goal Setting
- Section Z: Assessment Administration
- Section LTCMI: LTC Medicaid Information

Detailed explanations of the MN/LOC Assessment sections can be found at the following locations:

- Go to [www.tmhp.com/Pages/LTC/LTC_Forms.aspx](http://www.tmhp.com/Pages/LTC/LTC_Forms.aspx) and click the Medical Necessity and Level of Care 3.0 Instructions link found under the Community Waivers Programs heading.
- Click the Help link in the blue navigational bar and click the Medical Necessity and Level of Care 3.0 Instructions link.

Blank MN/LOC Assessments can be found at the following locations:

- Go to [www.tmhp.com/Pages/LTC/LTC_Forms.aspx](http://www.tmhp.com/Pages/LTC/LTC_Forms.aspx) and click the Medical Necessity and Level of Care 3.0 Assessment link found under the Community Waivers Programs heading.
- Click the Printable Forms link in the blue navigational bar and click the Waiver 3.0 MN and LOC link.
## Long Term Care Medicaid Information (LTCMI)

### LTC Community Services Waiver Programs User Guide

#### LTC Medicaid Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1a.</td>
<td>Medicaid Client Indicator</td>
</tr>
<tr>
<td>S1b.</td>
<td>Individual Address</td>
</tr>
<tr>
<td>S1c.</td>
<td>City</td>
</tr>
<tr>
<td>S1d.</td>
<td>State</td>
</tr>
<tr>
<td>S1e.</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>S1f.</td>
<td>Phone</td>
</tr>
</tbody>
</table>

#### S2. Claims Processing Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2a.</td>
<td>DADS Vendor/Site ID Number</td>
</tr>
<tr>
<td>S2b.</td>
<td>Contract/Provider Number</td>
</tr>
<tr>
<td>S2c.</td>
<td>Service Group</td>
</tr>
<tr>
<td>S2d.</td>
<td>NPI Number</td>
</tr>
<tr>
<td>S2e.</td>
<td>Region</td>
</tr>
<tr>
<td>S2f.</td>
<td>Purpose Code</td>
</tr>
<tr>
<td>S2g.</td>
<td>HHA License #</td>
</tr>
<tr>
<td>S2h.</td>
<td>HHA License # Expiration Date</td>
</tr>
</tbody>
</table>

#### S3. Primary Diagnosis

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S3a.</td>
<td>Primary Diagnosis ICD Code</td>
</tr>
<tr>
<td>S3b.</td>
<td>Primary Diagnosis ICD Description</td>
</tr>
</tbody>
</table>

#### S5. Licenses

Certification: To the best of my knowledge, I certify to the accuracy and completeness of this information.

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5a.</td>
<td>HHA RN Last Name</td>
</tr>
<tr>
<td>S5b.</td>
<td>HHA RN License #</td>
</tr>
<tr>
<td>S5c.</td>
<td>HHA RN License State</td>
</tr>
<tr>
<td>S5d.</td>
<td>DADS RN Last Name</td>
</tr>
<tr>
<td>S5e.</td>
<td>DADS RN License #</td>
</tr>
<tr>
<td>S5f.</td>
<td>DADS RN License State</td>
</tr>
<tr>
<td>S5g.</td>
<td>DADS RN Signature Date</td>
</tr>
<tr>
<td>S5h.</td>
<td>PACE RN Last Name</td>
</tr>
<tr>
<td>S5i.</td>
<td>PACE RN License #</td>
</tr>
<tr>
<td>S5j.</td>
<td>PACE RN License State</td>
</tr>
<tr>
<td>S5k.</td>
<td>HMO RN Last Name</td>
</tr>
<tr>
<td>S5l.</td>
<td>HMO RN License #</td>
</tr>
<tr>
<td>S5m.</td>
<td>HMO RN License State</td>
</tr>
</tbody>
</table>

#### S6. Additional MN Information

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S6a.</td>
<td>Tracheostomy Care</td>
</tr>
<tr>
<td>S6b.</td>
<td>Ventilator/Respirator</td>
</tr>
<tr>
<td>S6c.</td>
<td>Number of hospitalizations in the last 90 days</td>
</tr>
<tr>
<td>S6d.</td>
<td>Number of emergency room visits in the last 90 days</td>
</tr>
<tr>
<td>S6e.</td>
<td>Oxygen Therapy</td>
</tr>
<tr>
<td>S6f.</td>
<td>Special Ports/Central Lines/PICC</td>
</tr>
<tr>
<td>S6g.</td>
<td>At what developmental level is the individual functioning?</td>
</tr>
<tr>
<td>S6h.</td>
<td>Enter the number of times this individual has fallen in the last 90 days</td>
</tr>
<tr>
<td>S6i.</td>
<td>In how many of the falls listed above was the person physically restrained prior to the fall?</td>
</tr>
<tr>
<td>S6j.</td>
<td>In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)</td>
</tr>
</tbody>
</table>

| S6j.1   | Environmental (debris, slick or wet floors, lighting, etc.) |
| S6j.2   | Medication(s) |
| S6j.3   | Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.) |
| S6j.4   | Poor Balance/Weakness |
| S6j.5   | Confusion/Disorientation |
| S6j.6   | Assault by Individual or Caregiver |
• **S1. Medicaid Information.**
  
  – S1a. Medicaid Client Indicator.
   
   Auto Populated.
   
   › This field will be auto populated.
   
  – S1b. Individual Address.
   
   Required.
   
   › Enter the street address where the individual is presently living.
   
   › Individual's Address is used for mailing MN letters.
   
  – S1c. City.
   
   Required.
   
   › Enter the city where the individual is presently living.
   
   › Individual's Address is used for mailing MN letters.
– S1d. State.
  Required.
  › Choose the state where the individual is presently living from the drop-down box.
  › Individual’s Address is used for mailing MN letters.
– S1e. ZIP Code.
  Required.
  › Enter the ZIP Code where the individual is presently living.
  › Individual’s Address is used for mailing MN letters.
– S1f. Phone.
  Optional.
  › Enter the contact telephone number for the individual, if known.

• S2. Claims Processing Information.
  – S2a. DADS Vendor/Site ID Number.
    Auto Populated.
    › This field will be auto populated based on the user’s logon security credentials.
  – S2b. Contract/Provider Number.
    Auto Populated.
    › This field will be auto populated.
  – S2c. Service Group.
    Required.
    › Choose from the drop-down box:
      –  3. CBA
      –  11. PACE
      –  18. MDCP
      –  19. STAR+PLUS
  – S2d. NPI Number.
    Required.
    › This field will be auto populated.
    This is where API would be entered if using an API number. API is “D,” two zeros, then contract number (MDCP nurses use an API).
  – S2e. Region.
    Required.
    › Choose from the drop-down box:
      –  01 (Lubbock)
      –  02 (Abilene)
      –  03 (Arlington)
      –  04 (Tyler)
  › Purpose Code is auto populated when a Utilization Review or a Lookback assessment is submitted by a DADS RN. For Initial, Annual, and SCSA Assessments, this field is not available for data entry.
  › Purpose Code 1 is used for Utilization Review (UR) only.
  › Purpose Code L is used for a Lookback Review only.
  › S2f indicates DADS has submitted a UR or Lookback assessment on a previously submitted provider assessment for Service Groups (SG) 3 CBA, and SG 18 MDCP.

Note: DADS RNs perform UR and Lookback Reviews. A UR or Lookback Review will override the previously submitted assessment.

– S2g. Home Health Agency (HHA) License #.
  Required.
If you work for a Home Health Agency:
  › Enter the Home Health Agency License number.
  › HHA License # must be up to seven numeric digits.
If you do not work for a Home Health Agency:
  › Enter all zeros.

– S2h. HHA License # Expiration Date.
  Required.
  › Enter the license expiration date of the Home Health Agency License number.
  › HHA License # Expiration Date must be in mm/dd/yyyy format.

• S3. Primary Diagnosis.
    Required.
    › Enter a valid ICD code for the individual’s primary diagnosis. Use your best clinical judgment.
  – S3b. Primary Diagnosis ICD description.
    Optional.
    › Click the magnifying glass and the description will be auto populated based on the primary diagnosis ICD code.
• **S4. For DADS use only.**
  – When a successfully submitted LTCMI is printed, field S4b will show the calculated RUG value.
    
    **Note:** The RUG value also appears at the top of each page on all successfully submitted MN/LOC Assessments.

• **S5. Licenses.**
  
  Certification: To the best of my knowledge, I certify to the accuracy and completeness of this information.
  – **S5a. HHA RN Last Name.**
    
    Conditional.
    › This is a required field for Service Group (SG) 3 CBA.
    › Enter the last name of the RN completing the assessment.
  – **S5b. HHA RN License #.**
    
    Conditional.
    › This is a required field for Service Group (SG) 3 CBA.
    › Enter the license number of the RN.
    › Licenses issued in Texas will be validated against the Texas BON (Board of Nursing). Compact licenses will be validated with the issuing state’s nursing board.
    › This number is validated to ensure RUG training requirements have been met.
  – **S5c. HHA RN License State.**
    
    Conditional.
    › This is a required field for Service Group (SG) 3 CBA.
    › Choose the state in which the RN is licensed from the drop-down box.
  – **S5d. DADS RN Last Name.**
    
    Conditional.
    › This is a required field for SG 18 MDCP; Purpose code = 1 (UR), or Purpose code = L (Lookback).
    › Enter the last name of the RN completing the assessment.
  – **S5e. DADS RN License #**
    
    Conditional.
    › This is a required field for SG 18 MDCP; Purpose code = 1 (UR), or Purpose code = L (Lookback).
    › Enter the license number of the RN.
    › Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state’s nursing board.
    › This number is validated to ensure RUG training requirements have been met.
  – **S5f. DADS RN License State.**
    
    Conditional.
    › This is a required field for SG 18 MDCP; Purpose code = 1 (UR), or Purpose code = L (Lookback).
    › Enter the state in which the RN is licensed.
– S5g. DADS RN Signature Date.
  Conditional.
  › This is a required field for SG 18 MDCP, Purpose code = 1 (UR), or Purpose code = L (Lookback).
  › Enter the date the DADS RN signed the assessment as being complete.

– S5h. PACE RN Last Name.
  Conditional.
  › This is a required field for SG 11 PACE.
  › Enter the last name of the RN completing the assessment.

– S5i. PACE RN License #.
  Conditional.
  › This is a required field for SG 11 PACE.
  › Enter the license number of the RN.
  › Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state’s nursing board.
  › This number is validated to ensure RUG training requirements have been met.

– S5j. PACE RN License State.
  Conditional.
  › This is a required field for SG 11 PACE.
  › Choose the state in which the RN is licensed from the drop-down box.

– S5k. HMO RN Last Name
  Conditional.
  › This is a required field for SG 19 STAR+PLUS.
  › Enter the last name of the RN completing the assessment.

– S5l. HMO RN License #.
  Conditional.
  › This is a required field for SG 19 STAR+PLUS.
  › Enter the license number of the RN.
  › Licenses issued in Texas will be validated against the Texas BON. Compact licenses will be validated with the issuing state’s nursing board.
  › This number is validated to ensure RUG training requirements have been met.

– S5m. HMO RN License State.
  Conditional.
  › This is a required field for SG 19 STAR+PLUS.
  › Choose the state in which the RN is licensed from the drop-down box.
• **S6. Additional MN Information.**

  – **S6a. Tracheostomy Care.**

    Conditional.
    › This field is only required and available for data entry if O0100E, Tracheostomy care, is checked and the individual is 21 years of age or younger.
    › Choose from the drop-down box:
      1. Less than once a week
      2. 1 to 6 times a week
      3. Once a day
      4. Twice a day
      5. 3 – 11 times a day
      6. Every 2 hours
      7. Hourly / continuous

  – **S6b. Ventilator/Respirator (Do not include BiPAP or CPAP time).**

    Conditional.
    › This field is only required and available for data entry if O0100F, ventilator or respirator, is checked.
    › Choose from the drop-down box:
      1. Less than once a week
      2. 1 to 6 times a week
      3. Once a day
      4. Twice a day
      5. 3 – 11 times a day
      6. 6 – 23 hours
      7. 24-hour continuous

  – **S6c. Number of hospitalizations in the last 90 days.**

    Required.
    › Record the number of times the individual was admitted to hospital with an overnight stay in the last 90 days (or since last assessment if less than 90 days).
    › Enter 0 (zero) if no hospital admissions.
    › Valid range includes 0 – 90.

  – **S6d. Number of emergency room visits in the last 90 days.**

    Required.
    › Record the number of times the individual visited the emergency room (ER) without an overnight stay in the last 90 days (or since last assessment if less than 90 days).
    › Enter 0 (zero) if no ER visits.
    › Valid range includes 0 – 90.
– S6e. Oxygen Therapy
   Conditional.
   This field is only required and available for data entry if O0100C, Oxygen therapy, is checked.
   › Choose from the drop-down box:
     1. Less than once a week
     2. 1 to 6 times a week
     3. Once a day
     4. Twice a day
     5. 3 – 11 times a day
     6. 6 – 23 hours
     7. 24-hour continuous

– S6f. Special Ports/Central Lines/PICC.
   Optional.
   › Use this field to indicate if the individual has any type of implantable access system or central venous catheter (CVC). This includes epidural, intrathecal, or venous access or Peripherally Inserted Central Catheter (PICC) devices. This does not include hemodialysis or peritoneal dialysis access devices.
   › Choose from the drop-down box:
     0. N = none present
     1. Y = 1 or more implantable access system or CVC
     2. U = unknown

– S6g. At what developmental level is the individual functioning?
   Conditional.
   › This is a required field for all assessments for individuals who are 20 years of age and younger based on birth date minus date of submission (TMHP Received date). Not available for data entry if the individual is 21 years of age or older.
   › Choose from the drop-down box:
     – Unknown or unable to assess
     1. < 1 Infant
     2. 1 – 2 Toddler
     3. 3 – 5 Pre-School
     4. 6 – 10 School age
     5. 11 – 15 Young Adolescence
     6. 16 – 20 Older Adolescence

– S6h. Enter the number of times this individual has fallen in the last 90 days.
   Required.
   › Record number of times the individual has fallen in the last 90 days. Enter 0 (zero) if no falls.
   › Each fall should be counted separately. So, if the individual has fallen multiple times in one day, count each fall individually.
   › Valid range includes 0 – 999.
– S6i. In how many of the falls listed in S6h above was the individual physically restrained prior to the fall?  
   Conditional.  
   › This is a required field only if S6h indicates the individual has fallen.  
   › Valid range includes 0 with a maximum being the number entered in S6h.  
   › Enter 0 if no falls when the individual was physically restrained prior to the fall.

– S6j. In the falls listed in S6h above, how many had the following contributory factors?  
   Required  
   › More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.  
   – S6j1 - Environmental (debris, slick or wet floors, lighting, etc.).  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.  
   – S6j2 - Medication(s).  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.  
   – S6j3 - Major Change in Medical Condition (Myocardial Infarction [MI/Heart Attack], Cerebrovascular Accident [CVA/Stroke], Syncope [Fainting], etc.).  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.  
   – S6j4 - Poor Balance/Weakness.  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.  
   – S6j5 - Confusion/Disorientation.  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.  
   – S6j6 - Assault by Individual or Caregiver.  
      Conditional.  
      › This field is required only if S6h indicates the individual has fallen.  
      › Valid range includes 0 with a maximum being the number entered in S6h.

S7a. Did an MD/DO certify that this individual requires nursing facility services or alternative community-based services under the supervision of an MD/DO?

Required.

› In order to meet the requirements for these community programs, the individual must require nursing facility services or alternative community-based services under the supervision of an MD or DO. Submission of the assessment will not be allowed on the LTC Online Portal if No is selected.

› This is a required field for the Initial Assessment. This field is optional for Annual and SCSA Assessments.

› Choose from the drop-down box:
  1. No
  2. Yes

S7b. Did a military physician providing health care according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual?

Required.

› If the licensed physician providing health care to this individual is practicing in a health-care facility of the Department of Defense (DOD), a civilian facility affiliated with the DOD, or any other location authorized by the Secretary of Defense, and is not licensed by the State of Texas, answer Yes to this item.

› Choose from the drop-down box:
  1. No
  2. Yes

S7c. MD/DO Last Name.

Required.

› Enter the last name of the MD/DO.

S7d. MD/DO License #.

Required.

› Enter the license number of the MD/DO.

› This number is validated against the appropriate State Medical Board file.

› Physicians are not required to complete the RUG training.

Note: The physician’s licensing information is a vital piece of information. Therefore, the physician’s license number is required on all MN/LOC submissions, regardless of the Reason for Assessment (A0310A).

S7e. MD/DO License State.

Required.

› Choose the state in which the MD/DO is licensed from the drop-down box.

Indicate Physician Signature on file by checking box.

The box under the License State is required to be checked for Initial Assessments, it is optional for Annual and SCSA Assessments.

Fields S7f through S7j is required information if the MD/DO is not licensed in Texas.

Enter the address and telephone number of the facility in which the physician providing the evaluation and recommendation practices in S7g-S7k. This information will be used to mail MN determination letters.
– S7f. MD/DO First Name.
  Conditional.
  › This field is required if the MD/DO is not licensed in Texas.
  › Enter the first name of the individual’s MD/DO.
  › This information is used to mail MN determination letters.

– S7g. MD/DO Address.
  Conditional.
  › This field is required if the MD/DO is not licensed in Texas.
  › Enter the street address of the individual’s MD/DO.
  › This information is used to mail MN determination letters.

– S7h. MD/DO City.
  Conditional.
  › This field is required if the MD/DO is not licensed in Texas.
  › Enter the city of the individual’s MD/DO mailing address.
  › This information is used to mail MN determination letters.
  › If a city has a hyphen in the city name, replace the hyphen with a space.
  › If a city has an apostrophe in the city name, enter the city name without the apostrophe.

– S7i. MD/DO State.
  Conditional.
  › This field is required if the MD/DO is not licensed in Texas.
  › Choose the state of the individual’s MD/DO mailing address from the drop-down box.
  › This information is used to mail MN determination letters.

– S7j. MD/DO ZIP Code.
  Conditional.
  › This field is required if the MD/DO is not licensed in Texas.
  › Enter the ZIP Code of the individual’s MD/DO mailing address.
  › This information is used to mail MN determination letters.

– S7k. MD/DO Phone.
  Optional.
  › This field is optional if the MD/DO is not licensed in Texas.
  › Enter the telephone number of the individual’s MD/DO.
  › This information is used to contact MD/DO if necessary.
S9. Medications

30-Day Look-back

- Medication Certification. I certify this individual is taking no medications or the medications listed below are correct.
  
  Required.
  
  Check the Medication Certification box to verify that the individual has no medications or that the individual has medications and that they are listed correctly in the medication table to include name, dose, route of administration (RA), frequency (Freq), and as necessary – number of doses (PRN-n).

When a medication is added, the information that is required to be entered is:

- Medication Name and Dose Ordered
- Route of Administration
- Frequency
- PRN - Number of doses (required if the frequency chosen is PRN)

<table>
<thead>
<tr>
<th>Medication Name and Dose Ordered</th>
<th>Route of Administration</th>
<th>Frequency</th>
<th>PRN-n of doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depakote 125mg</td>
<td>1: by mouth (PO)</td>
<td>30: (TID) three times daily</td>
<td>Delete</td>
</tr>
<tr>
<td>Artane 2mg</td>
<td>1: by mouth (PO)</td>
<td>30: (TID) three times daily</td>
<td>Delete</td>
</tr>
<tr>
<td>VITAMINE E 200IU</td>
<td>1: by mouth (PO)</td>
<td>10: (QD or HS) once daily</td>
<td>Delete</td>
</tr>
<tr>
<td>Euroed 1 Vial</td>
<td>1: oral inhalation (PO)</td>
<td>10: (QD or HS) once daily</td>
<td>Delete</td>
</tr>
</tbody>
</table>

S10. Comments.

Optional.

The comments field allows up to 500 characters to be entered. It is essential to include signs and symptoms that present an accurate picture of the individual's condition. The “Comments” section can be used for additional qualifying data that indicates the need for skilled nursing care, such as:

- Pertinent medical history.
- Ability to understand medications.
- Ability to understand changes in condition.
- Abnormal vital signs.
- Previous attempts at outpatient management of medical condition.
- Results of abnormal lab work.
• **S11. Advanced Care Planning.**

What is Advance Care Planning?

Advance care planning means planning ahead for how the individual wants to be treated if ill or near death. Sometimes when people are in an accident or have an illness that will cause them to die they are not able to talk or to let others know how they feel.

Advance care planning is a five-step process that should be discussed with the individual.

1. Thinking about what you would want to happen if you could not talk or communicate with anyone.
2. Finding out about what kind of choices you will need to make if you become very ill at home, in a nursing home, or in a hospital.
3. Talking with your family and doctor about how you want to be treated.
4. Filling out papers that spell out what you want if you are in an accident or become sick.
5. Telling people what you have decided.

  › Legally Authorized Representative is a person authorized by law to act on behalf of a person, and may include a parent, guardian, or managing conservator of a minor, or the guardian of an adult.
  › Choose from the drop-down box:
    0. No
    1. Yes

  › Directive to Physician is a document that communicates an individual’s wishes about medical treatment at some time in the future when he or she is unable to make their wishes known because of illness or injury.
  › Choose from the drop-down box:
    0. No
    1. Yes

  › Choose from the drop-down box:
    0. No
    1. Yes
– S11d. Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order?
  Required.
  › What is an Out-of-Hospital Do Not Resuscitate Order (OOHDNR)?
  › This form is for use when an individual is not in the hospital. It lets the person tell health-care workers, including Emergency Medical Services (EMS) workers, not to do some things if the person stops breathing or their heart stops. If an individual does not have one of these forms filled out, EMS workers will always give the person Cardiopulmonary Resuscitation (CPR) or advanced life support, even if the advance care planning forms say not to. A person should complete this form as well as the Directive to Physicians and Family or Surrogates and the Medical Power of Attorney form if they do not want CPR.
  › Choose from the drop-down box:
    0. No
    1. Yes

• S12. Legally Authorized Representative (LAR) Address.
  Note: In the future, this information may be used to send MN determination letters to the LAR when indicated on the assessment.

  – S12a. LAR First Name.
    Conditional.
    › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
    › Enter the first name of the Legally Authorized Representative.

  – S12b. LAR Last Name.
    Conditional.
    › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
    › Enter the last name of the Legally Authorized Representative.

  – S12c. Address.
    Conditional.
    › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
    › Enter the street address of the Legally Authorized Representative.

  – S12d. City.
    Conditional.
    › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
    › Enter the city of the Legally Authorized Representative.
    › If a city has a hyphen in the city name, replace the hyphen with a space.
    › If a city has an apostrophe in the city name, enter the city name without the apostrophe.
– S12e. State.
  Conditional.
  › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
  › Enter the state of the Legally Authorized Representative.
– S12f. ZIP Code.
  Conditional.
  › This is a required field if S11a is indicated as 1. Yes, Does the individual report having a legally authorized representative?
  › Enter the ZIP Code of the Legally Authorized Representative.
– S12g. Phone.
  Optional.
  › Enter the contact telephone number for the Legally Authorized Representative, if known.
Medical Necessity and the MN Determination Process

Definition of Medical Necessity

40 TAC §19.101 (73) states:

Medical Necessity is the determination that a recipient requires the services of licensed nurses in an institutional setting to carry out the physician’s planned regimen for total care. A recipient’s need for custodial care in a 24-hour institutional setting does not constitute a medical need. A group of health-care professionals employed or contracted by the Medicaid claims administrator contracted with HHSC makes individual determinations of Medical Necessity regarding nursing facility care. These health-care professionals consist of physicians and registered nurses.

General Qualifications for Medical Necessity Determinations

40 TAC §19.2401 states:

Medical Necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. This section contains the general qualifications for a Medical Necessity determination. To verify that Medical Necessity exists, an individual must meet the conditions described in paragraphs (1) and (2) of this section.

(1) The individual must demonstrate a medical condition that:
   (A) is of sufficient seriousness that the individual’s needs exceed the routine care which may be given by an untrained person; and
   (B) requires licensed nurses’ supervision, assessment, planning, and intervention that are available only in an institution.

(2) The individual must require medical or nursing services that:
   (A) are ordered by the physician;
   (B) are dependent upon the individual’s documented medical conditions;
   (C) require the skills of a registered nurse or licensed vocational nurse;
   (D) are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
   (E) are required on a regular basis.

Note: MN is not the only prerequisite to qualify for LTC Medicaid Community Services Waiver programs.
Medical Necessity Determination Process

This flowchart provides a high-level overview of the process used for determination of MN.

1. The assessments are reviewed by the TMHP nurse within three business days to determine MN.

   TMHP systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the provider will see “The Form has failed Auto MN Approval” displayed in the History trail of the assessment. The assessment will then be sent to a nurse for manual MN review. The assessment will be set to status “Pending Review” on the FSI search results. However, the last message showing in the History trail will be “The Form has failed Auto MN Approval.”

2. Once reviewed, the assessment is either approved (meeting MN) or set to status “Pending Denial (need more information)” for up to 21 calendar days. FSI or Current Activity will allow the provider to view the status of an assessment during the MN determination process.

3. The provider may supply additional information clarifying nursing/medical needs through the “Add Note” feature on the LTC Online Portal or by calling TMHP and speaking with a TMHP nurse.

4. If the TMHP nurse determines that MN has been met, the assessment is approved.

5. If the TMHP nurse still cannot determine any licensed nursing need, the individual’s assessment is sent to the TMHP physician for an MN determination.

6. If the TMHP physician determines that MN has been met, the assessment is approved.
7. If the MN is denied by the TMHP physician, notification of denied MN is sent to the individual and the physician of record, as specified in the LTCMI, via mail. The provider will have access to the status of the assessment via FSI or Current Activity on the LTC Online Portal.

8. The attending physician may respond within 14 business days of the date of the denial letter by faxing or calling TMHP with additional medical information (40 TAC §19.2407). Or, a licensed nurse familiar with the individual may provide additional information by calling and speaking with a TMHP nurse.

9. If the TMHP physician or nurse determines that MN has been met, the assessment is approved.

10. If the TMHP physician determines that MN has not been met, the denial is upheld.

11. If the provider does not provide additional information clarifying nursing/medical needs within the 21 calendar days of “Pending Denial (need more information)” status, the assessment is sent to the TMHP physician for review, and steps 7 – 11 will apply.

12. The individual may initiate the appeal process when notified by a DADS case manager via the Form 2065-C, that MN has been denied by the TMHP physician. If a hearing is requested, additional information may be submitted at any time by the provider or by the individual’s physician either via a telephone call to the TMHP nurses or via fax.

Note: At any point, providers can check the status of the assessment and the MN determination for the assessment by utilizing the LTC Online Portal features FSI or Current Activity.

Request for Fair Hearing

The individual may initiate the appeal process when the initial denial letter is sent by TMHP or when notified by a DADS case manager. Although the individual may initiate the appeal process upon receipt of the denial letter from TMHP, it is recommended that the individual and Home and Community Support Services Agencies (HCSSA), first coordinate the submission of additional information, if available/appropriate. If submittal of additional information does not support an overturn of the TMHP denial, the case manager sends notification of denial of services to the individual. If the individual requests a hearing, additional information may be submitted at any time prior to the hearing by the individual or by the individual’s physician either via fax or a telephone call to the TMHP nurses. The provider and individual will be notified of the hearing date and time by the HHSC Fair Hearing Officer.

Note: The process for waiver managed care members and the HMOs to follow is included in the Uniform Managed Care Contract.
Assessment Statuses

Providers can monitor the status of their MN/LOC Assessment by utilizing FSI or Current Activity on the LTC Online Portal. The status is shown within the FSI or Current Activity results or once a specific assessment is selected, the status can be located at the top of the page or at the bottom of the assessment in the History trail. The following are statuses that a provider may see, and their definition:

- **Appealed:** The assessment was previously denied and the individual or their representative has requested a fair hearing.
- **Approved:** MN has been determined and approved. Assessments that are MN approved will only stay in this status momentarily. They will automatically move to the next status in the workflow. This status is not searchable using FSI.
- **Corrected:** This assessment has been corrected by the submitting provider. There will be a new DLN located in the History trail indicating the replacement DLN for the corrected assessment. No further actions are allowed on assessments with a status of corrected.
- **Denied:** The assessment has been reviewed by the TMHP doctor who has determined that the information did not support MN.
- **Escalated Needs Review:** The assessment has been escalated to a DADS case manager for review.
- **Form Inactivated:** This assessment has been inactivated by the submitting provider. No further action will be allowed on this assessment.
- **ID Invalid:** Medicaid ID validation failed. Contact the Medicaid Eligibility Worker to verify the individual’s name, SSN, and Medicaid ID. A new assessment with the correct information will need to be submitted.
- **Invalid/Complete:** Per DADS, this assessment has been deemed invalid. The reason can be found in the History trail. A new assessment must be submitted with the correct information.
- **Med ID Check Inactive:** Medicaid ID validation attempted nightly for six months and failed or the request was canceled. The provider may restart the assessment once the reason for failed validation has been resolved by the Medicaid Eligibility Worker by clicking the “Restart Form” button.
- **Medicaid ID Pending:** Medicaid ID validation is pending. Validation attempts occur nightly until deemed valid, invalid, or until six months has expired, whichever comes first. Contact the Medicaid Eligibility Worker to verify the individual's name, SSN, and Medicaid ID.
- **Out of State MD/DO License Invalid:** TMHP has performed a manual check on the out-of-state license and determined it to be invalid. If the information on the assessment is incorrect, the provider can submit a correction within 14 calendar days of original submission to correct the erroneous information. This status is only applicable for 3.0 Assessments.
- **Out of State MD/DO License Valid:** TMHP has performed a manual check on the out-of-state license and determined it to be valid. The assessment will continue through the workflow. This status is only applicable for 3.0 Assessments.
• **Out-of-State RN License Invalid:** TMHP has performed a manual check on the out-of-state license and determined it to be invalid. This often happens because the provider entered the wrong state. If the information on the assessment is incorrect, the provider can submit a correction within 14 calendar days of submission to fix the erroneous information.

• **Overturned Doctor Review:** Assessment was denied MN, and the provider has supplied additional information for review. The assessment is pending TMHP doctor review for MN determination.

• **Pending Denial (need more information):** This status occurs when the information is reviewed by a TMHP Nurse and does not support MN. The provider has up to 21 calendar days to give additional information for further consideration either by telephone or by using the “Add Note” feature on the LTC Online Portal. The TMHP nurse did not find the assessment to qualify for MN. Provider has 21 calendar days to submit additional information for consideration.

• **Pending MD/DO License Verification:** MD/DO License number is pending manual verification by TMHP for licenses that are issued from states other than Texas. TMHP will validate the MD/DO License number entered in field S7d of the LTCMI, and set assessment status to either “Out of State MD/DO License Valid” or “Out of State MD/DO License Invalid.” If status is set to “Out of State MD/DO License Valid,” the assessment will continue to process through the workflow.

• **Pending More Info:** DADS is waiting for more information from the provider. Information required may be found within the assessment History trail.

• **Pending Review:** Assessment is waiting for TMHP RN to manually review it for MN.

• **Pending RN License Verification:** RN License number is pending manual verification by TMHP from the Texas BON or the licensing state from which the compact license was issued.

• **Processed/Complete:** Assessment has been processed and complete. Please check Medicaid Eligibility and Service Authorization Verification (MESAV).

• **Provider Action Required:** Assessment must be reviewed by the provider due to the assessment being rejected by Service Authorization System (SAS). Refer to the assessment History trail for the specific error message. The error message must be resolved before further processing of assessment will occur.

• **SAS Request Pending:** Assessment has passed all TMHP validations and will be sent from TMHP to DADS for SAS processing. Please allow two to four business days for the next status change.

• **Submitted to manual workflow:** Assessment has been submitted to DADS due to the assessment being rejected by SAS. Refer to the assessment History trail for additional information. DADS will review this assessment within ten business days. While the assessment is being reviewed, no action is required on the part of the provider.
Provider Workflow Process

Provider workflow allows providers to independently manage their assessments when errors in the Medicaid system processing occur. The assessments going into the provider workflow are those situations where the provider is required to take action for resolution of the problem. The benefit to the provider is shorter time in resolution since providers can resolve their own errors.

In summary, assessments are sent to the provider workflow when the assessment is set to status “Provider Action Required.”

Assessments reach this status if:

- The assessment was not successfully processed.
- An error occurred during the nightly batch processing.

The provider workflow is the responsibility of the provider to monitor and manage. System processing errors, including rejection messages, are found within the History trail of the assessment and the assessment is set to status “Provider Action Required.” Once an assessment is set to status “Provider Action Required,” the assessment will require provider action before processing on that particular assessment continues.

If a system error occurs, the error will display in the History trail of the assessment. The assessment is set to status “Provider Action Required.”

Finding Assessments with “Provider Action Required” Status

To find the items in your provider workflow (i.e., those items with system processing errors to be resolved by the provider):

1. Click the Form Status Inquiry link in the blue navigational bar.
2. Choose Type of Form: **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

   **Note:** Waiver 2.0 Medical Necessity and Level of Care Assessment and Waiver 3.0: Medical Necessity and Level of Care Assessment “Type of Form” in the drop-down box could result in a status of “Provider Action Required.” Therefore, each of these “Type of Form” options must be reviewed individually. This example will continue with choosing the Waiver 3.0. Providers will need to review all the other applicable Type of Forms as well.

3. Enter the “From Date” and “To Date” range in the fields allocated.

4. Form Status: Choose **Provider Action Required** from the drop-down box.
5. Click the “Search” button located on the bottom right of the screen to submit the Inquiry.

6. All Waiver 3.0 Medical Necessity and Level of Care Assessments that are set to status “Provider Action Required” will display.

   **Note:** For confidentiality purposes, the assessment details (Medicaid #, etc.) have been hidden in the User Guide.

7. Click the **View Detail** link to open the assessment.
8. Scroll to the bottom of the page to view the History trail.

<table>
<thead>
<tr>
<th>History</th>
<th>Form Submitted</th>
<th>Provider Action Required</th>
</tr>
</thead>
</table>

9. Find “Provider Action Required” status on the far left. It should be the very last line in the History trail.

10. Find the rejection message in the white line just below “Provider Action Required.”

11. Perform the necessary research to resolve the error. See the provider workflow rejection messages later in the “Provider Workflow Rejection Messages” section for more information.

12. Perform the necessary research to resolve the error. See the “Provider Workflow Rejection Messages” section of this User Guide for more information.

   - **Correct this form.** Correct this form allows provider to submit a correction within 14 calendar days of the original submission date. The original assessment with a status of “Provider Action Required” will be set to status “Corrected” and will have a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.

   All fields are correctable except for the following:

<table>
<thead>
<tr>
<th>Waiver 3.0: MN/LOC Assessment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A0500c Individual Name (does not allow changes to last name)</td>
<td>A0600a Social Security Number</td>
</tr>
<tr>
<td>A0600b Medicare (or comparable railroad insurance number)</td>
<td>A0700 Medicaid Number</td>
</tr>
<tr>
<td>A0310a Type of Assessment/Tracking</td>
<td>Z0500b Date Assessment Completed</td>
</tr>
<tr>
<td>S5a-S5m Licenses section</td>
<td>S2a DADS Vendor/Site ID</td>
</tr>
<tr>
<td>S2b Contract/Provider Number</td>
<td>S2c Service Group</td>
</tr>
<tr>
<td>S2d NPI Number</td>
<td></td>
</tr>
</tbody>
</table>
Inactivate Form. Inactivate Form will inactivate the assessment. The status of the assessment will then set to status “Form Inactivated.” An example of when this “Inactivate Form” button would be used is when the provider research indicates the assessment being submitted is a duplicate.

Resubmit Form. Resubmit Form will set assessment to status “SAS Request Pending.” The assessment will process during the nightly system processing. Check the status of the assessment the next day to determine if the assessment processed successfully. The assessment will be set to status “Processed/Complete” if successfully processed. The Resubmit Form button will only be used after a provider has been instructed to do so by DADS.

If the provider clicks the “Correct this form” button, the provider will complete a new assessment. The original assessment that was in the status of “Provider Action Required” will be set to status “Corrected” with a parent relationship DLN to the new/child assessment. The new assessment replaces the original assessment.

If the provider clicks the “Inactivate Form” button, the provider will receive the following confirmation window:

From here you have two choices:

a. Click the “OK” button to Inactivate, and the assessment will set to status “Form Inactivated.”
b. Click the “Cancel” button to cancel the Inactivation request keeping the assessment set to status “Provider Action Required.”

14. If the provider clicks the “Resubmit Form” button, the following screen will appear allowing the provider to add any comments:

There is an option to select “2-System” or “1-ProviderFacing.”

- **2-System:** will allow comments entered by the provider to be seen only by internal state staff. The comments will not be seen by the provider.
- **1-ProviderFacing:** will allow comments entered to be seen by both state staff and the provider.

In either case, the comments will be seen in the History trail of the assessment and are for informational purposes only. These comments will *not* be used in the system processing of the assessments.

The provider may choose to enter comments. Entering comments is optional.

a. Click the “Cancel” button to cancel the request, keeping the assessment set to status “Provider Action Required.”

or

b. Click the “Change Status” button to move the assessment out of the “Provider Action Required.”

15. Once one of the actions have been completed—Correct this form, Inactivate form, or Resubmit Form—the status of the form or assessment will no longer be set to status “Provider Action Required.” Processing will continue based upon action chosen.

16. Repeat all of the steps for finding Wavier 3.0: Medical Necessity and Level of Care Assessments set to status “Provider Action Required” until there are no results found. You may repeat the same steps to locate any 2.0 Assessments set to “Provider Action Required” status.
Provider Workflow Rejection Messages

Below are the rejection messages providers will receive as a result of an error occurring during the nightly batch processing. The messages are in order of message number.

The table contains four columns:

1. **Message Number.** This is the specific error message that will be displayed in the portal.
2. **System Message.** Further clarification of the portal error message including basic example of the situation.
3. **Associated with Reason for Assessment.** What type of assessment can result in the error
4. **Suggested Action.** Most likely the Workflow Action Button to be used.

<table>
<thead>
<tr>
<th>Reject Message Description</th>
<th>Message Number</th>
<th>System Message (Displayed in History)</th>
<th>Associated with Reason for Assessment</th>
<th>Suggested Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS-0001</td>
<td></td>
<td>CS-0001: The request cannot be pro-</td>
<td>Initial</td>
<td>The request cannot be processed because an existing Initial Assessment has already been processed. Please contact the case manager or submit an Annual Assessment, or SCSA as appropriate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because an existing Initial Asse-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ssment has already been processed. Ple-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ase contact the case manager or submit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>an Annual Assessment, or SCSA as appro-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>priate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-0003</td>
<td></td>
<td>CS-0003: The request cannot be pro-</td>
<td>Annual</td>
<td>Inactivate Form and submit Annual Assessment when within the 90 days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because the Annual Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>is being submitted more than 90 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>prior to the Service Plan end date. Pe-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>lease resubmit the assessment at the ap-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>propriate time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-0004</td>
<td></td>
<td>CS-0004: The request cannot be pro-</td>
<td>Annual</td>
<td>The request cannot be processed because the Annual Assessment has been submitted more than 132 days after the end of the last Service Plan. Inactivate Annual Assessment and submit an Initial Assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because the Annual Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>has been submitted more than 132 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>after the end of the last Service Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Please submit an Initial Assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-0005</td>
<td></td>
<td>CS-0005: The request cannot be pro-</td>
<td>Annual</td>
<td>The request cannot be processed because a previous Service Plan cannot be found. Please submit an Initial Assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because a previous Service Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>cannot be found. Please submit an Ini-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>tial Assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-0006</td>
<td></td>
<td>CS-0006: The request cannot be pro-</td>
<td>Significant Change in Status Assess-</td>
<td>The request cannot be processed because an Initial Assessment for the individual cannot be found. Please verify data entry or contact the case manager.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because an Initial Assessment</td>
<td>ment (SCA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>for the individual cannot be found. Pe-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>lease verify data entry or contact the</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>case manager.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CS-0011</td>
<td></td>
<td>CS-0011: The request cannot be pro-</td>
<td>Significant Change in Status Assess-</td>
<td>Inactivate Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cessed because there is not an open Se-</td>
<td>ment (SCA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>rvice Plan for the individual. Please</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>verify data entry or contact the case</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>manager.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reject Message Description</td>
<td>Message Number</td>
<td>System Message (Displayed in History)</td>
<td>Associated with Reason for Assessment</td>
<td>Suggested Action</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>CS-0012</td>
<td>CS-0012</td>
<td>The request cannot be processed because the SCSA assessment is being submitted more than 30 days after the Service Plan end date.</td>
<td>Significant Change in Status Assessment</td>
<td>Inactivate Form.</td>
</tr>
<tr>
<td>CS-0020</td>
<td>CS-0020</td>
<td>The request cannot be processed because the Annual Assessment is being submitted more than 90 days prior to the Level of Service end date.</td>
<td>Annual</td>
<td>Inactivate this assessment by clicking the “Inactivate Form” button and submit an Annual Assessment within 90 days of the Level of Service end date.</td>
</tr>
<tr>
<td>CS-0021</td>
<td>CS-0021</td>
<td>The request cannot be processed because the Annual Assessment has been submitted more than 132 days after the end of the last Level of Service record.</td>
<td>Annual</td>
<td>Inactivate this assessment by clicking the “Inactivate Form” button and submit an Initial Assessment Waiver 3.0: 0310a=01.</td>
</tr>
<tr>
<td>CS-0023</td>
<td>CS-0023</td>
<td>The request cannot be processed because the individual is enrolled in PACE and has Permanent MN. Annual assessments for this individual are not needed. This assessment should be Inactivated.</td>
<td>Annual</td>
<td>Inactivate Form.</td>
</tr>
</tbody>
</table>
| GN-9248                   | GN-9248        | This form cannot be processed due to one or more invalid Diagnosis Codes. Correct the Diagnosis Codes and resubmit. | MN/LOC | The submitted Diagnosis International Classification of Diseases (ICD) Code is not valid.  
• Correct the Diagnosis Codes on the Long Term Care Medicaid Information (LTCMI) section or Section I as needed using the “Correct this form” button. If the Diagnosis Codes are valid: 
• Contact the DADS regional Claims Management System (CMS) Coordinator. Select the appropriate region per website link provided to locate the CMS Coordinator contact information. PACE Excluded. 
www.dads.state.tx.us/contact/regional_facility/index.html  
* If PACE, Contact DADS per website link provided. www.dads.state.tx.us/providers/PACE/contacts.html |
Corrections

If incorrect data is submitted on the MN/LOC Assessment, the provider can submit a correction within 14 calendar days of the original submission by clicking the “Correct this form” button. However, not all fields are correctable (see list of fields unable to be corrected in the “Provider Workflow” section).

Examples of incorrect data include:

- Individual is listed as a male, but is actually a female.
- Individual’s diagnosis indicates diabetes, but the individual actually has hypoglycemia.
- If corrections to the MN/LOC Assessment are needed, providers must access the assessment utilizing FSI or Current Activity.

**When to correct assessment?**

MN/LOC Assessments can only be corrected during the 14 calendar day time period following the original submission date.

**Who may submit the correction?**

It does not have to be the original submitter, but it has to be from the same vendor/contract number. Regardless of the current status of an MN/LOC Assessment, corrections will not be allowed to assessments that have at any time been set to status “Form Inactivated,” “Invalid/Complete,” “SAS Request Pending,” or “Corrected.” The “Correct this form” button will not be displayed in the yellow Form Actions bar on any assessment that cannot be corrected. Corrections are processed overnight, and providers must wait until the following day to see changes.

**How to Submit a Correction**

1. Click the [Form Status Inquiry](#) link in the blue navigational bar.
2. Type of Form: Choose **Waiver 3.0: Medical Necessity and Level of Care Assessment** from the drop-down box.

3. Enter data for all required fields as indicated by the red dots. Narrow results by entering specific criteria in the additional fields: “DLN,” “Last Name,” “First Name,” “SSN,” “Medicaid Number,” “Form Status,” “From Date,” and “To Date.”

4. Click the “Search” button.

5. Click the **View Detail** link of the requested assessment.

6. Click the “Correct this form” button.

7. Complete only the fields needing correction.

8. Click the “Submit Form” button.
9. The original assessment (parent) is set to status “Corrected” and the new assessment (child) DLN is assigned, creating the parent/child DLN relationship. The new child assessment replaces the parent assessment.

![Image of history showing form submitted and corrected dates]

![Image of medical necessity and level of care assessment form with parent DLN highlighted]
Inactivations

Assessments may need to be inactivated when fields cannot be corrected as needed (e.g., Medicaid #, Individual Name). MN/LOC Assessments can be inactivated through the LTC Online Portal by first retrieving the assessment using FSI or Current Activity. Once the assessment is inactivated, it will be set to status “Form Inactivated.” The assessment cannot be reactivated, however, it can still be used as a template.

When to inactivate?

There are no time limitations on performing an inactivation. Providers may perform an inactivation when an assessment needs to stop processing in the workflow, if an assessment needs to be canceled that has already processed to completion, or when fields cannot be corrected as needed (e.g., Medicaid #, Individual Name).

Who may inactivate?

Inactivations may be performed based on the vendor/contract who submitted the assessment originally. None of the DADS or TMHP teams (Community Services [CS] Workers, CS Team Leads, and TMHP Operations) may submit an inactivation on an MN/LOC Assessment.
How to Inactivate an Assessment

1. Log in to the LTC Online Portal.
2. Find your document using FSI or Current Activity.
3. Click the **View Detail** link.
4. Click the “Inactivate Form” button.
5. When the dialog box stating “Are you sure you want to Inactivate this form?” appears:
   a. Click the “OK” button to inactivate the assessment.
   or
   b. Click the “Cancel” button if you do not want to inactivate the assessment.

**Note:** Once inactivated, assessments cannot be reactivated and assessment will be set to status “Form Inactivated.”
RUG Training Requirements

RUG training is intended for LTC nurses and providers associated with the DADS Community Services Programs. RUG training is designed to instruct providers on the requirements for completing RUG fields in assessments for Texas Medicaid payment.

Texas State University, in cooperation with the HHSC Office of Inspector General (OIG) has made this training available through the Office of Continuing Education’s online course program.

To register for the RUG training, or for more information visit:
www.txstate.edu/continuinged/professional-development/PD-Online/RUG-Training.html

RUG training is valid for two years and must be renewed by completing the online RUG training via Texas State University.

Note: The MN/LOC 3.0 implementation did not impact the expiration date of a provider’s current RUG training completion. Providers are not required to complete MN/LOC 3.0 RUG training to submit MN/LOC 3.0 Assessments if the provider’s 2.0 completion is still valid.

RUG training is required for RNs who sign assessments as complete. The RN license number listed on section S5 of the LTCMI is validated for completion of RUG training. An error will occur if the license number does not pass validation. The assessment will not be considered successfully submitted until all errors are resolved.

RUG training can take two to seven business days (M-F, 8 a.m. -5 p.m.) to process and report completions of RUG training to TMHP, depending on current volume of enrollments and completions.
Reminders

- LTC Online Portal has 24/7 availability to submit and track assessments.
- Utilize FSI and Current Activity. These features will keep you informed of the status of your assessments.
- Print and sign the assessment prior to submission.
- Provide pertinent information in the “Comments” section.
- Submit additional information within 21 calendar days on the LTC Online Portal when the assessment is set to status “Pending Denial (need more information)” or call TMHP at 1-800-626-4117, Option 2.
- All RN and MD/DO licenses are validated against the appropriate licensing state board.
- Use the TMHP website at www.tmhp.com/Pages/LTC/ltc_home.aspx for recent updates and new information.
- This User Guide can be found under the Help link located on the blue navigational bar within the LTC Online Portal.
Reporting Medicaid Waste, Abuse, and Fraud

Medicaid fraud: “An intentional deceit or misrepresentation made by a person with the knowledge that deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.”

How to Report Waste, Abuse, and Fraud

Reports may be made through the following website: https://oig.hhsc.state.tx.us. This website gives instructions on how to submit a report, as well as how to submit additional documentation that cannot be transmitted over the Internet. The website also provides information on the types of waste, abuse, and fraud to report to OIG.

If you are not sure if an action is waste, abuse, or fraud of Texas Medicaid, report it to OIG and let the investigators decide. If you are uncomfortable about submitting a report online, there is a telephone number for Client Fraud and Abuse reporting: 1-800-436-6184.
Providers must comply with HIPAA. It is your responsibility to comply with HIPAA, to seek legal representation when needed, and to consult the manuals or speak to your TMHP Provider Representative when you have questions.
Resource Information

TMHP Call Center/Help Desk
  Telephone............................................................................................................................1-800-727-5436/1-800-626-4117
  General Inquiries: Press 1
  Medical Necessity: Press 2
  Technical Support: Press 3
  Audio Message Paper Submitters: Press 4
  Fax..............................................................................................................................................(512) 514-4223
Medicaid Hotline .......................................................................................................................1-800-252-8263
RUG Training Information ...........................................................................................................(512) 245-7118
EDI Help Desk ............................................................................................................................1-888-863-3638
LTC Help Desk ...........................................................................................................................1-800-626-4117
TMHP General Customer Service .............................................................................................1-800-925-9126
Medicaid Fraud ..........................................................................................................................1-800-436-6184
Community Based Alternatives MN/LOC Assessment Contacts
  Completing the MN/LOC Assessment: Contact your DADS Regional Nurse : www.dads.state.tx.us/providers/CBA/contacts.html
Community Services Regional Contacts : www.dads.state.tx.us/contact/regional_facility/index.html
Medically Dependent Children Program Contacts
  Completing the MN/LOC Assessment: Contact the Access and Intake State Office Nurse: (512) 438-5837
PACE Program Contacts
  Completing the MN/LOC Assessment: (512) 438-2013
STAR+PLUS Contacts
  Business Rule Questions: Contact David.Johnson@hhsc.state.tx.us
  Questions regarding MN Determinations: Contact TMHP at 1-800-727-5436
DADS Regional Nurse Contact Information

<table>
<thead>
<tr>
<th>Region</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1/10</td>
<td>(915) 834-7566</td>
</tr>
<tr>
<td>Region 2/9</td>
<td>(325) 795-5725</td>
</tr>
<tr>
<td>Region 3</td>
<td>(940) 320-8249</td>
</tr>
<tr>
<td>Region 4</td>
<td>(903) 737-0226</td>
</tr>
<tr>
<td>Region 5</td>
<td>(409) 383-5531</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 6</td>
<td>(713) 967-7678</td>
</tr>
<tr>
<td>Region 7</td>
<td>(512) 706-6018</td>
</tr>
<tr>
<td>Region 8</td>
<td>(210) 438-6216</td>
</tr>
<tr>
<td>Region 11</td>
<td>(956) 983-7645</td>
</tr>
</tbody>
</table>

DADS Utilization Review Contact Information

<table>
<thead>
<tr>
<th>Region</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1/2/9/10</td>
<td>(325) 795-5594</td>
</tr>
<tr>
<td>Region 3/4/5/7</td>
<td>(903) 737-0235</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 6/8</td>
<td>(210) 619-8165</td>
</tr>
<tr>
<td>Region 11</td>
<td>(956) 973-1236</td>
</tr>
</tbody>
</table>

Informational Websites

<table>
<thead>
<tr>
<th>Category</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td><a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></td>
</tr>
<tr>
<td>Community Services Policies</td>
<td><a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a></td>
</tr>
<tr>
<td>Community Services Programs</td>
<td><a href="http://www.dads.state.tx.us/providers/index.cfm">www.dads.state.tx.us/providers/index.cfm</a></td>
</tr>
<tr>
<td>Consumer Rights and Services (includes information about how to make a complaint)</td>
<td><a href="http://www.dads.state.tx.us/services/crs/index.html">www.dads.state.tx.us/services/crs/index.html</a></td>
</tr>
<tr>
<td>DADS Services</td>
<td><a href="http://www.dads.state.tx.us/services">www.dads.state.tx.us/services</a></td>
</tr>
<tr>
<td>Health and Human Services Commission</td>
<td><a href="http://www.hhsc.state.tx.us">www.hhsc.state.tx.us</a></td>
</tr>
<tr>
<td>HHSC Regions</td>
<td><a href="http://www.hhsc.state.tx.us/aboutHHS/HHS_Regions.shtml">www.hhsc.state.tx.us/aboutHHS/HHS_Regions.shtml</a></td>
</tr>
<tr>
<td>Long Term Care Updates and Banner Messages</td>
<td><a href="http://www.tmhp.com/Pages/LTC/Ltc_home.aspx">www.tmhp.com/Pages/LTC/Ltc_home.aspx</a></td>
</tr>
<tr>
<td>Medicaid Fraud</td>
<td><a href="https://oig.hhsc.state.tx.us/">https://oig.hhsc.state.tx.us/</a></td>
</tr>
<tr>
<td>Medicaid Nursing Facility Program</td>
<td><a href="http://www.dads.state.tx.us/providers/NF/index.cfm">www.dads.state.tx.us/providers/NF/index.cfm</a></td>
</tr>
<tr>
<td>Medical Necessity and Level of Care 3.0 Assessment and Instructions</td>
<td><a href="http://www.tmhp.com/Pages/LTC/LTC_Forms.aspx">www.tmhp.com/Pages/LTC/LTC_Forms.aspx</a></td>
</tr>
<tr>
<td>RUG Training</td>
<td><a href="http://www.txstate.edu/continuinged/professional-development/PD-Online/RUG-Training.html">www.txstate.edu/continuinged/professional-development/PD-Online/RUG-Training.html</a></td>
</tr>
<tr>
<td>Texas Administrative Code</td>
<td><a href="http://www.sos.state.tx.us/tac/index.html">www.sos.state.tx.us/tac/index.html</a></td>
</tr>
<tr>
<td>Texas Department of Aging and Disability Services</td>
<td><a href="http://www.dads.state.tx.us">www.dads.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Department of State Health Services</td>
<td><a href="http://www.dshs.state.tx.us">www.dshs.state.tx.us</a></td>
</tr>
<tr>
<td>Texas Medicaid &amp; Healthcare Partnership (TMHP)</td>
<td><a href="http://www.tmhp.com">www.tmhp.com</a></td>
</tr>
<tr>
<td>TMHP Long Term Care Division</td>
<td><a href="http://www.tmhp.com/Pages/LTC/Ltc_home.aspx">www.tmhp.com/Pages/LTC/Ltc_home.aspx</a></td>
</tr>
<tr>
<td>Vendor Drug Program</td>
<td><a href="http://www.hhsc.state.tx.us/hcf/vdp/vdpstart.html">www.hhsc.state.tx.us/hcf/vdp/vdpstart.html</a></td>
</tr>
</tbody>
</table>
Individual Service Plan (ISP) Table

For Community Based Alternatives (CBA) Providers

The due dates for the annual reassessment packets submitted by Home and Community Support Services (HCSS) agencies to the case managers are listed below.

Note: TMHP does not support any assessments other than the MN/LOC Assessment.

The table below lists the reassessment due dates based on the date of the ISP expiration:

<table>
<thead>
<tr>
<th>ISP Expiration Date (“To” date on ISP)</th>
<th>Reassessment Packet Due to Case Manager Between</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 31</td>
<td>November 1 – November 30</td>
</tr>
<tr>
<td>February 28 or 29</td>
<td>December 1 – December 31</td>
</tr>
<tr>
<td>March 31</td>
<td>January 1 – January 31</td>
</tr>
<tr>
<td>April 30</td>
<td>February 1 – February 28 or 29</td>
</tr>
<tr>
<td>May 31</td>
<td>March 1 – March 31</td>
</tr>
<tr>
<td>June 30</td>
<td>April 1 – April 30</td>
</tr>
<tr>
<td>July 31</td>
<td>May 1 – May 31</td>
</tr>
<tr>
<td>August 31</td>
<td>June 1 – June 30</td>
</tr>
<tr>
<td>September 30</td>
<td>July 1 – July 31</td>
</tr>
<tr>
<td>October 31</td>
<td>August 1 – August 31</td>
</tr>
<tr>
<td>November 30</td>
<td>September 1 – September 30</td>
</tr>
<tr>
<td>December 31</td>
<td>October 1 – October 31</td>
</tr>
</tbody>
</table>
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2300</td>
<td>Assessment Reference Date on an MN/LOC 3.0 Assessment</td>
</tr>
<tr>
<td>A3a</td>
<td>Assessment Reference Date on an MN/LOC 2.0 Assessment</td>
</tr>
<tr>
<td>API</td>
<td>Atypical Provider Identifier</td>
</tr>
<tr>
<td>ARD</td>
<td>Assessment Reference Date</td>
</tr>
<tr>
<td>BON</td>
<td>Texas Board of Nursing</td>
</tr>
<tr>
<td>CBA</td>
<td>Community Based Alternatives</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>CS</td>
<td>Community Services</td>
</tr>
<tr>
<td>CSHCN ID</td>
<td>Children with Special Health Care Needs Services Program Identification number</td>
</tr>
<tr>
<td>DADS</td>
<td>Department of Aging and Disability Services</td>
</tr>
<tr>
<td>DD</td>
<td>Developmental Disabilities</td>
</tr>
<tr>
<td>DLN</td>
<td>Document Locator Number</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathy</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>FSI</td>
<td>Form Status Inquiry</td>
</tr>
<tr>
<td>HCSS</td>
<td>Home and Community Support Services</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>ICD-9</td>
<td>International Classification of Diseases Ninth Revision</td>
</tr>
<tr>
<td>ID</td>
<td>Intellectual Disabilities</td>
</tr>
<tr>
<td>IDD</td>
<td>Intellectual and Developmental Disabilities</td>
</tr>
<tr>
<td>ISP</td>
<td>Individual Service Plan</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>LTCMI</td>
<td>Long Term Care Medicaid Information</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MDCP</td>
<td>Medically Dependent Children Program</td>
</tr>
<tr>
<td>MESAV</td>
<td>Medicaid Eligibility and Service Authorization Verification</td>
</tr>
<tr>
<td>MN</td>
<td>Medical Necessity</td>
</tr>
<tr>
<td>MN/LOC</td>
<td>Medical Necessity and Level of Care</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NPPES</td>
<td>National Plan and Provider Enumeration System</td>
</tr>
<tr>
<td>OES</td>
<td>Office of Eligibility Services</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of the Inspector General</td>
</tr>
<tr>
<td>OOHDNR</td>
<td>Out-of-Hospital Do Not Resuscitate Order</td>
</tr>
<tr>
<td>PACE</td>
<td>Program of the All-inclusive Care for the Elderly</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format</td>
</tr>
<tr>
<td>PRN</td>
<td>Pro re nata (Latin) — as needed</td>
</tr>
<tr>
<td>RA</td>
<td>Route of Administration</td>
</tr>
<tr>
<td>R&amp;S</td>
<td>Remittance and Status</td>
</tr>
<tr>
<td>R2b</td>
<td>Date Assessment was completed on an MN/LOC 2.0 Assessment</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RUG</td>
<td>Resource Utilization Group</td>
</tr>
<tr>
<td>SAS</td>
<td>Service Authorization System</td>
</tr>
<tr>
<td>SCSA</td>
<td>Significant Change in Status Assessment</td>
</tr>
<tr>
<td>SG</td>
<td>Service Group</td>
</tr>
<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>State of Texas Access Reform (STAR) + PLUS</td>
</tr>
<tr>
<td>TAC</td>
<td>Texas Administrative Code</td>
</tr>
<tr>
<td>THCA</td>
<td>Texas Health Care Association</td>
</tr>
<tr>
<td>TMB</td>
<td>Texas Medical Board</td>
</tr>
<tr>
<td>TMHP</td>
<td>Texas Medicaid &amp; Healthcare Partnership</td>
</tr>
<tr>
<td>UR</td>
<td>Utilization Review</td>
</tr>
<tr>
<td>Z0500B</td>
<td>Date Assessment was Completed on an MN/LOC 3.0 Assessment</td>
</tr>
</tbody>
</table>
Appendix A: LTC Online Portal Review

Test your knowledge by answering the questions on this page. Feel free to refer to sections of this LTC User Guide.

1. Name 3 benefits of using the LTC Online Portal.
   1. 
   2. 
   3. 

2. In order to access the LTC Online Portal, what is the first step you must take?

3. Name 2 options in the blue navigational bar.

4. When would you see the yellow Form Actions bar?

5. How can you tell if a field is required?
Review Answers

1. Name 3 benefits of using the LTC Online Portal.
   – The LTC Online Portal is a web-based application that is available 24 hours a day, 7 days a week.
   – TMHP provides LTC Online Portal technical support by telephone during normal business hours, Monday - Friday, 7:00 am - 7:00 pm, Central Time.
   – The LTC Online Portal provides error messages that must be resolved before submission.
   – Providers have the ability to monitor the status of their assessments and to submit additional information when needed.

2. In order to access the LTC Online Portal, what is the first step you must take?
   – Set up an administrator account or a user account if one is already available for that agency. You can find information for setting up an administrator account in the “How to Create an LTC Online Portal Administrator Account” in your User Guide.

3. Name 2 options in the blue navigational bar.
   – Home, Submit Form, Form Status Inquiry, Current Activity, Drafts, Printable Forms, and Help.

4. When would you see the yellow Form Actions bar?
   – When an individual assessment is being viewed in detail.

5. How can you tell if a field is required?
   – When it is marked with a red dot.
Appendix B: Word Search

Long Term Care Community Services Waiver Programs Workshop

Word Search

Use this activity to reinforce the terminology learned throughout this workshop.

Approved
Assessment
Claim
Community
Corrected
Dads
Denied
Determination
Medication
Necessity
Portal
Inactivate
License
Status
Medical
Thmhp
Waiver
Workflow
# Section A Identification Information

**A0310. Type of Assessment**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Type of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Reason for Assessment</td>
</tr>
<tr>
<td></td>
<td>01. Initial assessment</td>
</tr>
<tr>
<td></td>
<td>02. Annual assessment</td>
</tr>
<tr>
<td></td>
<td>03. Significant change in status assessment</td>
</tr>
</tbody>
</table>

**A0500. Legal Name of Individual**

| 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**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Male</td>
</tr>
<tr>
<td>2.</td>
<td>Female</td>
</tr>
</tbody>
</table>

**A0900. Birth Date**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**A1000. Race/Ethnicity**

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
## Section A  Identification Information

### A1100. Language

A. Does the individual 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:

```
   [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
```

### A1300. Optional Individual Items

B. Room number:

```
   [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
```

### A1550. Conditions Related to IDD Status

If the individual is 22 years of age or older, complete only if A0310A = 01
If the individual is 21 years of age or younger, complete always

Check all conditions that are related to IDD status that were manifested before age 22, and are likely to continue indefinitely

<table>
<thead>
<tr>
<th>Conditions Related to IDD Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A. Down syndrome</td>
</tr>
<tr>
<td>☐ B. Autism</td>
</tr>
<tr>
<td>☐ C. Epilepsy</td>
</tr>
<tr>
<td>☐ D. Other organic condition related to IDD</td>
</tr>
</tbody>
</table>

IDD Without Organic Condition

<table>
<thead>
<tr>
<th>CONDITIONS RELATED TO IDD STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ E. IDD with no organic condition</td>
</tr>
<tr>
<td>☐ No IDD</td>
</tr>
<tr>
<td>☐ Z. None of the above</td>
</tr>
</tbody>
</table>

### A2300. Assessment Date

Observation end date:

```
   [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
```

Month Day Year
**Look back period for all items is 7 days unless another time frame is indicated**

## Section B  Hearing, Speech, and Vision

### B0100. Comatose

<table>
<thead>
<tr>
<th>Enter</th>
<th>Persistent vegetative state/no discernible consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Continue to B0200, Hearing</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance</td>
</tr>
</tbody>
</table>

### B0200. Hearing

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

### B0300. Hearing Aid

<table>
<thead>
<tr>
<th>Enter</th>
<th>Hearing aid or other hearing appliance used in completing B0200, Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

### B0600. Speech Clarity

<table>
<thead>
<tr>
<th>Enter</th>
<th>Select best description of speech pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Clear speech – distinct intelligible words</td>
</tr>
<tr>
<td></td>
<td>1. Unclear speech – slurred or mumbled words</td>
</tr>
<tr>
<td></td>
<td>2. No speech – absence of spoken words</td>
</tr>
</tbody>
</table>

### B0700. Makes Self Understood

<table>
<thead>
<tr>
<th>Enter</th>
<th>Ability to express ideas and wants, consider both verbal and non-verbal expression. Enter ‘-’ Dash if unable to assess.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Understood</td>
</tr>
<tr>
<td></td>
<td>1. Usually understood – difficulty communicating some words or finishing thoughts but is able if prompted or given time</td>
</tr>
<tr>
<td></td>
<td>2. Sometimes understood – ability is limited to making concrete requests</td>
</tr>
<tr>
<td></td>
<td>3. Rarely/never understood</td>
</tr>
</tbody>
</table>

### B0799. Modes of Expression

<table>
<thead>
<tr>
<th></th>
<th>Check all used by individual to make needs known</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Speech</td>
</tr>
<tr>
<td>B.</td>
<td>Writing messages to express or clarify needs</td>
</tr>
<tr>
<td>C.</td>
<td>American sign language or Braille</td>
</tr>
<tr>
<td>D.</td>
<td>Signs/ Gestures/ Sounds</td>
</tr>
<tr>
<td>E.</td>
<td>Communication Board</td>
</tr>
<tr>
<td>F.</td>
<td>Voice Modulator</td>
</tr>
<tr>
<td>G.</td>
<td>Other</td>
</tr>
<tr>
<td>Z.</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

### B0800. Ability To Understand Others

<table>
<thead>
<tr>
<th>Enter</th>
<th>Understanding verbal content, however able (with hearing aid or device if used). Enter ‘-’ Dash if unable to assess.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Understands – clear comprehension</td>
</tr>
<tr>
<td></td>
<td>1. Usually understands – misses some part/intent of message but comprehends most conversation</td>
</tr>
<tr>
<td></td>
<td>2. Sometimes understands – responds adequately to simple, direct communication only</td>
</tr>
<tr>
<td></td>
<td>3. Rarely/never understands</td>
</tr>
</tbody>
</table>

### B1000. Vision

<table>
<thead>
<tr>
<th>Enter</th>
<th>Ability to see in adequate light (with glasses or other visual appliances)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Adequate – sees fine detail, such as regular print in newspapers/books</td>
</tr>
<tr>
<td></td>
<td>1. Impaired – sees large print, but not regular print in newspapers/books</td>
</tr>
<tr>
<td></td>
<td>2. Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects</td>
</tr>
<tr>
<td></td>
<td>3. Highly impaired – object identification in question, but eyes appear to follow objects</td>
</tr>
<tr>
<td></td>
<td>4. Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects</td>
</tr>
</tbody>
</table>

### B1200. Corrective Lenses

<table>
<thead>
<tr>
<th>Enter</th>
<th>Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
Section C  Cognitive Patterns

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

Enter 0.

No (individual is rarely/never understood) OR individual is less than 7 years of age, skip to and complete C0700-C1000, Caregiver Assessment for Mental Status

Enter 1. Yes → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask individual: "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 '-' Dash if unable to assess.

Number of words repeated after first attempt

Enter

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

After the individual'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 individual: "Please tell me what year it is right now." Enter '-' Dash if unable to assess.

A. Able to report correct year

Enter

0. Missed by > 5 years or no answer
1. Missed by 2–5 years
2. Missed by 1 year
3. Correct

Ask individual: "What month are we in right now?" Enter '-' Dash if unable to assess.

B. Able to report correct month

Enter

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

Ask individual: "What day of the week is today?" Enter '-' Dash if unable to assess.

C. Able to report correct day of the week

Enter

0. Incorrect or no answer
1. Correct

C0400. Recall

Ask individual: "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 '-' Dash if unable to assess.

A. Able to recall “sock”

Enter

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

B. Able to recall “blue”

Enter

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

C. Able to recall “bed”

Enter

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

C0500. Summary Score

Enter Score

The sum of the scores for questions C0200–C0400. The sum should be a number (00–15)

A score of 99 indicates that the individual was unable to complete the interview
## Section C  Cognitive Patterns

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No (Individual was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium</td>
</tr>
<tr>
<td>1</td>
<td>Yes (Individual was unable to complete interview OR individual is less than 7 years of age) → Continue to C0700, Short-term Memory OK</td>
</tr>
</tbody>
</table>

### Caregiver Assessment for Mental Status

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

### C0700. Short-term Memory OK

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Seems or appears to recall after 5 minutes. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.</td>
</tr>
<tr>
<td>1</td>
<td>Memory OK</td>
</tr>
<tr>
<td>2</td>
<td>Memory problem</td>
</tr>
</tbody>
</table>

### C0800. Long-term Memory OK

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Seems or appears to recall long past. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.</td>
</tr>
<tr>
<td>1</td>
<td>Memory OK</td>
</tr>
<tr>
<td>2</td>
<td>Memory problem</td>
</tr>
</tbody>
</table>

### C0900. Memory/Recall Ability

> Check all that the individual was normally able to recall

- A. Current season
- B. Location of own room
- C. Caregiver names and faces
- D. That he or she is in their own home/room
- Z. None of the above were recalled

### C1000. Cognitive Skills for Daily Decision Making

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Made decisions regarding tasks of daily life</td>
</tr>
<tr>
<td>1</td>
<td>Independent – decisions consistent/reasonable</td>
</tr>
<tr>
<td>2</td>
<td>Modified independence – some difficulty in new situations only</td>
</tr>
<tr>
<td>3</td>
<td>Moderately impaired – decisions poor; cues/supervision required</td>
</tr>
<tr>
<td>4</td>
<td>Severely impaired – never/rarely made decisions</td>
</tr>
</tbody>
</table>

### Delirium

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

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

**Coding:**

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

**Enter Codes in Boxes**

- **A. Inattention** – Did the individual have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- **B. Disorganized thinking** – Was the individual’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? Enter '-' Dash if unable to assess.
- **C. Altered level of consciousness** – Did the individual 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 individual 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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Section D  Mood

D0100. Should Individual Mood Interview be Conducted? – Attempt to conduct interview with the individual

Enter Code

0. No (Individual is rarely/never understood) OR individual is less than 7 years of age → Skip to and complete D0500 -D0600, Caregiver Assessment of Individual Mood (PHQ-9-OV)
1. Yes → Continue to D0200, Individual Mood Interview (PHQ-9©)

D0200. Individual Mood Interview (PHQ-9©)

Say to individual: “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 individual: “About how often have you been bothered by this?”

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

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2–6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7–11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

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

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-27).
A score of 99 indicates that the individual was 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 individual self harm

Enter Code

0. No
1. Yes

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**Section D Mood**

**D0500. Caregiver Assessment of Individual Mood (PHQ-9-OV*)**

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

**Over the last 2 weeks, did the individual 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.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2–6 days (several days)</td>
</tr>
<tr>
<td></td>
<td>2. 7–11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

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**

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-30).

**D0650. Safety Notification** — Complete only if D0500I1 = 1 indicating possibility of individual self harm

<table>
<thead>
<tr>
<th>Enter Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
</tbody>
</table>

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### Section E  Behavior

#### E0100. Potential Indicators of Psychosis

| 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>No → Skip to E0800, Rejection of Care</td>
</tr>
<tr>
<td>1.</td>
<td>Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below</td>
</tr>
</tbody>
</table>

#### E0500. Impact on Individual

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did any of the identified symptom(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Put the individual at significant risk for physical illness or injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly interfere with the individual’s care?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly interfere with the individual’s participation in activities or social interactions?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

#### E0600. Impact on Others

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did any of the identified symptom(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Put others at significant risk for physical injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly intrude on the privacy or activity of others?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly disrupt care or living environment?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

#### E0800. Rejection of Care – Presence & Frequency

Did the individual reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual’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 individual or family), and determined to be consistent with individual values, preferences, or goals.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did the individual reject evaluation or care?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Behavior not exhibited</td>
</tr>
<tr>
<td></td>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td></td>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td></td>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>
## Section E | Behavior

### E0900. Wandering – Presence & Frequency

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the individual wandered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms</td>
</tr>
<tr>
<td>1</td>
<td>Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td>2</td>
<td>Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td>3</td>
<td>Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>

### E1000. Wandering – Impact

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the wandering place the individual at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the residence/facility)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Does the wandering significantly intrude on the privacy or activities of others?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### E1100. Change in Behavior or Other Symptoms – Consider all of the symptoms assessed in items E0100 through E1000.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>How does individual’s current behavior status, care rejection, or wandering compare to prior assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Same</td>
</tr>
<tr>
<td>1</td>
<td>Improved</td>
</tr>
<tr>
<td>2</td>
<td>Worse</td>
</tr>
<tr>
<td>3</td>
<td>N/A because no prior assessment</td>
</tr>
</tbody>
</table>
Section G  Functional Status

G0110. Activities of Daily Living (ADL) Assistance

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 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 caregiver performance, and extensive assistance, code extensive assistance.
  ○ When there is a combination of full caregiver 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 individual's performance - 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 caregiver performance every time

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

   Activity Occurred 2 or Fewer Times
   7. Activity occurred only once or twice - activity did occur but only once or twice
   8. Activity did not occur - activity did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
   Code for most support provided; code regardless of individual's self-performance classification

Coding:
   0. No setup or physical help from caregiver
   1. Setup help only
   2. One person physical assist
   3. Two+ persons physical assist
   8. ADL activity itself did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period

Enter Codes in Boxes

<table>
<thead>
<tr>
<th></th>
<th>1. Self-Performance</th>
<th>2. Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bed mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Walk in room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Walk in home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Locomotion in room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Locomotion in home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Toilet use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Personal hygiene</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section G  Functional Status

#### G0120. Bathing
How individual 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Self-performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Independent – no help provided</td>
</tr>
<tr>
<td></td>
<td>1. Supervision – oversight help only</td>
</tr>
<tr>
<td></td>
<td>2. Physical help limited to transfer only</td>
</tr>
<tr>
<td></td>
<td>3. Physical help in part of bathing activity</td>
</tr>
<tr>
<td></td>
<td>4. Total dependence</td>
</tr>
<tr>
<td></td>
<td>8. Activity itself did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Bathing support codes are as defined in Item G0110 column 2, ADL Support Provided, above)</td>
</tr>
</tbody>
</table>

#### G0300. Balance During Transitions and Walking
After observing the individual, code the following walking and transition items for most dependent

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Steady at all times</td>
<td>A. Moving from seated to standing position</td>
</tr>
<tr>
<td>1. Not steady, but able to stabilize without human assistance</td>
<td>B. Walking (with assistive device if used)</td>
</tr>
<tr>
<td>2. Not steady, only able to stabilize with human assistance</td>
<td>C. Turning around and facing the opposite direction while walking</td>
</tr>
<tr>
<td>8. Activity did not occur</td>
<td>D. Moving on and off toilet</td>
</tr>
<tr>
<td></td>
<td>E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)</td>
</tr>
</tbody>
</table>

#### G0400. Functional Limitation in Range of Motion
Code for limitation that interfered with daily functions or placed individual at risk of injury

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No impairment</td>
<td>A. Upper extremity (shoulder, elbow, wrist, hand)</td>
</tr>
<tr>
<td>1. Impairment on one side</td>
<td>B. Lower extremity (hip, knee, ankle, foot)</td>
</tr>
<tr>
<td>2. Impairment on both sides</td>
<td></td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Individual believes he or she is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Caregiver believes individual is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
## 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 continence promotion program or trial** – Is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence?
  - 0. No
  - 1. Yes

### H0300. Urinary Continence

Enter Code

- Urinary continence – Select the one category that best describes the individual
  - 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**, individual had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

### H0400. Bowel Continence

Enter Code

- Bowel continence – Select the one category that best describes the individual
  - 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**, individual had an ostomy or did not have a bowel movement for the entire 7 days

### H0500. Bowel Continence Program

Enter Code

- Is an individualized continence promotion program currently being used to manage the individual's bowel continence?
  - 0. No
  - 1. Yes

### H0600. Bowel Patterns

Enter Code

- Constipation present?
  - 0. No
  - 1. Yes
### Section I  Active Diagnoses

**Active Diagnoses in the last 7 days – Check all that apply**

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists.

<table>
<thead>
<tr>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I0100. Cancer (with or without metastasis)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart/Circulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)</td>
</tr>
<tr>
<td>I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)</td>
</tr>
<tr>
<td>I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))</td>
</tr>
<tr>
<td>I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)</td>
</tr>
<tr>
<td>I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)</td>
</tr>
<tr>
<td>I0700. Hypertension</td>
</tr>
<tr>
<td>I0799a. Blood Pressure Reading # 1</td>
</tr>
<tr>
<td>I0799b. Blood Pressure Reading # 2</td>
</tr>
<tr>
<td>I0800. Orthostatic Hypotension</td>
</tr>
<tr>
<td>I0899a. Blood Pressure Reading # 1</td>
</tr>
<tr>
<td>I0899b. Blood Pressure Reading # 2</td>
</tr>
<tr>
<td>I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</td>
</tr>
<tr>
<td>I0999. Peripheral Edema</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1100. Cirrhosis</td>
</tr>
<tr>
<td>I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)</td>
</tr>
<tr>
<td>I1300. Ulcerative Colitis, Crohn’s Disease, or Inflammatory Bowel Disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genitourinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1400. Benign Prostatic Hyperplasia (BPH)</td>
</tr>
<tr>
<td>I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)</td>
</tr>
<tr>
<td>I1550. Neurogenic Bladder</td>
</tr>
<tr>
<td>I1650. Obstructive Uropathy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>I1700. Multidrug-Resistant Organism (MDRO)</td>
</tr>
<tr>
<td>I2000. Pneumonia</td>
</tr>
<tr>
<td>I2100. Septicemia</td>
</tr>
<tr>
<td>I2200. Tuberculosis</td>
</tr>
<tr>
<td>I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)</td>
</tr>
<tr>
<td>I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)</td>
</tr>
<tr>
<td>I2500. Wound Infection (other than foot)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metabolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)</td>
</tr>
<tr>
<td>I2999. Blood Sugar Range</td>
</tr>
<tr>
<td>I3100. Hyponatremia</td>
</tr>
<tr>
<td>I3200. Hyperkalemia</td>
</tr>
<tr>
<td>I3300. Hyperlipidemia (e.g., hypercholesterolemia)</td>
</tr>
<tr>
<td>I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto’s thyroiditis)</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I3700.  Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))</td>
</tr>
<tr>
<td>☐ I3800.  Osteoporosis</td>
</tr>
<tr>
<td>☐ 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)</td>
</tr>
<tr>
<td>☐ I3999.  Contractures</td>
</tr>
<tr>
<td>☐ I4000.  Other Fracture</td>
</tr>
<tr>
<td>☐ I4099.  Scoliosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I4200.  Alzheimer's Disease</td>
</tr>
<tr>
<td>☐ I4300.  Aphasia</td>
</tr>
<tr>
<td>☐ I4400.  Cerebral Palsy</td>
</tr>
<tr>
<td>☐ I4500.  Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke</td>
</tr>
<tr>
<td>☐ I4800.  Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)</td>
</tr>
<tr>
<td>☐ I4900.  Hemiplegia or Hemiparesis</td>
</tr>
<tr>
<td>☐ I5000.  Paraplegia</td>
</tr>
<tr>
<td>☐ I5100.  Quadriplegia</td>
</tr>
<tr>
<td>☐ I5199.  Tremors</td>
</tr>
<tr>
<td>☐ I5200.  Multiple Sclerosis (MS)</td>
</tr>
<tr>
<td>☐ I5250.  Huntington's Disease</td>
</tr>
<tr>
<td>☐ I5299.  Muscular Dystrophy</td>
</tr>
<tr>
<td>☐ I5300.  Parkinson's Disease</td>
</tr>
<tr>
<td>☐ I5350.  Tourette’s Syndrome</td>
</tr>
<tr>
<td>☐ I5399.  Hydrocephalus</td>
</tr>
<tr>
<td>☐ I5400.  Seizure Disorder or Epilepsy</td>
</tr>
</tbody>
</table>

**I5499.  Type of Seizure**

↓ Check all that apply

<table>
<thead>
<tr>
<th>A</th>
<th>Localized (partial or focal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Generalized (absence, myclonic, clonic, tonic and atonic)</td>
</tr>
</tbody>
</table>

**I5499C.  Average Frequency of Seizures in the last 7 days**

**Enter Code**

| 0  | No seizures                  |
| 1  | Less than 1 seizure/week     |
| 2  | 1-6 seizures/week            |
| 3  | 1 seizure/day                |
| 4  | 2-5 seizures/day             |
| 5  | 6-12 seizures/day            |
| 6  | More than 12 seizures/day    |

| ☐ I5500.  Traumatic Brain Injury (TBI) |
| ☐ I5599.  Spina Bifida                |
## Section I  Active Diagnoses

### Active Diagnoses in the last 7 days – Check all that apply

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional</td>
<td>I5600. Malnutrition (protein or calorie) or at risk for malnutrition</td>
</tr>
<tr>
<td></td>
<td>I5699. At risk for dehydration</td>
</tr>
<tr>
<td>Psychiatric/Mood Disorder</td>
<td>I5700. Anxiety Disorder</td>
</tr>
<tr>
<td></td>
<td>I5800. Depression (other than bipolar)</td>
</tr>
<tr>
<td></td>
<td>I5900. Manic Depression (bipolar disease)</td>
</tr>
<tr>
<td></td>
<td>I5950. Psychotic Disorder (other than schizophrenia)</td>
</tr>
<tr>
<td></td>
<td>I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)</td>
</tr>
<tr>
<td></td>
<td>I6100. Post Traumatic Stress Disorder (PTSD)</td>
</tr>
<tr>
<td></td>
<td>I6199. ADHD Syndrome</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)</td>
</tr>
<tr>
<td></td>
<td>I6299. Cystic Fibrosis</td>
</tr>
<tr>
<td></td>
<td>I6300. Respiratory Failure</td>
</tr>
<tr>
<td>Vision</td>
<td>I6500. Cataracts, Glaucoma, or Macular Degeneration</td>
</tr>
<tr>
<td></td>
<td>None of Above</td>
</tr>
<tr>
<td>Other</td>
<td>I7900. None of the above active diagnoses within the last 7 days</td>
</tr>
</tbody>
</table>

### Other

**Additional active diagnoses**

Enter diagnosis description and ICD code.

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________
7. ____________________________
8. ____________________________
9. ____________________________
10. ____________________________
### Section J  Health Conditions

#### J0100. Pain Management – Complete for the individual, regardless of current pain level

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

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Received scheduled pain medication regimen?</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td><strong>B.</strong> Received PRN pain medications OR was offered and declined?</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td><strong>C.</strong> Received non-medication intervention for pain?</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>

#### J0200. Should Pain Assessment Interview be Conducted? – Attempt to conduct interview with the individual.

If individual is comatose, skip to J1100, Shortness of Breath (dyspnea)

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>→ Continue to J0300, Pain Presence</td>
<td></td>
<td>0. (individual is rarely/never understood OR individual is less than 3 years of age) → Skip to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

---

### Pain Assessment Interview

#### J0300. Pain Presence

Ask individual: *Have you had pain or hurting at any time in the last 5 days?*

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>→ Skip to J1100, Shortness of Breath</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Unable to answer</td>
<td>→ Skip to J0800, Indicators of Pain or Possible Pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### J0400. Pain Frequency

Ask individual: *How much of the time have you experienced pain or hurting over the last 5 days?*

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost constantly</td>
<td></td>
<td></td>
<td>Frequently</td>
</tr>
<tr>
<td>Occasionally</td>
<td></td>
<td></td>
<td>Rarely</td>
</tr>
<tr>
<td>Unable to answer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### J0500. Pain Effect on Function

**A.** Ask individual: *Over the past 5 days, has pain made it hard for you to sleep at night?*

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Unable to answer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B.** Ask individual: *Over the past 5 days, have you limited your day-to-day activities because of pain?*

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Unable to answer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**A.** Numeric Rating Scale (00–10)

Ask individual: *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 individual 00 -10 pain scale)

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

**B.** Verbal Descriptor Scale

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

<table>
<thead>
<tr>
<th></th>
<th>Enter</th>
<th>Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
<td>Very severe, horrible</td>
</tr>
<tr>
<td>Unable to answer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section J  | Health Conditions

#### J0700. Should the Caregiver Assessment for Pain be Conducted?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (J0400=1 thru 4)</td>
<td>Skip to J1100, Shortness of Breath (dyspnea)</td>
</tr>
<tr>
<td>1. Yes (J0400=9)</td>
<td>Continue to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

#### Caregiver Assessment for Pain

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

- **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, wincing, 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicators of pain or possible pain observed 1 to 2 days</td>
<td></td>
</tr>
<tr>
<td>2. Indicators of pain or possible pain observed 3 to 4 days</td>
<td></td>
</tr>
<tr>
<td>3. Indicators of pain or possible pain observed daily</td>
<td></td>
</tr>
</tbody>
</table>

#### Other Health Conditions

**J1100. Shortness of Breath (dyspnea)**

- **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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

#### J1550. Problem Conditions

- **A.** Fever
- **B.** Vomiting
- **C.** Dehydrated
- **D.** Internal bleeding
- **E99.** Syncope
- **Z.** None of the above
### Section J  Health Conditions

**J1700. Fall History**

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
<th>A. Did the individual have a fall any time in the last month?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Unable to determine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
<th>B. Did the individual have a fall any time in the last 2–6 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Unable to determine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
<th>C. Did the individual have any fracture related to a fall in the last 6 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Unable to determine</td>
<td></td>
</tr>
</tbody>
</table>

**J1900. Number of Falls in the last 6 months with or without injury**

Complete only if J1700A or J1700B = 1

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

#### Enter Codes in Boxes
- A. No injury – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/caregiver.
- B. Injury (except major) – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain.
- C. Major injury – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

### Section K  Swallowing/Nutritional Status

**K0100. Swallowing Disorder**

Signs and symptoms of possible swallowing disorder

- 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

- A. Height (in inches). Record most recent height measure.
- 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.). Enter '-' Dash if unable to assess.

**K0300. Weight Loss**

- 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
Section K  Swallowing/Nutritional Status

K0310. Weight Gain

Gain of 5% or more in the last month or gain of 10% or more in last 6 months
0. No or unknown
1. Yes, on physician-prescribed weight-gain regimen
2. Yes, not on physician-prescribed weight-gain regimen

K0510. Nutritional Approaches

↓ Check all of the following nutritional approaches that were performed during the last 7 days
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 K0510A or K0510B is checked

A. Proportion of total calories the individual received through parenteral or tube feeding
   1. 25% or less
   2. 26–50%
   3. 51% or more

B. Average fluid intake per day by IV or tube feeding
   1. 500 cc/day or less
   2. 501 cc/day or more

Section L  Oral/Dental Status

L0200. Dental

↓ 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
### 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. Individual 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 individual at risk of developing pressure ulcers?
    - 0. No
    - 1. Yes

#### M0210. Unhealed Pressure Ulcer(s)

- **Enter Code**
  - Does this individual have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
    - 0. No → skip to M1030, Number of Venous and Arterial 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
    - 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3
    - 3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown
  - 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
  - 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
  - E. Unstageable – Non-removable dressing: Known but not stageable due to non-removable dressing/device
    - 1. Number of unstageable pressure ulcers due to non-removable dressing/device
  - F. Unstageable – Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
    - 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar
  - G. Unstageable – Deep tissue: Suspected deep tissue injury in evolution
    - 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution
### Section M  Skin Conditions

#### 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 individual 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:

- **Pressure ulcer length**: Longest length from head to toe
- **Pressure ulcer width**: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
- **Pressure ulcer depth**: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash)

#### M0700. Most Severe Tissue Type for Any Pressure Ulcer

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
5. **None of the Above**

#### M1030. Number of Venous and Arterial Ulcers

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)
  - G. Skin tear(s)
  - H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)

None of the Above

- **Z. None of the above** were present
Section M  Skin Conditions

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. Pressure 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

Section N  Medications

N0300. Injections

Enter Days

Record the number of days that injections of any type were received during the last 7 days
If 0 → Skip to N0410, Medications Received

N0350. Insulin

Enter Days

A. Insulin injections – Record the number of days that insulin injections were received during the last 7 days

B. Orders for insulin – Record the number of days the physician (or authorized assistant or practitioner) changed the individual’s insulin orders during the last 7 days

N0410. Medications Received

Indicate the number of DAYS the individual received the following medications during the last 7 days.
Enter "0" if medication was not received by the individual during the last 7 days.

- A. Antipsychotic
- B. Antianxiety
- C. Antidepressant
- D. Hypnotic
- E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
- F. Antibiotic
- G. Diuretic
### O0100. Special Treatments, Procedures, and Programs

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

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Treatments</strong></td>
</tr>
<tr>
<td>A. Chemotherapy</td>
</tr>
<tr>
<td>B. Radiation</td>
</tr>
<tr>
<td><strong>Respiratory Treatments</strong></td>
</tr>
<tr>
<td>C. Oxygen therapy</td>
</tr>
<tr>
<td>D. Suctioning</td>
</tr>
<tr>
<td>E. Tracheostomy care</td>
</tr>
<tr>
<td>F. Ventilator or respirator</td>
</tr>
<tr>
<td>G. BiPAP/CPAP</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>H. IV medications</td>
</tr>
<tr>
<td>I. Transfusions</td>
</tr>
<tr>
<td>J. Dialysis</td>
</tr>
<tr>
<td>K. Hospice care</td>
</tr>
<tr>
<td>L. Respite care</td>
</tr>
<tr>
<td>M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)</td>
</tr>
<tr>
<td>N99. Psychiatric care</td>
</tr>
<tr>
<td><strong>None of the Above</strong></td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>
## Section O  
Special Treatments, Procedures, and Programs

### O0400. Therapies

#### A. Speech-Language Pathology and Audiology Services

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

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 last assessment) started

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

#### B. Occupational Therapy

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

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 last assessment) started

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

#### C. Physical Therapy

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as part of a group of individuals in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

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 last assessment) started

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

---

O0400 continued on next page
**Section O**  
Special Treatments, Procedures, and Programs

### O0400. Therapies - Continued

#### D. Respiratory Therapy

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enter Number of Days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Enter Number of Minutes</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enter Number of Days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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)

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th>Enter Number of Minutes</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enter Number of Days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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)

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

### O0600. Physician Examinations

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

<table>
<thead>
<tr>
<th>Enter Days</th>
<th></th>
</tr>
</thead>
</table>

### O0700. Physician Orders

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

<table>
<thead>
<tr>
<th>Enter Days</th>
<th></th>
</tr>
</thead>
</table>
## 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 individual’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

<table>
<thead>
<tr>
<th>Coding</th>
<th>Used in Bed</th>
<th>Used in Chair or Out of Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Not used</td>
<td>A. Bed rail</td>
<td>E. Trunk restraint</td>
</tr>
<tr>
<td>1. Used less than daily</td>
<td>B. Trunk restraint</td>
<td>F. Limb restraint</td>
</tr>
<tr>
<td>2. Used daily</td>
<td>C. Limb restraint</td>
<td>G. Chair prevents rising</td>
</tr>
<tr>
<td></td>
<td>D. Other</td>
<td>H. Other</td>
</tr>
</tbody>
</table>

### Section Q  Participation in Assessment and Goal Setting

#### Q0100. Participation in Assessment

- **A. Individual participated in assessment**
  - 0. No
  - 1. Yes

- **B. Family or significant other participated in assessment**
  - 0. No
  - 1. Yes
  - 9. No family or significant other available

- **C. Guardian or legally authorized representative participated in assessment**
  - 0. No
  - 1. Yes
  - 9. No guardian or legally authorized representative available

#### Q0300. Individual’s Overall Expectation
Complete only if A0310A = 01

- **A. Select one for individual’s overall goal established during assessment process**
  - 1. Expects to be discharged to the home (i.e. currently in ALF)
  - 2. Expects to remain in the home
  - 3. Expects to be transferred to a facility/institution
  - 9. Unknown or uncertain

- **B. Indicate information source for Q0300A**
  - 1. Individual
  - 2. If not individual, then family or significant other
  - 3. If not individual, family, or significant other, then guardian or legally authorized representative
  - 9. Unknown or uncertain
<table>
<thead>
<tr>
<th>A. Signature</th>
<th>B. Date Assessment Completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
</tr>
</tbody>
</table>

**Section Z Assessment Administration**

**Z0500. Signature of RN Completing Assessment**

A. Signature

B. Date Assessment Completed:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**LTC Medicaid Information**

### S1. Medicaid Information

<table>
<thead>
<tr>
<th>S1a</th>
<th>Medicaid Client Indicator</th>
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<tbody>
<tr>
<td>1</td>
<td>Medicaid</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>S1b</th>
<th>Individual Address</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>S1c</th>
<th>City</th>
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<table>
<thead>
<tr>
<th>S1d</th>
<th>State</th>
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</table>

<table>
<thead>
<tr>
<th>S1e</th>
<th>ZIP Code</th>
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</table>

<table>
<thead>
<tr>
<th>S1f</th>
<th>Phone</th>
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### S2. Claims Processing Information

<table>
<thead>
<tr>
<th>S2a</th>
<th>DADS Vendor/Site ID Number</th>
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<table>
<thead>
<tr>
<th>S2b</th>
<th>Contract/Provider Number</th>
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<table>
<thead>
<tr>
<th>S2c</th>
<th>Service Group</th>
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<table>
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<tr>
<th>S2d</th>
<th>NPI Number</th>
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<table>
<thead>
<tr>
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<th>Region</th>
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<th>Purpose Code</th>
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<th>HHA License #</th>
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<table>
<thead>
<tr>
<th>S2h</th>
<th>HHA License # Expiration Date</th>
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</table>

### S3. Primary Diagnosis

<table>
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<tr>
<th>S3a</th>
<th>Primary Diagnosis ICD Code</th>
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<table>
<thead>
<tr>
<th>S3b</th>
<th>Primary Diagnosis ICD Description</th>
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### S4. For DADS use only

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<table>
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<tr>
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<th>RUG</th>
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<th>Expiration Date</th>
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<th>S4f</th>
<th>DADS RN Signature</th>
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<table>
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<tr>
<th>S4g</th>
<th>Signature Date</th>
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### S5. Licenses

**Certification:** To the best of my knowledge, I certify to the accuracy and completeness of this information.

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<tr>
<th>S5a</th>
<th>HHA RN Last Name</th>
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<table>
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<tr>
<th>S5b</th>
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<table>
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<tr>
<th>S5c</th>
<th>HHA RN License State</th>
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<table>
<thead>
<tr>
<th>S5d</th>
<th>DADS RN Last Name</th>
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</thead>
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<table>
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<tr>
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<th>S5f</th>
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<th>PACE RN License State</th>
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<th>S5k</th>
<th>HMO RN Last Name</th>
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<table>
<thead>
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### S6. Additional MN Information

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<tr>
<th>S6a</th>
<th>Tracheostomy Care</th>
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<table>
<thead>
<tr>
<th>S6b</th>
<th>Ventilator/Respirator</th>
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<th>S6c</th>
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<th>S6d</th>
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<table>
<thead>
<tr>
<th>S6e</th>
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<table>
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<tr>
<th>S6f</th>
<th>4. Twice a day</th>
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<th>S6g</th>
<th>5. 3 - 11 times a day</th>
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</thead>
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<table>
<thead>
<tr>
<th>S6h</th>
<th>6. Every 2 hours</th>
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<table>
<thead>
<tr>
<th>S6i</th>
<th>7. Hourly / continuous</th>
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<thead>
<tr>
<th>S6l</th>
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<th>6. Every 2 hours</th>
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<th>S6t</th>
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<table>
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<tr>
<th>S9</th>
<th>6. Every 2 hours</th>
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<table>
<thead>
<tr>
<th>S10</th>
<th>7. Hourly / continuous</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>S11</th>
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<tr>
<th>S12</th>
<th>2. 1 to 6 times a week</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>S13</th>
<th>3. Once a day</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>S14</th>
<th>4. Twice a day</th>
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<table>
<thead>
<tr>
<th>S15</th>
<th>5. 3 - 11 times a day</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>S16</th>
<th>6. Every 2 hours</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>S17</th>
<th>7. Hourly / continuous</th>
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</thead>
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<thead>
<tr>
<th>S18</th>
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</thead>
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<table>
<thead>
<tr>
<th>S19</th>
<th>2. 1 to 6 times a week</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>S20</th>
<th>3. Once a day</th>
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<table>
<thead>
<tr>
<th>S21</th>
<th>4. Twice a day</th>
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<table>
<thead>
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<th>S22</th>
<th>5. 3 - 11 times a day</th>
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</thead>
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<table>
<thead>
<tr>
<th>S23</th>
<th>6. Every 2 hours</th>
</tr>
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<table>
<thead>
<tr>
<th>S24</th>
<th>7. Hourly / continuous</th>
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<table>
<thead>
<tr>
<th>S25</th>
<th>1. Less than once a week</th>
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<table>
<thead>
<tr>
<th>S26</th>
<th>2. 1 to 6 times a week</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>S27</th>
<th>3. Once a day</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>S28</th>
<th>4. Twice a day</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>S29</th>
<th>5. 3 - 11 times a day</th>
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</thead>
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<table>
<thead>
<tr>
<th>S30</th>
<th>6. Every 2 hours</th>
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</table>

<table>
<thead>
<tr>
<th>S31</th>
<th>7. Hourly / continuous</th>
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## LTC Medicaid Information

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<tr>
<th>S6c</th>
<th>Number of hospitalizations in the last 90 days</th>
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</thead>
<tbody>
<tr>
<td>S6d</td>
<td>Number of emergency room visits in the last 90 days</td>
</tr>
</tbody>
</table>
| S6e | Oxygen Therapy  
1. Less than once a week  
2. 1 to 6 times a week  
3. Once a day  
4. Twice a day  
5. 3 - 11 times a day  
6. 6 - 23 hours  
7. 24-hour continuous |
| S6f | Special Ports/Central Lines/PICC  
Y/N/U |
| S6g | At what developmental level is the individual functioning?  
1. < 1 Infant  
2. 1 - 2 Toddler  
3. 3 - 5 Pre-School  
4. 6 - 10 School age  
5. 11 - 15 Young Adolescence  
6. 16 - 20 Older Adolescence  
- Unknown or unable to assess |
| S6h | Enter the number of times this individual has fallen in the last 90 days |
| S6i | In how many of the falls listed above was the person physically restrained prior to the fall? |
| S6j | In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)  
1. Environmental (debris, slick or wet floors, lighting, etc.)  
2. Medication(s)  
3. Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)  
4. Poor Balance/Weakness  
5. Confusion/Disorientation  
6. Assault by Individual or Caregiver |

## S7. Physician’s Evaluation & Recommendation

| S7a | Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO?  
Y/N |
| S7b | Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual?  
Y/N |
| S7c | MD/DO Last Name |
| S7d | MD/DO License # |
| S7e | MD/DO License State |
| S7f | MD/DO First Name |
| S7g | MD/DO Address |
| S7h | MD/DO City |
| S7i | MD/DO State |
| S7j | MD/DO ZIP Code |
| S7k | MD/DO Phone |

Indicate Physician Signature on file by checking box  
(Required for Initial Assessments)
LTC Medicaid Information

59. Medications
List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

- Medication Certification: I certify this individual is taking no medications OR the medications listed below are correct.

<table>
<thead>
<tr>
<th>1. Medication Name and Dose Ordered</th>
<th>2. RA</th>
<th>3. Freq</th>
<th>4. PRN-n</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
## LTC Medicaid Information

### S10. Comments

### S11. Advance Care Planning

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>S11a</td>
<td>Does the individual/caregiver report having a legally authorized representative?</td>
<td></td>
</tr>
<tr>
<td>S11b</td>
<td>Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates?</td>
<td></td>
</tr>
<tr>
<td>S11c</td>
<td>Does the individual/caregiver report having a Medical Power of Attorney?</td>
<td></td>
</tr>
<tr>
<td>S11d</td>
<td>Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order?</td>
<td></td>
</tr>
</tbody>
</table>

### S12. LAR Address

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S12a</td>
<td>LAR First Name</td>
</tr>
<tr>
<td>S12b</td>
<td>LAR Last Name</td>
</tr>
<tr>
<td>S12c</td>
<td>Address</td>
</tr>
<tr>
<td>S12d</td>
<td>City</td>
</tr>
<tr>
<td>S12e</td>
<td>State</td>
</tr>
<tr>
<td>S12f</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>S12g</td>
<td>Phone</td>
</tr>
</tbody>
</table>
Addendum
Enter a Note When Inactivating MN/LOC Assessments

Effective July 27, 2012, when inactivating MN/LOC Assessments (2.0 and 3.0), a note must be entered identifying why the form or screening was inactivated. This note will be added to the History trail. The steps to inactivate an assessment have been updated in the “Inactivations” section of this User Guide as follows:

How to Inactivate

1. Log in to the LTC Online Portal.
2. Click the Form Status Inquiry or Current Activity link in the blue navigational bar.
3. Click the View Detail link.
4. Click the “Inactivate Form” button.
5. Click the “OK” button when the pop-up window asks “Are you sure you want to Inactivate this form? If so, click ‘Ok’ and enter a note to explain the reason for inactivation.”
6. When the Change Status window appears, enter a note for the inactivation and click the “Change Status” button. The assessment will be set to status “Form Inactivated” and cannot be reactivated.

Addendum added 08/03/2012.
Addendum

MN/LOC Assessment 3.0 Field Updates

Effective October 25, 2012, the current wording for fields G0110 and G0120 on the MN/LOC Assessment – Version 3.0 has been updated and is included in the following pages. The change of wording to coding option 8 in fields G0110 (1), G0110 (2), and G0120 are listed below. A copy of the Assessment (version 14) is available at www.tmhp.com/Pages/LTC/ltc_forms.aspx.

<table>
<thead>
<tr>
<th>Field</th>
<th>Coding Option</th>
<th>Current Wording for the Coding Option</th>
<th>Updated Wording for the Coding Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0110 (1) ADL Self-Performance</td>
<td>8</td>
<td>Activity did not occur - activity did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period</td>
<td>Activity did not occur – activity (or any part of the ADL) was not performed by individual or caregiver at all over the entire 7-day period</td>
</tr>
<tr>
<td>(User Guide Appendix C, Page 10 of 31)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0110 (2) ADL Support Provided</td>
<td>8</td>
<td>ADL activity itself did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period</td>
<td>ADL activity itself did not occur during entire period</td>
</tr>
<tr>
<td>(User Guide Appendix C, Page 10 of 31)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0120 Bathing</td>
<td>8</td>
<td>Activity itself did not occur or family and/or caregiver provided care 100% of the time for that activity over the entire 7-day period</td>
<td>Activity itself did not occur during the entire period</td>
</tr>
<tr>
<td>(User Guide Appendix C, Page 11 of 31)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Addendum added 10/25/2012.
### Section A  Identification Information

#### A0310. Type of Assessment

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Reason for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01. Initial assessment</td>
</tr>
<tr>
<td></td>
<td>03. Annual assessment</td>
</tr>
<tr>
<td></td>
<td>04. Significant change in status assessment</td>
</tr>
</tbody>
</table>

#### A0500. Legal Name of Individual

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. First name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Middle initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Last name:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>D. Suffix:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

#### A0600. Social Security and Medicare Numbers

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Medicare number (or comparable railroad insurance number):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A0700. Medicaid Number – Enter “+” if pending, “N” if not a Medicaid recipient

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
</table>

#### A0800. Gender

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>2. Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A0900. Birth Date

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

#### A1000. Race/Ethnicity

↓ Check all that apply

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. American Indian or Alaska Native</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Asian</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>D. Hispanic or Latino</th>
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</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>E. Native Hawaiian or Other Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>F. White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section A  Identification Information

#### A1100. Language

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the individual need or want an interpreter to communicate with a doctor or health care staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Specify in A1100B, Preferred language</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Preferred language:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

#### A1300. Optional Individual Items

<table>
<thead>
<tr>
<th>B. Room number:</th>
</tr>
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<tbody>
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<td></td>
</tr>
</tbody>
</table>

#### A1550. Conditions Related to IDD Status

Check all conditions that are related to IDD status that were manifested before age 22, and are likely to continue indefinitely.

- [ ] A. Down syndrome
- [ ] B. Autism
- [ ] C. Epilepsy
- [ ] D. Other organic condition related to IDD

**IDD Without Organic Condition**

- [ ] E. IDD with no organic condition
- [ ] No IDD
- [ ] Z. None of the above

#### A2300. Assessment Date

Observation end date:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section B  Hearing, Speech, and Vision

#### B0100. Comatose
- **Enter Code**
  - **Persistent vegetative state/no discernible consciousness**
    - **Code:**
      - 0. *No* → Continue to B0200, Hearing
      - 1. *Yes* → Skip to G0100, Activities of Daily Living (ADL) Assistance

#### B0200. Hearing
- **Enter Code**
  - **Ability to hear (with hearing aid or hearing appliances if normally used)**
    - **Code:**
      - 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
    - **Code:**
      - 0. *No*
      - 1. *Yes*

#### B0600. Speech Clarity
- **Enter Code**
  - **Select best description of speech pattern**
    - **Code:**
      - 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. Enter '-' Dash if unable to assess.**
    - **Code:**
      - 0. *Understood* – clear comprehension
      - 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*

#### B0799. Modes of Expression
- **Check all used by individual to make needs known**
  - **A.** Speech
  - **B.** Writing messages to express or clarify needs
  - **C.** American sign language or Braille
  - **D.** Signs/ Gestures/ Sounds
  - **E.** Communication Board
  - **F.** Voice Modulator
  - **G.** Other
  - **Z.** None of the above

#### B0800. Ability To Understand Others
- **Enter Code**
  - **Understanding verbal content, however able (with hearing aid or device if used). Enter '-' Dash if unable to assess.**
    - **Code:**
      - 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)**
    - **Code:**
      - 0. *Adequate* – sees fine detail, such as 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
    - **Code:**
      - 0. *No*
      - 1. *Yes*
## Cognitive Patterns

### C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? – Attempt to conduct interview with the individual

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No (individual is rarely/never understood) OR individual is less than 7 years of age, skip to and complete C0700-C1000, Caregiver Assessment for Mental Status</td>
</tr>
</tbody>
</table>

1. Yes → Continue to C0200, Repetition of Three Words

### Brief Interview for Mental Status (BIMS)

#### C0200. Repetition of Three Words

Ask individual: *"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 ‘-’ Dash if unable to assess.

<table>
<thead>
<tr>
<th>Number of words repeated after first attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

After the individual'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 individual: "*Please tell me what year it is right now.*" Enter ‘-’ Dash if unable to assess.

<table>
<thead>
<tr>
<th>A. Able to report correct year</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Ask individual: "*What month are we in right now?*" Enter ‘-’ Dash if unable to assess.

<table>
<thead>
<tr>
<th>B. Able to report correct month</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

Ask individual: "*What day of the week is today?*" Enter ‘-’ Dash if unable to assess.

<table>
<thead>
<tr>
<th>C. Able to report correct day of the week</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

#### C0400. Recall

Ask individual: "*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 ‘-’ Dash if unable to assess.

<table>
<thead>
<tr>
<th>A. Able to recall “sock”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Able to recall “blue”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Able to recall “bed”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

#### C0500. Summary Score

The sum of the scores for questions C0200–C0400. The sum should be a number (00–15)

A score of 99 indicates that the individual was unable to complete the interview.
## Cognitive Patterns

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

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>(Individual was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium</td>
</tr>
<tr>
<td>1. Yes</td>
<td>(Individual was unable to complete interview OR individual is less than 7 years of age) → Continue to C0700, Short-term Memory OK</td>
</tr>
</tbody>
</table>

### Caregiver Assessment for Mental Status

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

#### C0700. Short-term Memory OK

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems or appears to recall after 5 minutes. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.</td>
<td>0. Memory OK</td>
</tr>
<tr>
<td>1. Memory problem</td>
<td></td>
</tr>
</tbody>
</table>

#### C0800. Long-term Memory OK

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seems or appears to recall long past. Enter '-' Dash if unable to assess OR individual is less than 2 years of age.</td>
<td>0. Memory OK</td>
</tr>
<tr>
<td>1. Memory problem</td>
<td></td>
</tr>
</tbody>
</table>

#### C0900. Memory/Recall Ability

↓ Check all that the individual was normally able to recall

- A. Current season
- B. Location of own room
- C. Caregiver names and faces
- D. That he or she is in their own home/room
- Z. None of the above were recalled

#### C1000. Cognitive Skills for Daily Decision Making

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made decisions regarding tasks of daily life</td>
<td>0. Independent – decisions consistent/reasonable</td>
</tr>
<tr>
<td>1. Modified independence – some difficulty in new situations only</td>
<td></td>
</tr>
<tr>
<td>2. Moderately impaired – decisions poor; cues/supervision required</td>
<td></td>
</tr>
<tr>
<td>3. Severely impaired – never/rarely made decisions</td>
<td></td>
</tr>
</tbody>
</table>

### Delirium

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

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

<table>
<thead>
<tr>
<th>Coding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Behavior not present</td>
</tr>
<tr>
<td>1. Behavior continuously present, does not fluctuate</td>
</tr>
<tr>
<td>2. Behavior present, fluctuates (comes and goes, changes in severity)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>↓ Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inattention – Did the individual have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?</td>
</tr>
<tr>
<td>B. Disorganized thinking – Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? Enter '-' Dash if unable to assess.</td>
</tr>
<tr>
<td>C. Altered level of consciousness – Did the individual 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)?</td>
</tr>
<tr>
<td>D. Psychomotor retardation – Did the individual have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?</td>
</tr>
</tbody>
</table>

### C1600. Acute Onset Mental Status Change

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there evidence of an acute change in mental status from the individual’s baseline?</td>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

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Section D  Mood

D0100. Should Individual Mood Interview be Conducted? – Attempt to conduct interview with the individual

- Enter 0. No (Individual is rarely/never understood) OR individual is less than 7 years of age → Skip to and complete D0500 -D0600, Caregiver Assessment of Individual Mood (PHQ-9-OV)
- Enter 1. Yes → Continue to D0200, Individual Mood Interview (PHQ-9©)

D0200. Individual Mood Interview (PHQ-9©)

Say to individual: “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 individual: “About how often have you been bothered by this?”

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

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2–6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7–11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

↓ 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

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-27)

A score of 99 indicates that the individual was 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 individual self harm

Enter Score

Was responsible caregiver, provider or appropriate entity informed that there is a potential for individual self harm?

- Enter 0. No
- Enter 1. Yes

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### Section D  Mood

**D0500. Caregiver Assessment of Individual Mood (PHQ-9-OV*)**

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

*Over the last 2 weeks, did the individual 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.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2–6 days (several days)</td>
</tr>
<tr>
<td></td>
<td>2. 7–11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

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**

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-30).

**D0650. Safety Notification** — Complete only if D0500I1 = 1 indicating possibility of individual self harm

Enter Code

Was responsible caregiver, provider or appropriate entity informed that there is a potential for individual self harm?

0. No
1. Yes

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### E0100. Potential Indicators of Psychosis

**Check all that apply**

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

### Behavioral Symptoms

#### E0200. Behavioral Symptom – Presence & Frequency

**Note presence of symptoms and their frequency**

**Coding:**

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

**Enter 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 Individual

**Enter Code**

- Did any of the identified symptom(s):
  - A. Put the individual at significant risk for physical illness or injury?
    - 0. No
    - 1. Yes
  - B. Significantly interfere with the individual’s care?
    - 0. No
    - 1. Yes
  - C. Significantly interfere with the individual’s participation in activities or social interactions?
    - 0. No
    - 1. Yes

#### E0600. Impact on Others

**Enter Code**

- Did any of the identified symptom(s):
  - A. Put others at significant risk for physical injury?
    - 0. No
    - 1. Yes
  - B. Significantly intrude on the privacy or activity of others?
    - 0. No
    - 1. Yes
  - C. Significantly disrupt care or living environment?
    - 0. No
    - 1. Yes

#### E0800. Rejection of Care – Presence & Frequency

**Enter Code**

- Did the individual reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual’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 individual or family), and determined to be consistent with individual 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

---

MN and LOC 3.0 V.14 8 of 31
## Section E  Behavior

### E0900. Wandering – Presence & Frequency

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the individual wandered?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms</td>
</tr>
<tr>
<td></td>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td></td>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td></td>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>

### E1000. Wandering – Impact

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the wandering place the individual at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the residence/facility)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Does the wandering significantly intrude on the privacy or activities of others?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

### E1100. Change in Behavior or Other Symptoms – Consider all of the symptoms assessed in items E0100 through E1000.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>How does individual’s current behavior status, care rejection, or wandering compare to prior assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Same</td>
</tr>
<tr>
<td></td>
<td>1. Improved</td>
</tr>
<tr>
<td></td>
<td>2. Worse</td>
</tr>
<tr>
<td></td>
<td>3. N/A because no prior assessment</td>
</tr>
</tbody>
</table>
### G0110. Activities of Daily Living (ADL) Assistance

#### 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 caregiver performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full caregiver 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 individual's performance - 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 caregiver performance every time.

**Coding:**

- **Activity Occurred 3 or More Times**
  0. Independent - no help or caregiver oversight at any time
  1. Supervision - oversight, encouragement or cueing
  2. Limited assistance - individual highly involved in activity; caregiver provide guided maneuvering of limbs or other non-weight-bearing assistance
  3. Extensive assistance - individual involved in activity, caregiver provide weight-bearing support
  4. Total dependence - full caregiver 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 individual or caregiver at all over the entire 7-day period

#### Self-Performance

- **A. Bed mobility** - how individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture
- **B. Transfer** - how individual moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)
- **C. Walk in room** - how individual walks between locations in room
- **D. Walk in home** - how individual walks in home or community setting
- **E. Locomotion in room** - how individual moves between locations in his/her room and adjacent hallway on same floor. If in wheelchair, self-sufficiency once in chair
- **F. Locomotion in home** - how individual moves to and returns from distant areas in his/her home or community setting. If in wheelchair, self-sufficiency once in chair
- **G. Dressing** - how individual 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 individual 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 individual 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 individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)

### 2. ADL Support Provided

Code for most support provided; code regardless of individual's self-performance classification

**Coding:**

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

---

**Enter Codes in Boxes**

<table>
<thead>
<tr>
<th>1. Self-Performance</th>
<th>2. Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section G  Functional Status**

### G0120. Bathing
How individual 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Self-performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Independent – no help provided</td>
</tr>
<tr>
<td></td>
<td>1. Supervision – oversight help only</td>
</tr>
<tr>
<td></td>
<td>2. Physical help limited to transfer only</td>
</tr>
<tr>
<td></td>
<td>3. Physical help in part of bathing activity</td>
</tr>
<tr>
<td></td>
<td>4. Total dependence</td>
</tr>
<tr>
<td></td>
<td>8. Activity itself did not occur during the entire period</td>
</tr>
</tbody>
</table>

### G0300. Balance During Transitions and Walking
After observing the individual, code the following walking and transition items for most dependent

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Bathing support codes are as defined in Item G0110 column 2, ADL Support Provided, above)</td>
</tr>
</tbody>
</table>

### G0400. Functional Limitation in Range of Motion
Code for limitation that interfered with daily functions or placed individual at risk of injury

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Upper extremity (shoulder, elbow, wrist, hand)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. Lower extremity (hip, knee, ankle, foot)</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Individual believes he or she is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Caregiver believes individual is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
### 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**

- Current continence promotion program or trial – Is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence?

  0. No
  
  1. Yes

**H0300. Urinary Continence**

- Urinary continence – Select the one category that best describes the individual

  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, individual had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

**H0400. Bowel Continence**

- Bowel continence – Select the one category that best describes the individual

  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, individual had an ostomy or did not have a bowel movement for the entire 7 days

**H0500. Bowel Continence Program**

- Is an individualized continence promotion program currently being used to manage the individual’s bowel continence?

  0. No
  
  1. Yes

**H0600. Bowel Patterns**

- Constipation present?

  0. No
  
  1. Yes
## Section I  
### Active Diagnoses

**Active Diagnoses in the last 7 days – Check all that apply**

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists.

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnosis</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong></td>
<td>I0100. Cancer</td>
<td>(with or without metastasis)</td>
</tr>
<tr>
<td><strong>Heart/Circulation</strong></td>
<td>I0200. Anemia</td>
<td>(e.g., aplastic, iron deficiency, pernicious, and sickle cell)</td>
</tr>
<tr>
<td></td>
<td>I0300. Atrial Fibrillation or Other Dysrhythmias</td>
<td>(e.g., bradycardias and tachycardias)</td>
</tr>
<tr>
<td></td>
<td>I0400. Coronary Artery Disease (CAD)</td>
<td>(e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))</td>
</tr>
<tr>
<td></td>
<td>I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0600. Heart Failure</td>
<td>(e.g., congestive heart failure (CHF) and pulmonary edema)</td>
</tr>
<tr>
<td></td>
<td>I0700. Hypertension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0799a. Blood Pressure Reading # 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0799b. Blood Pressure Reading # 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0800. Orthostatic Hypotension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0899a. Blood Pressure Reading # 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0899b. Blood Pressure Reading # 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I0999. Peripheral Edema</td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>I1100. Cirrhosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer</td>
<td>(e.g., esophageal, gastric, and peptic ulcers)</td>
</tr>
<tr>
<td></td>
<td>I1300. Ulcerative Colitis, Crohn’s Disease, or Inflammatory Bowel Disease</td>
<td></td>
</tr>
<tr>
<td><strong>Genitourinary</strong></td>
<td>I1400. Benign Prostatic Hyperplasia (BPH)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1550. Neurogenic Bladder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I1650. Obstructive Uropathy</td>
<td></td>
</tr>
<tr>
<td><strong>Infections</strong></td>
<td>I1700. Multidrug-Resistant Organism (MDRO)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2000. Pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2100. Septicemia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2200. Tuberculosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I2400. Viral Hepatitis</td>
<td>(e.g., Hepatitis A, B, C, D, and E)</td>
</tr>
<tr>
<td></td>
<td>I2500. Wound Infection</td>
<td>(other than foot)</td>
</tr>
<tr>
<td><strong>Metabolic</strong></td>
<td>I2900. Diabetes Mellitus (DM)</td>
<td>(e.g., diabetic retinopathy, nephropathy, and neuropathy)</td>
</tr>
<tr>
<td></td>
<td>I2999. Blood Sugar Range</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I3100. Hyponatremia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I3200. Hyperkalemia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I3300. Hyperlipidemia</td>
<td>(e.g., hypercholesterolemia)</td>
</tr>
<tr>
<td></td>
<td>I3400. Thyroid Disorder</td>
<td>(e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)</td>
</tr>
</tbody>
</table>
## 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.

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Neurological</th>
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<table>
<thead>
<tr>
<th>I5499. Type of Seizure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>□</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>I5499C. Average Frequency of Seizures in the last 7 days</th>
</tr>
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<tbody>
<tr>
<td></td>
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<th>Enter Code</th>
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</table>

| □ | I5500. Traumatic Brain Injury (TBI) |
| □ | I5599. Spina Bifida |
## Section I  Active Diagnoses

### Active Diagnoses in the last 7 days – Check all that apply

<table>
<thead>
<tr>
<th>Nutritional</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I5600. Malnutrition</td>
<td>(protein or calorie) or at risk for malnutrition</td>
</tr>
<tr>
<td>I5699. At risk for dehydration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric/Mood Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>I5700. Anxiety Disorder</td>
</tr>
<tr>
<td>I5800. Depression (other than bipolar)</td>
</tr>
<tr>
<td>I5900. Manic Depression (bipolar disease)</td>
</tr>
<tr>
<td>I5950. Psychotic Disorder (other than schizophrenia)</td>
</tr>
<tr>
<td>I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)</td>
</tr>
<tr>
<td>I6100. Post Traumatic Stress Disorder (PTSD)</td>
</tr>
<tr>
<td>I6199. ADHD Syndrome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)</td>
</tr>
<tr>
<td>I6299. Cystic Fibrosis</td>
</tr>
<tr>
<td>I6300. Respiratory Failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6500. Cataracts, Glaucoma, or Macular Degeneration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None of Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>I7900. None of the above active diagnoses within the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I8000. Additional active diagnoses</td>
</tr>
</tbody>
</table>

Enter diagnosis description and ICD code.

<table>
<thead>
<tr>
<th>A.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>B.</td>
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<tr>
<td></td>
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<tr>
<td>C.</td>
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<td>D.</td>
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<td>G.</td>
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<td>H.</td>
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<tr>
<td>I.</td>
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<td></td>
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<tr>
<td>J.</td>
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</tr>
</tbody>
</table>
Section J  Health Conditions

J0100. Pain Management – Complete for the individual, regardless of current pain level

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

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

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

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

J0200. Should Pain Assessment Interview be Conducted? – Attempt to conduct interview with the individual.

If individual is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter
Code
0. No (individual is rarely/never understood OR individual is less than 3 years of age) → Skip to J0800, Indicators of Pain or Possible Pain
1. Yes → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter
Code
Ask individual: “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 individual: “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

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

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

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

A. Numeric Rating Scale (00–10)
   Ask individual: “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 individual 00-10 pain scale)
   Enter two-digit response. Enter 99 if unable to answer.

B. Verbal Descriptor Scale
   Ask individual: “Please rate the intensity of your worst pain over the last 5 days.” (Show individual verbal scale)
   1. Mild
   2. Moderate
   3. Severe
   4. Very severe, horrible
   9. Unable to answer
### Section J  Health Conditions

#### J0700. Should the Caregiver Assessment for Pain be Conducted?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>No (J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)</td>
</tr>
<tr>
<td>1.</td>
<td>Yes (J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

#### Caregiver Assessment for Pain

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

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)</td>
</tr>
<tr>
<td>B. Vocal complaints of pain (e.g., that hurts, ouch, stop)</td>
</tr>
<tr>
<td>C. Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency with which individual complains or shows evidence of pain or possible pain</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Indicators of pain or possible pain observed 1 to 2 days</td>
</tr>
<tr>
<td>2.</td>
<td>Indicators of pain or possible pain observed 3 to 4 days</td>
</tr>
<tr>
<td>3.</td>
<td>Indicators of pain or possible pain observed daily</td>
</tr>
</tbody>
</table>

#### Other Health Conditions

**J1100. Shortness of Breath (dyspnea)**

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring)</td>
</tr>
<tr>
<td>B. Shortness of breath or trouble breathing when sitting at rest</td>
</tr>
<tr>
<td>C. Shortness of breath or trouble breathing when lying flat</td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>

#### J1400. Prognosis

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the individual have a condition or chronic disease that may result in a life expectancy of less than 6 months?</td>
<td></td>
</tr>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### J1550. Problem Conditions

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Fever</td>
</tr>
<tr>
<td>B. Vomiting</td>
</tr>
<tr>
<td>C. Dehydrated</td>
</tr>
<tr>
<td>D. Internal bleeding</td>
</tr>
<tr>
<td>E99. Syncope</td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>
Section J  Health Conditions

J1700. Fall History

Enter Code

A. Did the individual have a fall any time in the last month?

0. No
1. Yes
9. Unable to determine

B. Did the individual have a fall any time in the last 2–6 months?

0. No
1. Yes
9. Unable to determine

C. Did the individual have any fracture related to a fall in the last 6 months?

0. No
1. Yes
9. Unable to determine

J1900. Number of Falls in the last 6 months with or without injury

Complete only if J1700A or J1700B = 1

↓ Enter Codes in Boxes

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

A. No injury – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/caregiver.

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

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

Section K  Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

↓ Check all that apply

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

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

A. Height (in inches). Record most recent height measure.

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.). Enter '-' Dash if unable to assess.

K0300. Weight Loss

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
### Section K  Swallowing/Nutritional Status

**K0310. Weight Gain**
- Gain of 5% or more in the last month or gain of 10% or more in last 6 months
  - 0. No or unknown
  - 1. Yes, on physician-prescribed weight-gain regimen
  - 2. Yes, not on physician-prescribed weight-gain regimen

**K0510. Nutritional Approaches**
- Check all of the following nutritional approaches that were performed during the last 7 days
  - 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 K0510A or K0510B is checked
  - A. Proportion of total calories the individual received through parenteral or tube feeding
    1. 25% or less
    2. 26–50%
    3. 51% or more
  - B. Average fluid intake per day by IV or tube feeding
    1. 500 cc/day or less
    2. 501 cc/day or more

### Section L  Oral/Dental Status

**L0200. Dental**
- 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
Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.

### Section M - Skin Conditions

#### M0100. Determination of Pressure Ulcer Risk

- **A.** Individual 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

Check all that apply:
- Is this individual at risk of developing pressure ulcers?
  - **0.** No
  - **1.** Yes

#### M0210. Unhealed Pressure Ulcer(s)

- Does this individual have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
  - **0.** No → skip to M01030, Number of Venous and Arterial 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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Stage 1</td>
<td>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</td>
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<tr>
<td><strong>B.</strong> Stage 2</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td><strong>C.</strong> Stage 3</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td><strong>D.</strong> Stage 4</td>
<td>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</td>
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</tr>
<tr>
<td><strong>E.</strong> Unstageable – Non-removable dressing</td>
<td>Known but not stageable due to non-removable dressing/device</td>
<td></td>
</tr>
<tr>
<td><strong>F.</strong> Unstageable – Slough and/or eschar</td>
<td>Known but not stageable due to coverage of wound bed by slough and/or eschar</td>
<td></td>
</tr>
<tr>
<td><strong>G.</strong> Unstageable – Deep tissue</td>
<td>Suspected deep tissue injury in evolution</td>
<td></td>
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</tbody>
</table>
# Section M  Skin Conditions

## 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 individual 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:

- **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)
  - 
  - 
  - cm

## M0700. Most Severe Tissue Type for Any Pressure Ulcer

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
5. **None of the Above**

## M1030. Number of Venous and Arterial Ulcers

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)
- **G. Skin tear(s)**
- **H. Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage)

- **None of the Above**
- **Z. None of the above** were present
### Section M  Skin Conditions

#### M1200. Skin and Ulcer Treatments

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

### Section N  Medications

#### N0300. Injections

Enter Days

Record the **number of days that injections of any type were received** during the last 7 days.

If 0 → Skip to N0410, Medications Received

#### N0350. Insulin

Enter Days

- **A.** Insulin injections – Record the **number of days that insulin injections were received** during the last 7 days
- **B.** Orders for insulin – Record the **number of days the physician (or authorized assistant or practitioner) changed the individual’s insulin orders** during the last 7 days

#### N0410. Medications Received

↓ Indicate the number of DAYS the individual received the following medications during the last 7 days.

Enter "0" if medication was not received by the individual during the last 7 days.

- **A.** Antipsychotic
- **B.** Antianxiety
- **C.** Antidepressant
- **D.** Hypnotic
- **E.** Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
- **F.** Antibiotic
- **G.** Diuretic
<table>
<thead>
<tr>
<th>O0100. Special Treatments, Procedures, and Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all of the following treatments, procedures, and programs that were performed during the last 14 days</td>
</tr>
<tr>
<td><strong>Check all that apply</strong></td>
</tr>
</tbody>
</table>

**Cancer Treatments**

<table>
<thead>
<tr>
<th>A. Chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Radiation</td>
</tr>
</tbody>
</table>

**Respiratory Treatments**

<table>
<thead>
<tr>
<th>C. Oxygen therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Suctioning</td>
</tr>
<tr>
<td>E. Tracheostomy care</td>
</tr>
<tr>
<td>F. Ventilator or respirator</td>
</tr>
<tr>
<td>G. BiPAP/CPAP</td>
</tr>
</tbody>
</table>

**Other**

<table>
<thead>
<tr>
<th>H. IV medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Transfusions</td>
</tr>
<tr>
<td>J. Dialysis</td>
</tr>
<tr>
<td>K. Hospice care</td>
</tr>
<tr>
<td>L. Respite care</td>
</tr>
<tr>
<td>M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)</td>
</tr>
<tr>
<td>N99. Psychiatric care</td>
</tr>
</tbody>
</table>

**None of the Above**

| Z. None of the above |
### Section O
**Special Treatments, Procedures, and Programs**

#### O0400. Therapies

**A. Speech-Language Pathology and Audiology Services**

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

   If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

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 last assessment) started

   **Month** - **Day** - **Year**

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

   **Month** - **Day** - **Year**

---

**B. Occupational Therapy**

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

   If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

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 last assessment) started

   **Month** - **Day** - **Year**

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

   **Month** - **Day** - **Year**

---

**C. Physical Therapy**

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

   If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

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 last assessment) started

   **Month** - **Day** - **Year**

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

   **Month** - **Day** - **Year**

---

**O0400 continued on next page**
**Section O  Special Treatments, Procedures, and Programs**

**O0400. Therapies - Continued**

**D. Respiratory Therapy**

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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)**

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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)**

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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).

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

**O0600. Physician Examinations**

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

**O0700. Physician Orders**

Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the individual’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 individual’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used in Bed</strong></td>
</tr>
<tr>
<td>A. Bed rail</td>
</tr>
<tr>
<td>B. Trunk restraint</td>
</tr>
<tr>
<td>C. Limb restraint</td>
</tr>
<tr>
<td>D. Other</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Used in Chair or Out of Bed</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>E. Trunk restraint</td>
</tr>
<tr>
<td>F. Limb restraint</td>
</tr>
<tr>
<td>G. Chair prevents rising</td>
</tr>
<tr>
<td>H. Other</td>
</tr>
</tbody>
</table>

### Section Q  Participation in Assessment and Goal Setting

**Q0100. Participation in Assessment**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Individual participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Family or significant other participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. No family or significant other available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Guardian or legally authorized representative participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. No guardian or legally authorized representative available</td>
</tr>
</tbody>
</table>

**Q0300. Individual’s Overall Expectation**

Complete only if A0310A = 01

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Select one for individual’s overall goal established during assessment process</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Expects to be discharged to the home (i.e. currently in ALF)</td>
</tr>
<tr>
<td></td>
<td>2. Expects to remain in the home</td>
</tr>
<tr>
<td></td>
<td>3. Expects to be transferred to a facility/institution</td>
</tr>
<tr>
<td></td>
<td>9. Unknown or uncertain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Indicate information source for Q0300A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Individual</td>
</tr>
<tr>
<td></td>
<td>2. If not individual, then family or significant other</td>
</tr>
<tr>
<td></td>
<td>3. If not individual, family, or significant other, then guardian or legally authorized representative</td>
</tr>
<tr>
<td></td>
<td>9. Unknown or uncertain</td>
</tr>
</tbody>
</table>
### Section Z  Assessment Administration

<table>
<thead>
<tr>
<th>Z0500. Signature of RN Completing Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Signature</td>
</tr>
<tr>
<td>B. Date Assessment Completed:</td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

**MN and LOC 3.0 V.14**
**LTC Medicaid Information**

### S1. Medicaid Information

<table>
<thead>
<tr>
<th>S1a</th>
<th>Medicaid Client Indicator 1. Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1b</td>
<td>Individual Address</td>
</tr>
<tr>
<td>S1c</td>
<td>City</td>
</tr>
<tr>
<td>S1d</td>
<td>State</td>
</tr>
<tr>
<td>S1e</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>S1f</td>
<td>Phone</td>
</tr>
</tbody>
</table>

### S2. Claims Processing Information

<table>
<thead>
<tr>
<th>S2a</th>
<th>DADS Vendor/Site ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2b</td>
<td>Contract/Provider Number</td>
</tr>
<tr>
<td>S2c</td>
<td>Service Group</td>
</tr>
<tr>
<td></td>
<td>3. CBA</td>
</tr>
<tr>
<td></td>
<td>11. PACE</td>
</tr>
<tr>
<td></td>
<td>17. CWP</td>
</tr>
<tr>
<td></td>
<td>18. MDCP</td>
</tr>
<tr>
<td></td>
<td>19. Star + Plus</td>
</tr>
<tr>
<td>S2d</td>
<td>NPI Number</td>
</tr>
<tr>
<td>S2e</td>
<td>Region</td>
</tr>
<tr>
<td>S2f</td>
<td>Purpose Code</td>
</tr>
<tr>
<td>S2g</td>
<td>HHA License #</td>
</tr>
<tr>
<td>S2h</td>
<td>HHA License # Expiration Date</td>
</tr>
</tbody>
</table>

### S3. Primary Diagnosis

<table>
<thead>
<tr>
<th>S3a</th>
<th>Primary Diagnosis ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>S3b</td>
<td>Primary Diagnosis ICD Description</td>
</tr>
</tbody>
</table>

### S4. For DADS use only

<table>
<thead>
<tr>
<th>S4a</th>
<th>MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>S4b</td>
<td>RUG</td>
</tr>
<tr>
<td>S4c</td>
<td>Effective Date</td>
</tr>
<tr>
<td>S4d</td>
<td>Expiration Date</td>
</tr>
<tr>
<td>S4e</td>
<td>County</td>
</tr>
<tr>
<td>S4f</td>
<td>DADS RN Signature</td>
</tr>
<tr>
<td>S4g</td>
<td>Signature Date</td>
</tr>
</tbody>
</table>

### S5. Licenses

**Certification:** To the best of my knowledge, I certify to the accuracy and completeness of this information.

<table>
<thead>
<tr>
<th>S5a</th>
<th>HHA RN Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5b</td>
<td>HHA RN License #</td>
</tr>
<tr>
<td>S5c</td>
<td>HHA RN License State</td>
</tr>
<tr>
<td>S5d</td>
<td>DADS RN Last Name</td>
</tr>
<tr>
<td>S5e</td>
<td>DADS RN License #</td>
</tr>
<tr>
<td>S5f</td>
<td>DADS RN License State</td>
</tr>
<tr>
<td>S5g</td>
<td>DADS RN Signature Date</td>
</tr>
<tr>
<td>S5h</td>
<td>PACE RN Last Name</td>
</tr>
<tr>
<td>S5i</td>
<td>PACE RN License #</td>
</tr>
<tr>
<td>S5j</td>
<td>PACE RN License State</td>
</tr>
<tr>
<td>S5k</td>
<td>HMO RN Last Name</td>
</tr>
<tr>
<td>S5l</td>
<td>HMO RN License #</td>
</tr>
<tr>
<td>S5m</td>
<td>HMO RN License State</td>
</tr>
</tbody>
</table>

### S6. Additional MN Information

<table>
<thead>
<tr>
<th>S6a</th>
<th>Tracheostomy Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Less than once a week</td>
</tr>
<tr>
<td></td>
<td>2. 1 to 6 times a week</td>
</tr>
<tr>
<td></td>
<td>3. Once a day</td>
</tr>
<tr>
<td></td>
<td>4. Twice a day</td>
</tr>
<tr>
<td></td>
<td>5. 3 - 11 times a day</td>
</tr>
<tr>
<td></td>
<td>6. Every 2 hours</td>
</tr>
<tr>
<td></td>
<td>7. Hourly / continuous</td>
</tr>
<tr>
<td>S6b</td>
<td>Ventilator/Respirator</td>
</tr>
<tr>
<td></td>
<td>1. Less than once a week</td>
</tr>
<tr>
<td></td>
<td>2. 1 to 6 times a week</td>
</tr>
<tr>
<td></td>
<td>3. Once a day</td>
</tr>
<tr>
<td></td>
<td>4. Twice a day</td>
</tr>
<tr>
<td></td>
<td>5. 3 - 11 times a day</td>
</tr>
<tr>
<td></td>
<td>6. 6 - 23 hours</td>
</tr>
<tr>
<td></td>
<td>7. 24-hour continuous</td>
</tr>
</tbody>
</table>
### S7. Physician's Evaluation & Recommendation

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>S7a Did an MD/DO certify that this individual requires nursing facility</td>
<td>Y/N</td>
</tr>
<tr>
<td>services or alternative community based services under the supervision</td>
<td></td>
</tr>
<tr>
<td>of an MD/DO?</td>
<td></td>
</tr>
<tr>
<td>S7b Did a military physician providing healthcare according to requirements</td>
<td></td>
</tr>
<tr>
<td>stipulated in 10 US Code 1094 provide the evaluation and recommendation</td>
<td></td>
</tr>
<tr>
<td>for this individual?</td>
<td></td>
</tr>
<tr>
<td>S7c MD/DO Last Name</td>
<td></td>
</tr>
<tr>
<td>S7d MD/DO License #</td>
<td></td>
</tr>
<tr>
<td>S7e MD/DO License State</td>
<td></td>
</tr>
<tr>
<td>S7f Indicate Physician Signature on file by checking box</td>
<td></td>
</tr>
<tr>
<td>[Required for Initial Assessments]</td>
<td></td>
</tr>
<tr>
<td>The following MD/DO information is required if MD/DO is <strong>not</strong> licensed</td>
<td></td>
</tr>
<tr>
<td>in Texas.</td>
<td></td>
</tr>
<tr>
<td>S7g MD/DO First Name</td>
<td></td>
</tr>
<tr>
<td>S7h MD/DO City</td>
<td></td>
</tr>
<tr>
<td>S7i MD/DO State</td>
<td></td>
</tr>
<tr>
<td>S7j MD/DO ZIP Code</td>
<td></td>
</tr>
<tr>
<td>S7k MD/DO Phone</td>
<td></td>
</tr>
</tbody>
</table>
LTC Medicaid Information

S9. Medications

List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

☐ Medication Certification: I certify this individual is taking no medications OR the medications listed below are correct

<table>
<thead>
<tr>
<th>1. Medication Name and Dose Ordered</th>
<th>2. RA</th>
<th>3. Freq</th>
<th>4. PRN-n</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
**LTC Medicaid Information**

### S10. Comments


### S11. Advance Care Planning

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S11a</td>
<td>Does the individual/caregiver report having a legally authorized representative?</td>
</tr>
<tr>
<td>S11b</td>
<td>Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates?</td>
</tr>
<tr>
<td>S11c</td>
<td>Does the individual/caregiver report having a Medical Power of Attorney?</td>
</tr>
<tr>
<td>S11d</td>
<td>Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order?</td>
</tr>
</tbody>
</table>

### S12. LAR Address

Required if individual/caregiver has reported having a legally authorized representative.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S12a</td>
<td>LAR First Name</td>
</tr>
<tr>
<td>S12b</td>
<td>LAR Last Name</td>
</tr>
<tr>
<td>S12c</td>
<td>Address</td>
</tr>
<tr>
<td>S12d</td>
<td>City</td>
</tr>
<tr>
<td>S12e</td>
<td>State</td>
</tr>
<tr>
<td>S12f</td>
<td>ZIP Code</td>
</tr>
<tr>
<td>S12g</td>
<td>Phone</td>
</tr>
</tbody>
</table>
Addendum
MDS 3.0 and MN/LOC Changes

LTC Online Portal MDS 3.0 and MN/LOC Specification Changes

Effective October 1, 2013, Texas Medicaid & Healthcare Partnership (TMHP) has implemented modifications to the Long Term Care (LTC) Online Portal in support of the federal Centers for Medicare & Medicaid Services changes to the Minimum Data Set (MDS) 3.0 and Medical Necessity and Level of Care (MN/LOC) 3.0 Assessments required on October 1, 2013.

MDS 3.0 Changes:

• Removed K0700 field.
• New field K0710: Percent Intake by Artificial Route. Includes options K0710 A1- K0710 A3, K0710B1-B3
• Modified O0400A3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.
• New field O0400B3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.
• New field O0400C3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.
• New field O0420: Distinct Calendar Days of Therapy – record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.
• On MDS 3.0 NQ only: field H0200A currently present on MDS 3.0 NC will also be added to MDS 3.0 NQ: “Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?”
• Modified M0300: Changes item label from “Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage” to “Current Number of Unhealed Pressure Ulcers at Each Stage.”
• Modified M0210 field text to: “1. Yes - Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage.”
• Deleted M0610: “non-epithelialized” from the field instructions.
• Modified M0700: “Most Severe Tissue Type for Any Pressure Ulcer” field to change Option 4 from “Necrotic tissue (Eschar)” to “Eschar.”
• Modified Q0100B Option 9 to: “Resident has no family or significant other.”
- Modified Q0100C Option 9 to: “Resident has no guardian or legally authorized representative.”
- Modified Q500B: Changed phrase from: “or family or significant other” to “or family or significant other or guardian or legally authorized representative.”
- Modified Q0550A to: “Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)”
- On MDS NC only: Modified O0400F1: instructions must read: “Total minutes – record the total number of minutes this therapy was administered to the individual in the last 7 days. If zero, → skip to O0420, Distinct Calendar Days of Therapy.”

**MN/LOC 3.0 Changes:**

- Modified C1600: Acute Onset Mental Status Change field to enable providers to select the “No information/Not assessed” option.
- Modified G0900B: Functional Rehabilitation Potential field to enable providers to select the “No information/Not assessed” option.
- Removed blood pressure reading fields: I0799b, I0899a, and I0899b.
- New field K0710: “Percent Intake by Artificial Route” field is replacing K0700. It includes K0710A1 through K0710B3.
- Modified M0210: Unhealed Pressure Ulcer to remove “Non-epithelialized” from Option 1.
- Modified M0300: Current Number of Unhealed Pressure Ulcers at Each Stage to remove “Non-epithelialized” from the field label.
- Modified M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar field to remove “Non-epithelialized” from the field instructions.
- Modified M0700: Most Severe Tissue Type for Any Pressure Ulcer field to change Option 4 from “Necrotic tissue (Eschar)” to “Eschar.”
- Modified O0400A3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days.
- New field O0400B3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days.
- New field O0400C3A: Co-treatment minutes – record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 days.
- New field O0420: Distinct Calendar Days of Therapy – record the number of calendar days that the individual received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.
- Modified O0400F1: instructions must read: “Total minutes – record the total number of minutes this therapy was administered to the individual in the last 7 days. If zero, → skip to O0420, Distinct Calendar Days of Therapy.”

For questions about these modifications to the LTC Online Portal, contact the LTC Helpdesk at 1-800-626-4117, Option 1.
### Section A: Identification Information

#### A0050. Type of Record
- **Enter Code**
  - 1. **Add new record**  → Continue to A0100, Facility Provider Numbers
  - 2. **Modify existing record**  → Continue to A0100, Facility Provider Numbers
  - 3. **Inactivate existing record**  → Skip to X0150, Type of Provider

#### A0100. Facility Provider Numbers

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. National Provider Identifier (NPI):</td>
<td></td>
</tr>
<tr>
<td>B. CMS Certification Number (CCN):</td>
<td></td>
</tr>
<tr>
<td>C. State Provider Number:</td>
<td></td>
</tr>
</tbody>
</table>

#### A0200. Type of Provider
- **Enter Code**
  - 1. **Nursing home (SNF/NF)**
  - 2. **Swing Bed**

#### A0310. Type of Assessment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Federal OBRA Reason for Assessment</td>
<td></td>
</tr>
</tbody>
</table>
  - 01. **Admission** assessment (required by day 14)
  - 02. **Quarterly** review assessment
  - 03. **Annual** assessment
  - 04. **Significant change in status** assessment
  - 05. **Significant correction to prior comprehensive** assessment
  - 06. **Significant correction to prior quarterly** assessment
  - 99. **None of the above**

<table>
<thead>
<tr>
<th>B. PPS Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPS Scheduled Assessments for a Medicare Part A Stay</strong></td>
</tr>
</tbody>
</table>
  - 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. **None of the above**

<table>
<thead>
<tr>
<th>C. PPS Other Medicare Required Assessment - OMRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. <strong>No</strong></td>
</tr>
<tr>
<td>1. <strong>Start of therapy</strong> assessment</td>
</tr>
<tr>
<td>2. <strong>End of therapy</strong> assessment</td>
</tr>
<tr>
<td>3. <strong>Both Start and End of therapy</strong> assessment</td>
</tr>
<tr>
<td>4. <strong>Change of therapy</strong> assessment</td>
</tr>
</tbody>
</table>

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

---

A0310 continued on next page
Section A  Identification Information

A0310. Type of Assessment - Continued

E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?

0. No
1. Yes

F. Entry/discharge reporting

01. Entry tracking record
10. Discharge assessment-return not anticipated
11. Discharge assessment-return anticipated
99. None of the above

G. Type of discharge - Complete only if A0310F = 10 or 11

1. Planned
2. Unplanned

A0410. Submission Requirement

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

1. Male
2. Female

A0900. Birth Date

Month - Day - Year

A1000. Race/Ethnicity

Check all that apply

A. American Indian or Alaska Native
B. Asian
C. Black or African American
D. Hispanic or Latino
E. Native Hawaiian or Other Pacific Islander
F. White
### Section A  Identification Information

#### A1100. Language

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes ➔ Specify in A1100B, Preferred language</td>
</tr>
<tr>
<td>9</td>
<td>Unable to determine</td>
</tr>
</tbody>
</table>

| B. Preferred language: | |

#### A1200. Marital Status

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Never married</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Married</td>
</tr>
<tr>
<td>3</td>
<td>Widowed</td>
</tr>
<tr>
<td>4</td>
<td>Separated</td>
</tr>
<tr>
<td>5</td>
<td>Divorced</td>
</tr>
</tbody>
</table>

#### A1300. Optional Resident Items

| A. Medical record number: | |
| B. Room number:           | |
| C. Name by which resident prefers to be addressed: | |
| D. Lifetime occupation(s) - put “/” between two occupations: | |

#### A1500. Preadmission Screening and Resident Review (PASRR)

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (&quot;mental retardation&quot; in federal regulation) or a related condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No ➔ Skip to A1550, Conditions Related to ID/DD Status</td>
</tr>
<tr>
<td>1</td>
<td>Yes ➔ Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</td>
</tr>
<tr>
<td>9</td>
<td>Not a Medicaid-certified unit ➔ Skip to A1550, Conditions Related to ID/DD Status</td>
</tr>
</tbody>
</table>

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

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

Check all that apply

- [ ] A. Serious mental illness
- [ ] B. Intellectual Disability ("mental retardation" in federal regulation)
- [ ] C. Other related conditions
### Section A: Identification Information

#### A1550. Conditions Related to ID/DD Status

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

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

**ID/DD With Organic Condition**

- A. Down syndrome
- B. Autism
- C. Epilepsy
- D. Other organic condition related to ID/DD

**ID/DD Without Organic Condition**

- E. ID/DD with no organic condition
- No ID/DD
- Z. None of the above

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

#### A1700. Type of Entry

1. Admission
2. Reentry

#### A1800. Entered From

Enter Code

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

#### A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

#### A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
08. Deceased
09. Long Term Care Hospital (LTCH)
99. Other
<table>
<thead>
<tr>
<th>Section A</th>
<th>Identification Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A2200. Previous Assessment Reference Date for Significant Correction</strong>&lt;br&gt;Complete only if A0310A = 05 or 06</td>
<td><img src="image" alt="Date fields" /></td>
</tr>
<tr>
<td><strong>A2300. Assessment Reference Date</strong>&lt;br&gt;Observation end date:</td>
<td><img src="image" alt="Date fields" /></td>
</tr>
<tr>
<td><strong>A2400. Medicare Stay</strong>&lt;br&gt;A. Has the resident had a Medicare-covered stay since the most recent entry?&lt;br&gt;0. No — Skip to B0100, Comatose&lt;br&gt;1. Yes — Continue to A2400B, Start date of most recent Medicare stay&lt;br&gt;B. Start date of most recent Medicare stay:</td>
<td><img src="image" alt="Date fields" /></td>
</tr>
<tr>
<td><strong>C. End date of most recent Medicare stay</strong> - Enter dashes if stay is ongoing:</td>
<td><img src="image" alt="Date fields" /></td>
</tr>
</tbody>
</table>
### Section B  
**Hearing, Speech, and Vision**

#### B0100. Comatose
- **Persistent vegetative state/no discernible consciousness**
  - **Enter Code**
  - **No** ➔ Continue to B0200, Hearing
  - **Yes** ➔ Skip to G0110, Activities of Daily Living (ADL) Assistance

#### B0200. Hearing
- **Ability to hear** (with hearing aid or hearing appliances if normally used)
  - **Enter Code**
  - **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
- **Hearing aid or other hearing appliance used** in completing B0200, Hearing
  - **Enter Code**
  - **0. No**
  - **1. Yes**

#### B0600. Speech Clarity
- **Select best description of speech pattern**
  - **Enter Code**
  - **0. Clear speech** - distinct intelligible words
  - **1. Unclear speech** - slurred or mumbled words
  - **2. No speech** - absence of spoken words

#### B0700. Makes Self Understood
- **Ability to express ideas and wants**, consider both verbal and non-verbal expression
  - **Enter Code**
  - **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
- **Understanding verbal content, however able** (with hearing aid or device if used)
  - **Enter Code**
  - **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
- **Ability to see in adequate light** (with glasses or other visual appliances)
  - **Enter Code**
  - **0. Adequate** - sees fine detail, such as 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
- **Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision
  - **Enter Code**
  - **0. No**
  - **1. Yes**
## Section C  Cognitive Patterns

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Skip to and complete C0700-C1000, Staff Assessment for Mental Status</td>
</tr>
<tr>
<td>1</td>
<td>Continue to C0200, Repetition of Three Words</td>
</tr>
</tbody>
</table>

Attempt to conduct interview with all residents.

### 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."

**Number of words repeated after first attempt**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>One</td>
</tr>
<tr>
<td>2</td>
<td>Two</td>
</tr>
<tr>
<td>3</td>
<td>Three</td>
</tr>
</tbody>
</table>

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)

**A.** Able to report correct year

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Missed by &gt; 5 years or no answer</td>
</tr>
<tr>
<td>1</td>
<td>Missed by 2-5 years</td>
</tr>
<tr>
<td>2</td>
<td>Missed by 1 year</td>
</tr>
<tr>
<td>3</td>
<td>Correct</td>
</tr>
</tbody>
</table>

**B.** Able to report correct month

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Missed by &gt; 1 month or no answer</td>
</tr>
<tr>
<td>1</td>
<td>Missed by 6 days to 1 month</td>
</tr>
<tr>
<td>2</td>
<td>Accurate within 5 days</td>
</tr>
</tbody>
</table>

**C.** Able to report correct day of the week

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Incorrect or no answer</td>
</tr>
<tr>
<td>1</td>
<td>Correct</td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>A.</th>
<th>Able to recall &quot;sock&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1</td>
<td>Yes, after cueing (&quot;something to wear&quot;)</td>
</tr>
<tr>
<td>2</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B.</th>
<th>Able to recall &quot;blue&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1</td>
<td>Yes, after cueing (&quot;a color&quot;)</td>
</tr>
<tr>
<td>2</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C.</th>
<th>Able to recall &quot;bed&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1</td>
<td>Yes, after cueing (&quot;a piece of furniture&quot;)</td>
</tr>
<tr>
<td>2</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

#### C0500. Summary 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.
**Section C  Cognitive Patterns**

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. <strong>No</strong> (resident was able to complete interview) ➔ Skip to C1300, Signs and Symptoms of Delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. <strong>Yes</strong> (resident was unable to complete interview) ➔ Continue to C0700, Short-term Memory OK</td>
</tr>
</tbody>
</table>

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

### C0700. Short-term Memory OK

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Seems or appears to recall after 5 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Memory OK</td>
</tr>
<tr>
<td></td>
<td>1. Memory problem</td>
</tr>
</tbody>
</table>

### C0800. Long-term Memory OK

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Seems or appears to recall long past</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Memory OK</td>
</tr>
<tr>
<td></td>
<td>1. Memory problem</td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Made decisions regarding tasks of daily life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Independent - decisions consistent/reasonable</td>
</tr>
<tr>
<td></td>
<td>1. Modified independence - some difficulty in new situations only</td>
</tr>
<tr>
<td></td>
<td>2. Moderately impaired - decisions poor; cues/supervision required</td>
</tr>
<tr>
<td></td>
<td>3. Severely impaired - never/rarely made decisions</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
<th><strong>A.</strong> Inattention - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>B.</strong> 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)?</td>
</tr>
<tr>
<td></td>
<td><strong>C.</strong> 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)?</td>
</tr>
<tr>
<td></td>
<td><strong>D.</strong> 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?</td>
</tr>
</tbody>
</table>

### C1600. Acute Onset Mental Status Change

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Is there evidence of an acute change in mental status from the resident’s baseline?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>
### 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)

| 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

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 | 0. No |
| 1. Yes |
### 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.

<table>
<thead>
<tr>
<th>Symptom Presence</th>
<th>Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td></td>
<td>2. 7-11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12-14 days (nearly every day)</td>
</tr>
</tbody>
</table>

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**

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

Was responsible staff or provider informed that there is a potential for resident self harm?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. No</th>
<th>1. Yes</th>
</tr>
</thead>
</table>

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MDS 3.0 Nursing Home Comprehensive (NC) Version 1.11.2 Effective 10/01/2013
# Section E  Behavior

## E0100. Potential Indicators of Psychosis

Check all that apply

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

## Behavioral Symptoms

### E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

**Coding:**

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

**Enter 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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?</td>
</tr>
<tr>
<td></td>
<td>0. No → Skip to E0800, Rejection of Care</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below</td>
</tr>
</tbody>
</table>

## E0500. Impact on Resident

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did any of the identified symptom(s):</td>
</tr>
<tr>
<td></td>
<td>A. Put the resident at significant risk for physical illness or injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly interfere with the resident's care?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly interfere with the resident's participation in activities or social interactions?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

## E0600. Impact on Others

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did any of the identified symptom(s):</td>
</tr>
<tr>
<td></td>
<td>A. Put others at significant risk for physical injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly intrude on the privacy or activity of others?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly disrupt care or living environment?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

## E0800. Rejection of Care - Presence & Frequency

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.</td>
</tr>
<tr>
<td></td>
<td>0. Behavior not exhibited</td>
</tr>
<tr>
<td></td>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td></td>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td></td>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>
## Section E  Behavior

### E0900. Wandering - Presence & Frequency

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the resident wandered?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms</td>
</tr>
<tr>
<td></td>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td></td>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td></td>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>

### E1000. Wandering - Impact

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Does the wandering significantly intrude on the privacy or activities of others?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

### E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>How does resident’s current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Same</td>
</tr>
<tr>
<td></td>
<td>1. Improved</td>
</tr>
<tr>
<td></td>
<td>2. Worse</td>
</tr>
<tr>
<td></td>
<td>3. N/A because no prior MDS assessment</td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>(resident is rarely/never understood and family/significant other not available) — Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to F0400, Interview for Daily Preferences</td>
</tr>
</tbody>
</table>

**F0400. Interview for Daily Preferences**
Show resident the response options and say: "While you are in this facility..."

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Very important</td>
<td></td>
</tr>
<tr>
<td>2. Somewhat important</td>
<td></td>
</tr>
<tr>
<td>3. Not very important</td>
<td></td>
</tr>
<tr>
<td>4. Not important at all</td>
<td></td>
</tr>
<tr>
<td>5. Important, but can't do or no choice</td>
<td></td>
</tr>
<tr>
<td>9. No response or non-responsive</td>
<td></td>
</tr>
</tbody>
</table>

- **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..."

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Very important</td>
<td></td>
</tr>
<tr>
<td>2. Somewhat important</td>
<td></td>
</tr>
<tr>
<td>3. Not very important</td>
<td></td>
</tr>
<tr>
<td>4. Not important at all</td>
<td></td>
</tr>
<tr>
<td>5. Important, but can't do or no choice</td>
<td></td>
</tr>
<tr>
<td>9. No response or non-responsive</td>
<td></td>
</tr>
</tbody>
</table>

- **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**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resident</td>
<td></td>
</tr>
<tr>
<td>2. Family or significant other (close friend or other representative)</td>
<td></td>
</tr>
<tr>
<td>9. Interview could not be completed by resident or family/significant other (&quot;No response&quot; to 3 or more items)</td>
<td></td>
</tr>
</tbody>
</table>
## Section F: Preferences for Customary Routine and Activities

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>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</td>
</tr>
<tr>
<td>1.</td>
<td>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</td>
</tr>
</tbody>
</table>

### 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
Section G  Functional Status

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

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

If none of the above are met, code supervision.

1. ADL Self-Performance
   Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time
   Coding:
   - Activity Occurred 3 or More Times
     0. Independent - no help or staff oversight at any time
     1. Supervision - oversight, encouragement or cueing
     2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
     3. Extensive assistance - resident involved in activity, staff provide weight-bearing support
     4. Total dependence - full staff performance every time during entire 7-day period
   - Activity Occurred 2 or Fewer Times
     7. Activity occurred only once or twice - activity did occur but only once or twice
     8. Activity did not occur - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
   Code for most support provided over all shifts; code regardless of resident's self-performance classification
   Coding:
   0. No setup or physical help from staff
   1. Setup help only
   2. One person physical assist
   3. Two+ persons physical assist
   8. ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Enter Codes in Boxes

Parents: Enter Codes in Boxes

1. Self-Performance
2. Support

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)
### 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.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Self-performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0. <strong>Independent</strong> - no help provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Supervision</strong> - oversight help only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Physical help limited to transfer only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Physical help in part of bathing activity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Total dependence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Activity itself did not occur</strong> or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>Coding</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. <strong>Steady at all times</strong></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Not steady, but able to stabilize without staff assistance</strong></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Not steady, only able to stabilize with staff assistance</strong></td>
<td></td>
</tr>
<tr>
<td>8. <strong>Activity did not occur</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### G0400. Functional Limitation in Range of Motion

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

<table>
<thead>
<tr>
<th>Coding</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. <strong>No impairment</strong></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Impairment on one side</strong></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Impairment on both sides</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### 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**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. <strong>Resident believes he or she is capable of increased independence</strong> in at least some ADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0. <strong>No</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Yes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. <strong>Unable to determine</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B. <strong>Direct care staff believe resident is capable of increased independence</strong> in at least some ADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0. <strong>No</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Yes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Section H  Bladder and Bowel

### H0100. Appliances

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Indwelling catheter (including suprapubic catheter and nephrostomy tube)</td>
</tr>
<tr>
<td>B.</td>
<td>External catheter</td>
</tr>
<tr>
<td>C.</td>
<td>Ostomy (including urostomy, ileostomy, and colostomy)</td>
</tr>
<tr>
<td>D.</td>
<td>Intermittent catheterization</td>
</tr>
<tr>
<td>Z.</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

### H0200. Urinary Toileting Program

**Enter Code**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?</td>
</tr>
<tr>
<td></td>
<td>No ➔ Skip to H0300, Urinary Continence</td>
</tr>
<tr>
<td>1.</td>
<td>Yes ➔ Continue to H0200B, Response</td>
</tr>
<tr>
<td>9.</td>
<td>Unable to determine ➔ Skip to H0200C, Current toileting program or trial</td>
</tr>
<tr>
<td>B.</td>
<td>Response - What was the resident’s response to the trial program?</td>
</tr>
<tr>
<td>0.</td>
<td>No improvement</td>
</tr>
<tr>
<td>1.</td>
<td>Decreased wetness</td>
</tr>
<tr>
<td>2.</td>
<td>Completely dry (continent)</td>
</tr>
<tr>
<td>9.</td>
<td>Unable to determine or trial in progress</td>
</tr>
<tr>
<td>C.</td>
<td>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?</td>
</tr>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### H0300. Urinary Continence

**Enter Code**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinary continence - Select the one category that best describes the resident</td>
<td></td>
</tr>
<tr>
<td>0.</td>
<td>Always continent</td>
</tr>
<tr>
<td>1.</td>
<td>Occasionally incontinent (less than 7 episodes of incontinence)</td>
</tr>
<tr>
<td>2.</td>
<td>Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)</td>
</tr>
<tr>
<td>3.</td>
<td>Always incontinent (no episodes of continent voiding)</td>
</tr>
<tr>
<td>9.</td>
<td>Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days</td>
</tr>
</tbody>
</table>

### H0400. Bowel Continence

**Enter Code**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel continence - Select the one category that best describes the resident</td>
<td></td>
</tr>
<tr>
<td>0.</td>
<td>Always continent</td>
</tr>
<tr>
<td>1.</td>
<td>Occasionally incontinent (one episode of bowel incontinence)</td>
</tr>
<tr>
<td>2.</td>
<td>Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)</td>
</tr>
<tr>
<td>3.</td>
<td>Always incontinent (no episodes of continent bowel movements)</td>
</tr>
<tr>
<td>9.</td>
<td>Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days</td>
</tr>
</tbody>
</table>

### H0500. Bowel Toileting Program

**Enter Code**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is a toileting program currently being used to manage the resident’s bowel continence?</td>
<td></td>
</tr>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### H0600. Bowel Patterns

**Enter Code**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation present?</td>
<td></td>
</tr>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
# Section I  
## Active Diagnoses

<table>
<thead>
<tr>
<th>Active Diagnoses in the last 7 days - Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists</td>
</tr>
</tbody>
</table>

### 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. Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick’s disease; and dementia related to stroke, Parkinson’s or Creutzfeldt-Jakob diseases)

**Neurological Diagnoses continued on next page**
### 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.

<table>
<thead>
<tr>
<th>Neurological - Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>I4900. Hemiplegia or Hemiparesis</td>
</tr>
<tr>
<td>I5000. Paraplegia</td>
</tr>
<tr>
<td>I5100. Quadriplegia</td>
</tr>
<tr>
<td>I5200. Multiple Sclerosis (MS)</td>
</tr>
<tr>
<td>I5250. Huntington’s Disease</td>
</tr>
<tr>
<td>I5300. Parkinson’s Disease</td>
</tr>
<tr>
<td>I5350. Tourette’s Syndrome</td>
</tr>
<tr>
<td>I5400. Seizure Disorder or Epilepsy</td>
</tr>
<tr>
<td>I5500. Traumatic Brain Injury (TBI)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional</th>
</tr>
</thead>
<tbody>
<tr>
<td>I5600. Malnutrition (protein or calorie) or at risk for malnutrition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric/Mood Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>I5700. Anxiety Disorder</td>
</tr>
<tr>
<td>I5800. Depression (other than bipolar)</td>
</tr>
<tr>
<td>I5900. Manic Depression (bipolar disease)</td>
</tr>
<tr>
<td>I5950. Psychotic Disorder (other than schizophrenia)</td>
</tr>
<tr>
<td>I6000. Schizophrenia (e.g., schizoaffective and schizopreniform disorders)</td>
</tr>
<tr>
<td>I6100. Post Traumatic Stress Disorder (PTSD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)</td>
</tr>
<tr>
<td>I6300. Respiratory Failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6500. Cataracts, Glaucoma, or Macular Degeneration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None of Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>I7900. None of the above active diagnoses within the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>I8000. Additional active diagnoses</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
</tr>
<tr>
<td>C.</td>
</tr>
<tr>
<td>D.</td>
</tr>
<tr>
<td>E.</td>
</tr>
<tr>
<td>F.</td>
</tr>
<tr>
<td>G.</td>
</tr>
<tr>
<td>H.</td>
</tr>
<tr>
<td>I.</td>
</tr>
<tr>
<td>J.</td>
</tr>
</tbody>
</table>
### 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:

**A. Received scheduled pain medication regimen?**
- 0. No
- 1. Yes

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

**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)

- 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**

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**

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**

**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

**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)

**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.

**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
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
### Section J  
#### Health Conditions

**J1700. Fall History on Admission/Entry or Reentry**  
Complete only if A0310A = 01 or A0310E = 1

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Did the resident have a fall any time in the last month prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Skip to K0100, Swallowing Disorder</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Coding:</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. None</td>
<td>1. One</td>
</tr>
<tr>
<td>2. Two or more</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>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</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</th>
</tr>
</thead>
</table>
### Section K  Swallowing/Nutritional Status

**K0100. Swallowing Disorder**

Signs and symptoms of possible swallowing disorder

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>A. Loss of liquids/solids from mouth when eating or drinking</td>
</tr>
<tr>
<td>☐</td>
<td>B. Holding food in mouth/cheeks or residual food in mouth after meals</td>
</tr>
<tr>
<td>☐</td>
<td>C. Coughing or choking during meals or when swallowing medications</td>
</tr>
<tr>
<td>☐</td>
<td>D. Complaints of difficulty or pain with swallowing</td>
</tr>
<tr>
<td>☐</td>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry</td>
</tr>
<tr>
<td>☐</td>
<td>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.)</td>
</tr>
</tbody>
</table>

**K0300. Weight Loss**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Loss of 5% or more in the last month or loss of 10% or more in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>0. No or unknown</td>
</tr>
<tr>
<td>☐</td>
<td>1. Yes, on physician-prescribed weight-loss regimen</td>
</tr>
<tr>
<td>☐</td>
<td>2. Yes, not on physician-prescribed weight-loss regimen</td>
</tr>
</tbody>
</table>

**K0310. Weight Gain**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Gain of 5% or more in the last month or gain of 10% or more in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>0. No or unknown</td>
</tr>
<tr>
<td>☐</td>
<td>1. Yes, on physician-prescribed weight-gain regimen</td>
</tr>
<tr>
<td>☐</td>
<td>2. Yes, not on physician-prescribed weight-gain regimen</td>
</tr>
</tbody>
</table>

**K0510. Nutritional Approaches**

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

<table>
<thead>
<tr>
<th></th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Parenteral/IV feeding</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. Feeding tube - nasogastric or abdominal (PEG)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Z. None of the above</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### Section K  Swallowing/Nutritional Status

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

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

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

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

<table>
<thead>
<tr>
<th>A. Proportion of total calories the resident received through parenteral or tube feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 25% or less</td>
</tr>
<tr>
<td>2. 26-50%</td>
</tr>
<tr>
<td>3. 51% or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Average fluid intake per day by IV or tube feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 500 cc/day or less</td>
</tr>
<tr>
<td>2. 501 cc/day or more</td>
</tr>
</tbody>
</table>

### 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
**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

Is this resident at risk of developing pressure ulcers?

0. No
1. Yes

### M0210. Unhealed Pressure Ulcer(s)

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 Pressure Ulcers at Each Stage

### M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

**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

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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
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

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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

**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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page
### Section M  Skin Conditions

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage** - Continued

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

1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

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

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

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue

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

**G. Unstageable - Deep tissue:** Suspected deep tissue injury in evolution

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

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

**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 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:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>cm</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Pressure ulcer length:</td>
<td>Longest length from head to toe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cm</td>
</tr>
<tr>
<td>B.</td>
<td>Pressure ulcer width:</td>
<td>Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cm</td>
</tr>
<tr>
<td>C.</td>
<td>Pressure ulcer depth:</td>
<td>Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)</td>
</tr>
</tbody>
</table>

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

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. Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
- 9. None of the Above

**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry**

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 or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Stage 2</td>
</tr>
<tr>
<td>B.</td>
<td>Stage 3</td>
</tr>
<tr>
<td>C.</td>
<td>Stage 4</td>
</tr>
</tbody>
</table>
**Section M**  
**Skin Conditions**

---

**M0900. Healed Pressure Ulcers**  
*Complete only if A0310E = 0*

- **A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?**
  - **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 or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.

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

---

**M1030. Number of Venous and Arterial Ulcers**

Enter the total number of venous and arterial ulcers present.

---

**M1040. Other Ulcers, Wounds and Skin Problems**

- **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)
  - **G. Skin tear(s)**
  - **H. Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage)

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

---

**M1200. Skin and Ulcer Treatments**

- **A. Pressure reducing device for chair**
- **B. Pressure reducing device for bed**
- **C. Turning/repositioning program**
- **D. Nutrition or hydration intervention** to manage skin problems
- **E. Pressure ulcer 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

---

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Page 27 of 41
**Section N  Medications**

### N0300. Injections

<table>
<thead>
<tr>
<th>Enter Days</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Record the number of days that injections of any type</strong> were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received</td>
<td></td>
</tr>
</tbody>
</table>

### N0350. Insulin

<table>
<thead>
<tr>
<th>Enter Days</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Insulin injections</strong> Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days</td>
<td></td>
</tr>
<tr>
<td><strong>B. Orders for insulin</strong> Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days</td>
<td></td>
</tr>
</tbody>
</table>

### N0410. Medications Received

<table>
<thead>
<tr>
<th>Enter Days</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter &quot;0&quot; if medication was not received by the resident during the last 7 days</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A. Antipsychotic</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B. Antianxiety</strong></td>
<td></td>
</tr>
<tr>
<td><strong>C. Antidepressant</strong></td>
<td></td>
</tr>
<tr>
<td><strong>D. Hypnotic</strong></td>
<td></td>
</tr>
<tr>
<td><strong>E. Anticoagulant</strong> (warfarin, heparin, or low-molecular weight heparin)</td>
<td></td>
</tr>
<tr>
<td><strong>F. Antibiotic</strong></td>
<td></td>
</tr>
<tr>
<td><strong>G. Diuretic</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Section O  
**Special Treatments, Procedures, and Programs**

**OO100. 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**.

- **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

**OO250. Influenza Vaccine** - Refer to current version of RAI manual for current flu season and reporting period

- **A.** Did the resident receive the Influenza vaccine in this facility for this year’s Influenza season?
  - 0. No ➔ Skip to OO250C, If Influenza vaccine not received, state reason
  - 1. Yes ➔ Continue to OO250B, Date vaccine received

- **B.** Date vaccine received ➔ Complete date and skip to OO300A, Is the resident’s Pneumococcal vaccination up to date?

- **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
  7. None of the above

**OO300. Pneumococcal Vaccine**

- **A.** Is the resident’s Pneumococcal vaccination up to date?
  - 0. No ➔ Continue to OO300B, If Pneumococcal vaccine not received, state reason
  - 1. Yes ➔ Skip to OO400, Therapies

- **B.** If Pneumococcal vaccine not received, state reason:
  1. Not eligible - medical contraindication
  2. Offered and declined
  3. Not offered
### Section O  Special Treatments, Procedures, and Programs

<table>
<thead>
<tr>
<th>O0400. Therapies</th>
</tr>
</thead>
</table>

#### A. Speech-Language Pathology and Audiology Services

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

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.

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

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

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

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.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

#### B. Occupational Therapy

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

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.

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

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

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

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.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>
### Section O | Special Treatments, Procedures, and Programs

**O0400. Therapies - Continued**

<table>
<thead>
<tr>
<th><strong>C. Physical Therapy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Individual minutes</strong> - record the total number of minutes this therapy was administered to the resident <strong>individually</strong> in the last 7 days</td>
</tr>
<tr>
<td>2. <strong>Concurrent minutes</strong> - record the total number of minutes this therapy was administered to the resident <strong>concurrently with one other resident</strong> in the last 7 days</td>
</tr>
<tr>
<td>3. <strong>Group minutes</strong> - record the total number of minutes this therapy was administered to the resident as <strong>part of a group</strong> of residents in the last 7 days</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>3A. Co-treatment minutes</strong> - record the total number of minutes this therapy was administered to the resident in <strong>co-treatment sessions</strong> in the last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. <strong>Days</strong> - record the <strong>number of days</strong> this therapy was administered for <strong>at least 15 minutes</strong> a day in the last 7 days</td>
</tr>
</tbody>
</table>

| **5. Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started |
| **6. Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing |

<table>
<thead>
<tr>
<th><strong>D. Respiratory Therapy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Total minutes</strong> - record the total number of minutes this therapy was administered to the resident in the last 7 days</td>
</tr>
<tr>
<td>If zero, → skip to O0400E, Psychological Therapy</td>
</tr>
<tr>
<td>2. <strong>Days</strong> - record the <strong>number of days</strong> this therapy was administered for <strong>at least 15 minutes</strong> a day in the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>E. Psychological Therapy</strong> (by any licensed mental health professional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Total minutes</strong> - record the total number of minutes this therapy was administered to the resident in the last 7 days</td>
</tr>
<tr>
<td>If zero, → skip to O0400F, Recreational Therapy</td>
</tr>
<tr>
<td>2. <strong>Days</strong> - record the <strong>number of days</strong> this therapy was administered for <strong>at least 15 minutes</strong> a day in the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>F. Recreational Therapy</strong> (includes recreational and music therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Total minutes</strong> - record the total number of minutes this therapy was administered to the resident in the last 7 days</td>
</tr>
<tr>
<td>If zero, → skip to O0420, Distinct Calendar Days of Therapy</td>
</tr>
<tr>
<td>2. <strong>Days</strong> - record the <strong>number of days</strong> this therapy was administered for <strong>at least 15 minutes</strong> a day in the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>O0420. Distinct Calendar Days of Therapy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>O0450. Resumption of Therapy</strong> - Complete only if A0310C = 2 or 3 and A0310F = 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</td>
</tr>
<tr>
<td>0. <strong>No</strong> → Skip to O0500, Restorative Nursing Programs</td>
</tr>
<tr>
<td>1. <strong>Yes</strong></td>
</tr>
<tr>
<td>B. Date on which therapy regimen resumed:</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>Month - Day - Year</td>
</tr>
</tbody>
</table>
**Section O: Special Treatments, Procedures, and Programs**

**O0500. Restorative Nursing Programs**

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

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Not used</td>
<td><strong>Used in Bed</strong></td>
</tr>
<tr>
<td>1. Used less than daily</td>
<td>A. Bed rail</td>
</tr>
<tr>
<td>2. Used daily</td>
<td>B. Trunk restraint</td>
</tr>
<tr>
<td></td>
<td>C. Limb restraint</td>
</tr>
<tr>
<td></td>
<td>D. Other</td>
</tr>
<tr>
<td></td>
<td><strong>Used in Chair or Out of Bed</strong></td>
</tr>
<tr>
<td></td>
<td>E. Trunk restraint</td>
</tr>
<tr>
<td></td>
<td>F. Limb restraint</td>
</tr>
<tr>
<td></td>
<td>G. Chair prevents rising</td>
</tr>
<tr>
<td></td>
<td>H. Other</td>
</tr>
</tbody>
</table>

### Section Q  Participation in Assessment and Goal Setting

**Q0100. Participation in Assessment**

A. Resident participated in assessment
   - 0. No
   - 1. Yes

B. Family or significant other participated in assessment
   - 0. No
   - 1. Yes
   - 9. Resident has no family or significant other

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

**Q0300. Resident's Overall Expectation**

Complete only if A0310E = 1

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

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

**Q0400. Discharge Plan**

A. Is active discharge planning already occurring for the resident to return to the community?
   - 0. No
   - 1. Yes ➔ Skip to Q0600, Referral
### Section Q Participation in Assessment and Goal Setting

#### Q0490. Resident’s Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Skip to Q0600, Referral</td>
</tr>
<tr>
<td></td>
<td>8. Information not available</td>
</tr>
</tbody>
</table>

#### Q0500. Return to Community

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): &quot;Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unknown or uncertain</td>
</tr>
</tbody>
</table>

#### Q0550. Resident’s Preference to Avoid Being Asked Question Q0500B Again

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No - then document in resident’s clinical record and ask again only on the next comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>8. Information not available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Indicate information source for Q0550A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Resident</td>
</tr>
<tr>
<td></td>
<td>2. If not resident, then family or significant other</td>
</tr>
<tr>
<td></td>
<td>3. If not resident, family or significant other, then guardian or legally authorized representative</td>
</tr>
<tr>
<td></td>
<td>8. No information source available</td>
</tr>
</tbody>
</table>

#### Q0600. Referral

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Has a referral been made to the Local Contact Agency? (Document reasons in resident’s clinical record)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No - referral not needed</td>
</tr>
<tr>
<td></td>
<td>1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)</td>
</tr>
<tr>
<td></td>
<td>2. Yes - referral made</td>
</tr>
</tbody>
</table>
### 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

<table>
<thead>
<tr>
<th>A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>01.</strong> Admission assessment (required by day 14)</td>
</tr>
<tr>
<td><strong>02.</strong> Quarterly review assessment</td>
</tr>
<tr>
<td><strong>03.</strong> Annual assessment</td>
</tr>
<tr>
<td><strong>04.</strong> Significant change in status assessment</td>
</tr>
<tr>
<td><strong>05.</strong> Significant correction to prior comprehensive assessment</td>
</tr>
<tr>
<td><strong>06.</strong> Significant correction to prior quarterly assessment</td>
</tr>
<tr>
<td><strong>99.</strong> None of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>01.</strong> 5-day scheduled assessment</td>
</tr>
<tr>
<td><strong>02.</strong> 14-day scheduled assessment</td>
</tr>
<tr>
<td><strong>03.</strong> 30-day scheduled assessment</td>
</tr>
<tr>
<td><strong>04.</strong> 60-day scheduled assessment</td>
</tr>
<tr>
<td><strong>05.</strong> 90-day scheduled assessment</td>
</tr>
<tr>
<td><strong>06.</strong> Readmission/return assessment</td>
</tr>
<tr>
<td><strong>07.</strong> Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)</td>
</tr>
<tr>
<td><strong>99.</strong> None of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Prior Assessment Reference Date (A2300 value from prior assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month - Day - Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)</th>
</tr>
</thead>
</table>
### Section V  Care Area Assessment (CAA) Summary

**V0200. CAAs and Care Planning**

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

#### A. CAA Results

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

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

1. Signature

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

1. Signature

2. Date

   Month - Day - Year
**Section X**  **Correction Request**

**Complete Section X only if A0050 = 2 or 3**

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

**X0150. Type of Provider**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Type of provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Nursing home (SNF/NF)</td>
</tr>
<tr>
<td></td>
<td>2. Swing Bed</td>
</tr>
</tbody>
</table>

**X0200. Name of Resident** on existing record to be modified/inactivated

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. First name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**X0300. Gender** on existing record to be modified/inactivated

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Female</td>
</tr>
</tbody>
</table>

**X0400. Birth Date** on existing record to be modified/inactivated

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**X0500. Social Security Number** on existing record to be modified/inactivated

| __ | __ | __ |

**X0600. Type of Assessment** on existing record to be modified/inactivated

**A. Federal OBRA Reason for Assessment**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>01. Admission assessment (required by day 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>02. Quarterly review assessment</td>
</tr>
<tr>
<td></td>
<td>03. Annual assessment</td>
</tr>
<tr>
<td></td>
<td>04. Significant change in status assessment</td>
</tr>
<tr>
<td></td>
<td>05. Significant correction to prior comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td>06. Significant correction to prior quarterly assessment</td>
</tr>
<tr>
<td></td>
<td>99. None of the above</td>
</tr>
</tbody>
</table>

**B. PPS Assessment**

**PPS Scheduled Assessments for a Medicare Part A Stay**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>01. 5-day scheduled assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>02. 14-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>03. 30-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>04. 60-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>05. 90-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>06. Readmission/return assessment</td>
</tr>
</tbody>
</table>

**PPS Unscheduled Assessments for a Medicare Part A Stay**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not PPS Assessment</td>
</tr>
<tr>
<td></td>
<td>99. None of the above</td>
</tr>
</tbody>
</table>

**C. PPS Other Medicare Required Assessment - OMRA**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Start of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>2. End of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>3. Both Start and End of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>4. Change of therapy assessment</td>
</tr>
</tbody>
</table>

**X0600 continued on next page**
### Section X Correction Request

#### X0600. Type of Assessment - Continued

**D. Is this a Swing Bed clinical change assessment?** Complete only if X0150 = 2

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

**F. Entry/discharge reporting**

- 01. **Entry** tracking record
- 10. **Discharge** assessment - return not anticipated
- 11. **Discharge** assessment - return anticipated
- 99. **None of the above**

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

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

Check all that apply

- A. **Transcription error**
- B. **Data entry error**
- C. **Software product error**
- D. **Item coding error**
- E. **End of Therapy - Resumption (EOT-R) date**
- Z. **Other error requiring modification**

If "Other" checked, please specify:

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

Check all that apply

- A. **Event did not occur**
- Z. **Other error requiring inactivation**

If "Other" checked, please specify:
### 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** [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
### Section Z Assessment Administration

#### Z0100. Medicare Part A Billing

<table>
<thead>
<tr>
<th>A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Is this a Medicare Short Stay assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
</tbody>
</table>

#### Z0150. Medicare Part A Non-Therapy Billing

<table>
<thead>
<tr>
<th>A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A. RUG Case Mix group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A. RUG Case Mix group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### Z0300. Insurance Billing

<table>
<thead>
<tr>
<th>A. RUG billing code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. RUG billing version:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Sections</th>
<th>Date Section Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**

A. Signature:  

B. Date RN Assessment Coordinator signed assessment as complete:  

- Month  - Day  - Year

---

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### MINIMUM DATA SET (MDS) - Version 3.0

#### RESIDENT ASSESSMENT AND CARE SCREENING

**Nursing Home Quarterly (NQ) Item Set**

### Section A  Identification Information

#### A0050. Type of Record

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Add new record</th>
<th>Continue to A0100, Facility Provider Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Modify existing record</td>
<td>Continue to A0100, Facility Provider Numbers</td>
</tr>
<tr>
<td></td>
<td>3. Inactivate existing record</td>
<td>Skip to X0150, Type of Provider</td>
</tr>
</tbody>
</table>

#### A0100. Facility Provider Numbers

| A. National Provider Identifier (NPI): |
| B. CMS Certification Number (CCN): |
| C. State Provider Number: |

#### A0200. Type of Provider

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Type of provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Nursing home (SNF/NF)</td>
</tr>
<tr>
<td></td>
<td>2. Swing Bed</td>
</tr>
</tbody>
</table>

#### A0310. Type of Assessment

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Federal OBRA Reason for Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01. Admission assessment (required by day 14)</td>
</tr>
<tr>
<td></td>
<td>02. Quarterly review assessment</td>
</tr>
<tr>
<td></td>
<td>03. Annual assessment</td>
</tr>
<tr>
<td></td>
<td>04. Significant change in status assessment</td>
</tr>
<tr>
<td></td>
<td>05. Significant correction to prior comprehensive assessment</td>
</tr>
<tr>
<td></td>
<td>06. Significant correction to prior quarterly assessment</td>
</tr>
<tr>
<td></td>
<td>99. None of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. PPS Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>PPS Scheduled Assessments for a Medicare Part A Stay</strong></td>
</tr>
<tr>
<td></td>
<td>01. 5-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>02. 14-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>03. 30-day scheduled assessment</td>
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<tr>
<td></td>
<td>04. 60-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>05. 90-day scheduled assessment</td>
</tr>
<tr>
<td></td>
<td>06. Readmission/return assessment</td>
</tr>
<tr>
<td></td>
<td><strong>PPS Unscheduled Assessments for a Medicare Part A Stay</strong></td>
</tr>
<tr>
<td></td>
<td>07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)</td>
</tr>
<tr>
<td></td>
<td><strong>Not PPS Assessment</strong></td>
</tr>
<tr>
<td></td>
<td>99. None of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. PPS Other Medicare Required Assessment - OMRA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Start of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>2. End of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>3. Both Start and End of therapy assessment</td>
</tr>
<tr>
<td></td>
<td>4. Change of therapy assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>D. Is this a Swing Bed clinical change assessment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Complete only if A0200 = 2</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

A0310 continued on next page
### Section A: Identification Information

**A0310. Type of Assessment - Continued**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E.</strong> Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F.</strong> Entry/discharge reporting</td>
<td></td>
</tr>
<tr>
<td>01. Entry tracking record</td>
<td></td>
</tr>
<tr>
<td>10. Discharge assessment-return not anticipated</td>
<td></td>
</tr>
<tr>
<td>11. Discharge assessment-return anticipated</td>
<td></td>
</tr>
<tr>
<td>12. Death in facility tracking record</td>
<td></td>
</tr>
<tr>
<td>99. None of the above</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G.</strong> Type of discharge - Complete only if A0310F = 10 or 11</td>
<td></td>
</tr>
<tr>
<td>1. Planned</td>
<td></td>
</tr>
<tr>
<td>2. Unplanned</td>
<td></td>
</tr>
</tbody>
</table>

**A0410. Submission Requirement**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Neither federal nor state required submission</td>
<td></td>
</tr>
<tr>
<td>2. State but not federal required submission (FOR NURSING HOMES ONLY)</td>
<td></td>
</tr>
<tr>
<td>3. Federal required submission</td>
<td></td>
</tr>
</tbody>
</table>

**A0500. Legal Name of Resident**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> First name:</td>
<td><strong>B.</strong> Middle initial:</td>
</tr>
<tr>
<td><strong>C.</strong> Last name:</td>
<td><strong>D.</strong> Suffix:</td>
</tr>
</tbody>
</table>

**A0600. Social Security and Medicare Numbers**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong> Social Security Number:</td>
<td><strong>B.</strong> Medicare number (or comparable railroad insurance number):</td>
</tr>
</tbody>
</table>

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

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**A0800. Gender**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Male</td>
<td></td>
</tr>
<tr>
<td>2. Female</td>
<td></td>
</tr>
</tbody>
</table>

**A0900. Birth Date**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month</strong></td>
<td><strong>Day</strong></td>
</tr>
</tbody>
</table>

**A1000. Race/Ethnicity**

**Check all that apply**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. American Indian or Alaska Native</td>
<td></td>
</tr>
<tr>
<td>B. Asian</td>
<td></td>
</tr>
<tr>
<td>C. Black or African American</td>
<td></td>
</tr>
<tr>
<td>D. Hispanic or Latino</td>
<td></td>
</tr>
<tr>
<td>E. Native Hawaiian or Other Pacific Islander</td>
<td></td>
</tr>
<tr>
<td>F. White</td>
<td></td>
</tr>
</tbody>
</table>
## Section A  Identification Information

### A1100. Language

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Specify in A1100B, Preferred language</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Preferred language:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### A1200. Marital Status

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1. Never married</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Married</td>
</tr>
<tr>
<td></td>
<td>3. Widowed</td>
</tr>
<tr>
<td></td>
<td>4. Separated</td>
</tr>
<tr>
<td></td>
<td>5. Divorced</td>
</tr>
</tbody>
</table>

### A1300. Optional Resident Items

<table>
<thead>
<tr>
<th>A. Medical record number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Room number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Name by which resident prefers to be addressed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Lifetime occupation(s) - put &quot;/&quot; between two occupations:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### A1500. Preadmission Screening and Resident Review (PASRR)

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability (&quot;mental retardation&quot; in federal regulation) or a related condition?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Skip to A1550, Conditions Related to ID/DD Status</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</td>
</tr>
<tr>
<td></td>
<td>9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Serious mental illness</td>
</tr>
<tr>
<td>B. Intellectual Disability (&quot;mental retardation&quot; in federal regulation)</td>
</tr>
<tr>
<td>C. Other related conditions</td>
</tr>
</tbody>
</table>
### Section A  Identification Information

#### A1550. Conditions Related to ID/DD Status
If the resident is 22 years of age or older, complete only if A0310A = 01.
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05.

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

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ID/DD With Organic Condition</td>
<td></td>
</tr>
<tr>
<td>A. Down syndrome</td>
<td></td>
</tr>
<tr>
<td>B. Autism</td>
<td></td>
</tr>
<tr>
<td>C. Epilepsy</td>
<td></td>
</tr>
<tr>
<td>D. Other organic condition related to ID/DD</td>
<td></td>
</tr>
<tr>
<td>ID/DD Without Organic Condition</td>
<td></td>
</tr>
<tr>
<td>E. ID/DD with no organic condition</td>
<td></td>
</tr>
<tr>
<td>No ID/DD</td>
<td></td>
</tr>
<tr>
<td>Z. None of the above</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A1700. Type of Entry

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

#### A1800. Entered From

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Community (private home/apt., board/care, assisted living, group home)</td>
</tr>
<tr>
<td>02</td>
<td>Another nursing home or swing bed</td>
</tr>
<tr>
<td>03</td>
<td>Acute hospital</td>
</tr>
<tr>
<td>04</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>05</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>06</td>
<td>ID/DD facility</td>
</tr>
<tr>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>09</td>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
</tr>
</tbody>
</table>

#### A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Community (private home/apt., board/care, assisted living, group home)</td>
</tr>
<tr>
<td>02</td>
<td>Another nursing home or swing bed</td>
</tr>
<tr>
<td>03</td>
<td>Acute hospital</td>
</tr>
<tr>
<td>04</td>
<td>Psychiatric hospital</td>
</tr>
<tr>
<td>05</td>
<td>Inpatient rehabilitation facility</td>
</tr>
<tr>
<td>06</td>
<td>ID/DD facility</td>
</tr>
<tr>
<td>07</td>
<td>Hospice</td>
</tr>
<tr>
<td>08</td>
<td>Deceased</td>
</tr>
<tr>
<td>09</td>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>99</td>
<td>Other</td>
</tr>
</tbody>
</table>
### Section A

#### Identification Information

<table>
<thead>
<tr>
<th>A2200. Previous Assessment Reference Date for Significant Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete only if A0310A = 05 or 06</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Month</td>
</tr>
<tr>
<td>-------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2300. Assessment Reference Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation end date:</td>
</tr>
<tr>
<td>Month</td>
</tr>
<tr>
<td>-------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2400. Medicare Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>
### Section B  Hearing, Speech, and Vision

#### B0100. Comatose

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Persistent vegetative state/no discernible consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>No</strong> → Continue to B0200, Hearing</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Yes</strong> → Skip to G0110, Activities of Daily Living (ADL) Assistance</td>
</tr>
</tbody>
</table>

#### B0200. Hearing

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

#### B0300. Hearing Aid

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Hearing aid or other hearing appliance used in completing B0200, Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>No</strong></td>
</tr>
<tr>
<td></td>
<td>1. <strong>Yes</strong></td>
</tr>
</tbody>
</table>

#### B0600. Speech Clarity

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Select best description of speech pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>Clear speech</strong> - distinct intelligible words</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Unclear speech</strong> - slurred or mumbled words</td>
</tr>
<tr>
<td></td>
<td>2. <strong>No speech</strong> - absence of spoken words</td>
</tr>
</tbody>
</table>

#### B0700. Makes Self Understanded

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Ability to express ideas and wants, consider both verbal and non-verbal expression</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>Understood</strong></td>
</tr>
<tr>
<td></td>
<td>1. <strong>Usually understood</strong> - difficulty communicating some words or finishing thoughts but is able if prompted or given time</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Sometimes understood</strong> - ability is limited to making concrete requests</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Rarely/never understood</strong></td>
</tr>
</tbody>
</table>

#### B0800. Ability To Understand Others

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Understanding verbal content, however able (with hearing aid or device if used)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>Understands</strong> - clear comprehension</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Usually understands</strong> - misses some part/intent of message but comprehends most conversation</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Sometimes understands</strong> - responds adequately to simple, direct communication only</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Rarely/never understands</strong></td>
</tr>
</tbody>
</table>

#### B1000. Vision

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Ability to see in adequate light (with glasses or other visual appliances)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>Adequate</strong> - sees fine detail, such as regular print in newspapers/books</td>
</tr>
<tr>
<td></td>
<td>1. <strong>Impaired</strong> - sees large print, but not regular print in newspapers/books</td>
</tr>
<tr>
<td></td>
<td>2. <strong>Moderately impaired</strong> - limited vision; not able to see newspaper headlines but can identify objects</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Highly impaired</strong> - object identification in question, but eyes appear to follow objects</td>
</tr>
<tr>
<td></td>
<td>4. <strong>Severely impaired</strong> - no vision or sees only light, colors or shapes; eyes do not appear to follow objects</td>
</tr>
</tbody>
</table>

#### B1200. Corrective Lenses

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. <strong>No</strong></td>
</tr>
<tr>
<td></td>
<td>1. <strong>Yes</strong></td>
</tr>
</tbody>
</table>
## 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>(resident is rarely/never understood) Skip to and complete C0700-C1000, Staff Assessment for Mental Status</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to C0200, Repetition of Three Words</td>
</tr>
</tbody>
</table>

**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."**

**Number of words repeated after first attempt**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>1.</td>
<td>One</td>
</tr>
<tr>
<td>2.</td>
<td>Two</td>
</tr>
<tr>
<td>3.</td>
<td>Three</td>
</tr>
</tbody>
</table>

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."**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Able to report correct year</td>
</tr>
<tr>
<td>0.</td>
<td>Missed by &gt; 5 years or no answer</td>
</tr>
<tr>
<td>1.</td>
<td>Missed by 2-5 years</td>
</tr>
<tr>
<td>2.</td>
<td>Missed by 1 year</td>
</tr>
<tr>
<td>3.</td>
<td>Correct</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Able to report correct month</td>
</tr>
<tr>
<td>0.</td>
<td>Missed by &gt; 1 month or no answer</td>
</tr>
<tr>
<td>1.</td>
<td>Missed by 6 days to 1 month</td>
</tr>
<tr>
<td>2.</td>
<td>Accurate within 5 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>Able to report correct day of the week</td>
</tr>
<tr>
<td>0.</td>
<td>Incorrect or no answer</td>
</tr>
<tr>
<td>1.</td>
<td>Correct</td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Able to recall &quot;sock&quot;</td>
</tr>
<tr>
<td>0.</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1.</td>
<td>Yes, after cueing (&quot;something to wear&quot;)</td>
</tr>
<tr>
<td>2.</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Able to recall &quot;blue&quot;</td>
</tr>
<tr>
<td>0.</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1.</td>
<td>Yes, after cueing (&quot;a color&quot;)</td>
</tr>
<tr>
<td>2.</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.</td>
<td>Able to recall &quot;bed&quot;</td>
</tr>
<tr>
<td>0.</td>
<td>No - could not recall</td>
</tr>
<tr>
<td>1.</td>
<td>Yes, after cueing (&quot;a piece of furniture&quot;)</td>
</tr>
<tr>
<td>2.</td>
<td>Yes, no cue required</td>
</tr>
</tbody>
</table>

#### C0500. Summary 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
### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Seems or appears to recall after 5 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Memory OK</td>
<td></td>
</tr>
<tr>
<td>1. Memory problem</td>
<td></td>
</tr>
</tbody>
</table>

#### C0800. Long-term Memory OK

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Seems or appears to recall long past</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Memory OK</td>
<td></td>
</tr>
<tr>
<td>1. Memory problem</td>
<td></td>
</tr>
</tbody>
</table>

#### 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

Made decisions regarding tasks of daily life

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. Independent - decisions consistent/reasonable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Modified independence - some difficulty in new situations only</td>
<td></td>
</tr>
<tr>
<td>2. Moderately impaired - decisions poor; cues/supervision required</td>
<td></td>
</tr>
<tr>
<td>3. Severely impaired - never/rarely made decisions</td>
<td></td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0. No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>
### Section D Mood

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (resident is rarely/never understood)</td>
<td>Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to D0200, Resident Mood Interview (PHQ-9©)</td>
<td></td>
</tr>
</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7-11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12-14 days (nearly every day)</td>
</tr>
</tbody>
</table>

| 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

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td></td>
<td>2. 7-11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12-14 days (nearly every day)</td>
</tr>
</tbody>
</table>

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**

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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Was responsible staff or provider informed that there is a potential for resident self harm?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

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### E0100. Potential Indicators of Psychosis

Check all that apply

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

### Behavioral Symptoms

#### E0200. Behavioral Symptom - Presence & Frequency

**Note presence of symptoms and their frequency**

**Coding:**

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

**Enter 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

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

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

#### E0900. Wandering - Presence & Frequency

Has the resident wandered?

- [ ] 0. Behavior not exhibited
- [ ] 1. Behavior of this type occurred 1 to 3 days
- [ ] 2. Behavior of this type occurred 4 to 6 days, but less than daily
- [ ] 3. Behavior of this type occurred daily
### Section G: Functional Status

#### G0110. Activities of Daily Living (ADL) Assistance

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

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

**If none of the above are met, code supervision.**

#### 1. ADL Self-Performance

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

**Coding:**
- **Activity Occurred 3 or More Times**
  - **Independent** - no help or staff oversight at any time
  - **Supervision** - oversight, encouragement or cueing
  - **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
  - **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
  - **Total dependence** - full staff performance every time during entire 7-day period

- **Activity Occurred 2 or Fewer Times**
  - **Activity occurred only once or twice** - activity did occur but only once or twice
  - **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

#### 2. ADL Support Provided

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

**Coding:**
- **No setup or physical help from staff**
- **Setup help only**
- **One person physical assist**
- **Two+ persons physical assist**
- **ADL activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

<table>
<thead>
<tr>
<th>Activity Occurred 2 or Fewer Times</th>
<th>1. Self-Performance</th>
<th>2. Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bed mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Walk in room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Walk in corridor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Locomotion on unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Locomotion off unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Dressing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Toilet use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Personal hygiene</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

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

- **Activity Occurred 2 or Fewer Times**
  - **Activity occurred only once or twice** - activity did occur but only once or twice
  - **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

**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.
### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Self-performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Independent - no help provided</td>
</tr>
<tr>
<td></td>
<td>1. Supervision - oversight help only</td>
</tr>
<tr>
<td></td>
<td>2. Physical help limited to transfer only</td>
</tr>
<tr>
<td></td>
<td>3. Physical help in part of bathing activity</td>
</tr>
<tr>
<td></td>
<td>4. Total dependence</td>
</tr>
<tr>
<td></td>
<td>8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)</td>
</tr>
</tbody>
</table>

#### G0300. Balance During Transitions and Walking

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

<table>
<thead>
<tr>
<th>Coding</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Steady at all times</td>
<td>A. Moving from seated to standing position</td>
</tr>
<tr>
<td>1. Not steady, but able to stabilize without staff assistance</td>
<td>B. Walking (with assistive device if used)</td>
</tr>
<tr>
<td>2. Not steady, only able to stabilize with staff assistance</td>
<td>C. Turning around and facing the opposite direction while walking</td>
</tr>
<tr>
<td>8. Activity did not occur</td>
<td>D. Moving on and off toilet</td>
</tr>
<tr>
<td></td>
<td>E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)</td>
</tr>
</tbody>
</table>

#### G0400. Functional Limitation in Range of Motion

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

<table>
<thead>
<tr>
<th>Coding</th>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No impairment</td>
<td>A. Upper extremity (shoulder, elbow, wrist, hand)</td>
</tr>
<tr>
<td>1. Impairment on one side</td>
<td>B. Lower extremity (hip, knee, ankle, foot)</td>
</tr>
<tr>
<td>2. Impairment on both sides</td>
<td></td>
</tr>
</tbody>
</table>

#### 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
## 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/entry or reentry or since urinary incontinence was noted in this facility?**
  - **0. No** → Skip to H0300, Urinary Continence
  - **1. Yes** → Continue to H0200C, Current toileting program or trial
  - **9. Unable to determine** → Continue to H0200C, Current toileting program or trial

**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**
## 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.

<table>
<thead>
<tr>
<th>Heart/Circulation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)</td>
<td></td>
</tr>
<tr>
<td>I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)</td>
<td></td>
</tr>
<tr>
<td>I0700. Hypertension</td>
<td></td>
</tr>
<tr>
<td>I0800. Orthostatic Hypotension</td>
<td></td>
</tr>
<tr>
<td>I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genitourinary</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I1550. Neurogenic Bladder</td>
<td></td>
</tr>
<tr>
<td>I1650. Obstructive Uropathy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infections</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I1700. Multidrug-Resistant Organism (MDRO)</td>
<td></td>
</tr>
<tr>
<td>I2000. Pneumonia</td>
<td></td>
</tr>
<tr>
<td>I2100. Septicemia</td>
<td></td>
</tr>
<tr>
<td>I2200. Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)</td>
<td></td>
</tr>
<tr>
<td>I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)</td>
<td></td>
</tr>
<tr>
<td>I2500. Wound Infection (other than foot)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metabolic</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)</td>
<td></td>
</tr>
<tr>
<td>I3100. Hyponatremia</td>
<td></td>
</tr>
<tr>
<td>I3200. Hyperkalemia</td>
<td></td>
</tr>
<tr>
<td>I3300. Hyperlipidemia (e.g., hypercholesterolemia)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>I4000. Other Fracture</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I4200. Alzheimer’s Disease</td>
<td></td>
</tr>
<tr>
<td>I4300. Aphasia</td>
<td></td>
</tr>
<tr>
<td>I4400. Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td>I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke</td>
<td></td>
</tr>
<tr>
<td>I4800. Non-Alzheimer’s Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick’s disease; and dementia related to stroke, Parkinson’s or Creutzfeldt-Jakob diseases)</td>
<td></td>
</tr>
<tr>
<td>I4900. Hemiplegia or Hemiparesis</td>
<td></td>
</tr>
<tr>
<td>I5000. Paraplegia</td>
<td></td>
</tr>
<tr>
<td>I5100. Quadriplegia</td>
<td></td>
</tr>
<tr>
<td>I5200. Multiple Sclerosis (MS)</td>
<td></td>
</tr>
<tr>
<td>I5250. Huntington’s Disease</td>
<td></td>
</tr>
<tr>
<td>I5300. Parkinson’s Disease</td>
<td></td>
</tr>
<tr>
<td>I5350. Tourette’s Syndrome</td>
<td></td>
</tr>
<tr>
<td>I5400. Seizure Disorder or Epilepsy</td>
<td></td>
</tr>
<tr>
<td>I5500. Traumatic Brain Injury (TBI)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I5600. Malnutrition (protein or calorie) or at risk for malnutrition</td>
<td></td>
</tr>
</tbody>
</table>
## 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

<table>
<thead>
<tr>
<th>Psychiatric/Mood Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 15700. Anxiety Disorder</td>
</tr>
<tr>
<td>□ 15800. Depression (other than bipolar)</td>
</tr>
<tr>
<td>□ 15900. Manic Depression (bipolar disease)</td>
</tr>
<tr>
<td>□ 15950. Psychotic Disorder (other than schizophrenia)</td>
</tr>
<tr>
<td>□ 16000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)</td>
</tr>
<tr>
<td>□ 16100. Post Traumatic Stress Disorder (PTSD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 16200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)</td>
</tr>
<tr>
<td>□ 16300. Respiratory Failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 18000. Additional active diagnoses</td>
</tr>
</tbody>
</table>

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. ____________
### 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:

| A. Received scheduled pain medication regimen? |
|---|---|
| 0. No | 1. Yes |

| B. Received PRN pain medications OR was offered and declined? |
|---|---|
| 0. No | 1. Yes |

| 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)

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain</td>
</tr>
<tr>
<td>1. Yes → Continue to J0300, Pain Presence</td>
</tr>
</tbody>
</table>

#### Pain Assessment Interview

#### J0300. Pain Presence
Ask resident: "Have you had pain or hurting at any time in the last 5 days?"

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No → Skip to J1100, Shortness of Breath</td>
</tr>
<tr>
<td>1. Yes → Continue to J0400, Pain Frequency</td>
</tr>
<tr>
<td>9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

#### J0400. Pain Frequency
Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?"

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Almost constantly</td>
</tr>
<tr>
<td>2. Frequently</td>
</tr>
<tr>
<td>3. Occasionally</td>
</tr>
<tr>
<td>4. Rarely</td>
</tr>
<tr>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

#### J0500. Pain Effect on Function

**A.** Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

**B.** Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>

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

**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.

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

<table>
<thead>
<tr>
<th>Enter Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mild</td>
</tr>
<tr>
<td>2. Moderate</td>
</tr>
<tr>
<td>3. Severe</td>
</tr>
<tr>
<td>4. Very severe, horrible</td>
</tr>
<tr>
<td>9. Unable to answer</td>
</tr>
</tbody>
</table>
**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
### Section J  Health Conditions

**J1700. Fall History on Admission/Entry or Reentry**  
Complete only if A0310A = 01 or A0310E = 1

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>A. Did the resident have a fall any time in the last month prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>B. Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>C. Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or scheduled PPS), whichever is more recent?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Skip to K0100, Swallowing Disorder</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Coding</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma</td>
</tr>
</tbody>
</table>

### Section K  Swallowing/Nutritional Status

**K0100. Swallowing Disorder**  
Signs and symptoms of possible swallowing disorder  
Check all that apply

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
<th>A. Loss of liquids/solids from mouth when eating or drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. Holding food in mouth/cheeks or residual food in mouth after meals</td>
</tr>
<tr>
<td></td>
<td>C. Coughing or choking during meals or when swallowing medications</td>
</tr>
<tr>
<td></td>
<td>D. Complaints of difficulty or pain with swallowing</td>
</tr>
<tr>
<td>Z. None of the above</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.)</td>
</tr>
</tbody>
</table>

**K0300. Weight Loss**  
Loss of 5% or more in the last month or loss of 10% or more in last 6 months

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Loss of 5% or more in the last month or loss of 10% or more in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No or unknown</td>
</tr>
<tr>
<td></td>
<td>1. Yes, on physician-prescribed weight-loss regimen</td>
</tr>
<tr>
<td></td>
<td>2. Yes, not on physician-prescribed weight-loss regimen</td>
</tr>
</tbody>
</table>
## Section K  Swallowing/Nutritional Status

### K0310. Weight Gain

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Gain of 5% or more in the last month or gain of 10% or more in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No or unknown</td>
</tr>
<tr>
<td></td>
<td>1. Yes, on physician-prescribed weight-gain regimen</td>
</tr>
<tr>
<td></td>
<td>2. Yes, not on physician-prescribed weight-gain regimen</td>
</tr>
</tbody>
</table>

### K0510. Nutritional Approaches

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

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

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

<table>
<thead>
<tr>
<th><strong>A. Parenteral/IV feeding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. Feeding tube - nasogastric or abdominal (PEG)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Z. None of the above</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th><strong>A. Proportion of total calories the resident received through parenteral or tube feeding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 25% or less</td>
</tr>
<tr>
<td>2. 26-50%</td>
</tr>
<tr>
<td>3. 51% or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>B. Average fluid intake per day by IV or tube feeding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 500 cc/day or less</td>
</tr>
<tr>
<td>2. 501 cc/day or more</td>
</tr>
</tbody>
</table>

### 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
## 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

Is this resident at risk of developing pressure ulcers?

- [ ] 0. No
- [ ] 1. Yes

### M0210. Unhealed Pressure Ulcer(s)

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 Pressure Ulcers at Each Stage

### M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

<table>
<thead>
<tr>
<th>A. Number of Stage 1 pressure ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1:</strong> 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</td>
</tr>
</tbody>
</table>

| 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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

| 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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

| 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/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page
Section M  
Skin Conditions

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued

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

1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

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

1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue
2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

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

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 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:

A. Pressure ulcer length: Longest length from head to toe

B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

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

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. Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
5. None of the above

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry
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 or scheduled PPS) or last admission/entry or reentry. If no current pressure ulcer at a given stage, enter 0

A. Stage 2

B. Stage 3

C. Stage 4
### Section M  Skin Conditions

**M0900. Healed Pressure Ulcers**

Complete only if A0310E = 0

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.

**A. Stage 2**

**B. Stage 3**

**C. Stage 4**

**M1030. Number of Venous and Arterial Ulcers**

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)*
  - G. Skin tear(s)
  - H. Moisture Associated Skin Damage *(MASD)* *(i.e. incontinence (IAD), perspiration, drainage)*

**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. Pressure 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.
**Section N  Medications**

<table>
<thead>
<tr>
<th><strong>N0300. Injections</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>N0350. Insulin</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>N0410. Medications Received</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter &quot;0&quot; if medication was not received by the resident during the last 7 days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
<tr>
<td>Enter Days</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Cancer Treatments</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Chemotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Radiation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Treatments</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Oxygen therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Suctioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Tracheostomy care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Ventilator or respirator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>H. IV medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Transfusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Hospice care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M. Isolation or quarantine for active infectious disease</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>(does not include standard body/fluid precautions)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**O0250. Influenza Vaccine** - Refer to current version of RAI manual for current flu season and reporting period

<table>
<thead>
<tr>
<th>A. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No → Skip to O0250C, If Influenza vaccine not received, state reason</td>
</tr>
<tr>
<td>1. Yes → Continue to O0250B, Date vaccine received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. If Influenza vaccine not received, state reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Resident not in facility during this year's flu season</td>
</tr>
<tr>
<td>2. Received outside of this facility</td>
</tr>
<tr>
<td>3. Not eligible - medical contraindication</td>
</tr>
<tr>
<td>4. Offered and declined</td>
</tr>
<tr>
<td>5. Not offered</td>
</tr>
<tr>
<td>6. Inability to obtain vaccine due to a declared shortage</td>
</tr>
<tr>
<td>9. None of the above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O0300. Pneumococcal Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A. Is the resident's Pneumococcal vaccination up to date?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason</td>
</tr>
<tr>
<td>1. Yes → Skip to O0400, Therapies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. If Pneumococcal vaccine not received, state reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Not eligible - medical contraindication</td>
</tr>
<tr>
<td>2. Offered and declined</td>
</tr>
<tr>
<td>3. Not offered</td>
</tr>
</tbody>
</table>
## Section O

### Special Treatments, Procedures, and Programs

#### O0400. Therapies

**A. Speech-Language Pathology and Audiology Services**

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

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.

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

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

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

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

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

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

**B. Occupational Therapy**

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

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.

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

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

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

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

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

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

O0400 continued on next page
### Section O  Special Treatments, Procedures, and Programs

**O0400. Therapies - Continued**

**C. Physical Therapy**

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

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.

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

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

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

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

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

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

**D. Respiratory 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)

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

### O0420. Distinct Calendar Days of Therapy

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

### O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

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

0. No → Skip to O0500, Restorative Nursing Programs

1. Yes

**B. Date on which therapy regimen resumed:**

Month - Day - Year
# Section O  Special Treatments, Procedures, and Programs

## O0500. Restorative Nursing Programs

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

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

## O0600. Physician Examinations

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

Enter Days

## O0700. Physician Orders

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

Enter Days
**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.

**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

**Coding:**

0. Not used
1. Used less than daily
2. Used daily

---

**Section Q  Participation in Assessment and Goal Setting**

**Q0100. Participation in Assessment**

- A. Resident participated in assessment
  - 0. No
  - 1. Yes

- B. Family or significant other participated in assessment
  - 0. No
  - 1. Yes
  - 9. Resident has no family or significant other

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

**Q0300. Resident’s Overall Expectation**

Complete only if A0310E = 1

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

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

**Q0400. Discharge Plan**

- A. Is active discharge planning already occurring for the resident to return to the community?
  - 0. No
  - 1. Yes → Skip to Q0600, Referral
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q0490.</td>
<td>Resident's Preference to Avoid Being Asked Question Q0500B</td>
<td>Complete only if A0310A = 02, 06, or 99&lt;br&gt;Does the resident's clinical record document a request that this question be asked only on comprehensive assessments? &lt;br&gt;Enter Code: 0. No, 1. Yes ➔ Skip to Q0600, Referral, 8. Information not available</td>
</tr>
<tr>
<td>Q0500.</td>
<td>Return to Community</td>
<td>B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): &quot;Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?&quot; &lt;br&gt;Enter Code: 0. No, 1. Yes, 9. Unknown or uncertain</td>
</tr>
<tr>
<td>Q0550.</td>
<td>Resident's Preference to Avoid Being Asked Question Q0500B Again</td>
<td>A. Does the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.) &lt;br&gt;Enter Code: 0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment, 1. Yes, 8. Information not available&lt;br&gt;B. Indicate information source for Q0550A &lt;br&gt;Enter Code: 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, 8. No information source available</td>
</tr>
<tr>
<td>Q0600.</td>
<td>Referral</td>
<td>Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record) &lt;br&gt;Enter Code: 0. No - referral not needed, 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20), 2. Yes - referral made</td>
</tr>
</tbody>
</table>
**Section X**  
**Correction Request**

**Complete Section X only if A0050 = 2 or 3**

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

**X0150. Type of Provider**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Type of provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Nursing home (SNF/NF)</td>
</tr>
<tr>
<td></td>
<td>2. Swing Bed</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Male</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Female</td>
<td></td>
</tr>
</tbody>
</table>

**X0400. Birth Date on existing record to be modified/inactivated**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**X0500. Social Security Number on existing record to be modified/inactivated**

|   |   |   |

**X0600. Type of Assessment on existing record to be modified/inactivated**

**A. Federal OBRA Reason for Assessment**

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

**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. None of the above

**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
- 4. Change of therapy assessment

*X0600 continued on next page*
### Section X Correction Request

**X0600. Type of Assessment - Continued**

**D. Is this a Swing Bed clinical change assessment?** Complete only if X0150 = 2

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

**F. Entry/discharge reporting**

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

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

<table>
<thead>
<tr>
<th>A. Assessment Reference Date</th>
<th>Complete only if X0600F = 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Discharge Date</th>
<th>Complete only if X0600F = 10, 11, or 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Entry Date</th>
<th>Complete only if X0600F = 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

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

**X0800. Correction Number**

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

<table>
<thead>
<tr>
<th>Enter Number</th>
</tr>
</thead>
</table>

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

- Check all that apply

  - A. Transcription error
  - B. Data entry error
  - C. Software product error
  - D. Item coding error
  - E. End of Therapy - Resumption (EOT-R) date
  - Z. Other error requiring modification
    If "Other" checked, please specify: ___________________________

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

- Check all that apply

  - A. Event did not occur
  - Z. Other error requiring inactivation
    If "Other" checked, please specify: ___________________________
## Section X  
**Correction Request**

**X1100. RN Assessment Coordinator Attestation of Completion**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Attesting individual's first name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Attesting individual's last name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Attesting individual's title:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Signature</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Attestation date</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
<td></td>
</tr>
</tbody>
</table>
### Section Z Assessment Administration

#### Z0100. Medicare Part A Billing

<table>
<thead>
<tr>
<th></th>
<th>Medicare Part A HIPPS code (RUG group followed by assessment type indicator):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**C. Is this a Medicare Short Stay assessment?**

0. No
1. Yes

#### Z0150. Medicare Part A Non-Therapy Billing

<table>
<thead>
<tr>
<th></th>
<th>Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>RUG Case Mix group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>RUG Case Mix group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>RUG version code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Z0300. Insurance Billing

<table>
<thead>
<tr>
<th></th>
<th>RUG billing code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>RUG billing version:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 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.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Sections</th>
<th>Date Section Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>D.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F.</td>
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</tr>
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<td>G.</td>
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<td>H.</td>
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</tr>
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<td>I.</td>
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<td></td>
</tr>
<tr>
<td>J.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. **Signature:**

B. **Date RN Assessment Coordinator signed assessment as complete:**

   
   

---

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Medical Necessity and Level of Care Assessment - Version 3.0

Section A  Identification Information

A0310. Type of Assessment

A. Reason for Assessment
   01. Initial assessment
   03. Annual assessment
   04. Significant change in status assessment

A0500. Legal Name of Individual

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
### Section A  Identification Information

#### A1100. Language

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Does the individual need or want an interpreter to communicate with a doctor or health care staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>1. Yes → Specify in A1100B, Preferred language</td>
</tr>
<tr>
<td>9. Unable to determine</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Preferred language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### A1300. Optional Individual Items

<table>
<thead>
<tr>
<th>B. Room number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### A1550. Conditions Related to IDD Status

If the individual is 22 years of age or older, complete only if A0310A = 01
If the individual is 21 years of age or younger, complete always

- [ ] Check all conditions that are related to IDD status that were manifested before age 22, and are likely to continue indefinitely

- [ ] IDD With Organic Condition
  - A. Down syndrome
  - B. Autism
  - C. Epilepsy
  - D. Other organic condition related to IDD

- [ ] IDD Without Organic Condition
  - E. IDD with no organic condition
  - No IDD
  - Z. None of the above

#### A2300. Assessment Date

Observation end date:

- [ ] Month
- [ ] Day
- [ ] Year
# Section B  Hearing, Speech, and Vision

## B0100. Comatose
- Persistent vegetative state/no discernible consciousness
  - No → Continue to B0200, Hearing
  - Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance

## B0200. Hearing
- Ability to hear (with hearing aid or hearing appliances if normally used)
  - Adequate – no difficulty in normal conversation, social interaction, listening to TV
  - Minimal difficulty – difficulty in some environments (e.g., when person speaks softly or setting is noisy)
  - Moderate difficulty – speaker has to increase volume and speak distinctly
  - Highly impaired – absence of useful hearing

## B0300. Hearing Aid
- Hearing aid or other hearing appliance used in completing B0200, Hearing
  - No
  - Yes

## B0600. Speech Clarity
- Select best description of speech pattern
  - Clear speech – distinct intelligible words
  - Unclear speech – slurred or mumbled words
  - No speech – absence of spoken words

## B0700. Makes Self Understood
- Ability to express ideas and wants, consider both verbal and non-verbal expression. Enter "-" Dash if unable to assess.
  - Understood
  - Usually understood – difficulty communicating some words or finishing thoughts but is able if prompted or given time
  - Sometimes understood – ability is limited to making concrete requests
  - Rarely/never understood

## B0799. Modes of Expression
- Check all used by individual to make needs known
  - A. Speech
  - B. Writing messages to express or clarify needs
  - C. American sign language or Braille
  - D. Signs/ Gestures/ Sounds
  - E. Communication Board
  - F. Voice Modulator
  - G. Other
  - Z. None of the above

## B0800. Ability To Understand Others
- Understanding verbal content, however able (with hearing aid or device if used). Enter "-" Dash if unable to assess.
  - Understands – clear comprehension
  - Usually understands – misses some part/intent of message but comprehends most conversation
  - Sometimes understands – responds adequately to simple, direct communication only
  - Rarely/never understands

## B1000. Vision
- Ability to see in adequate light (with glasses or other visual appliances)
  - Adequate – sees fine detail, such as regular print in newspapers/books
  - Impaired – sees large print, but not regular print in newspapers/books
  - Moderately impaired – limited vision; not able to see newspaper headlines but can identify objects
  - Highly impaired – object identification in question, but eyes appear to follow objects
  - Severely impaired – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

## B1200. Corrective Lenses
- Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
  - No
  - Yes
C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? – Attempt to conduct interview with the individual

Enter Code

0. No (individual is rarely/never understood) OR individual is less than 7 years of age, skip to and complete C0700-C1000, Caregiver 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 individual: "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 '-' Dash if unable to assess.

Number of words repeated after first attempt

Enter Code

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

After the individual'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 individual: "Please tell me what year it is right now." Enter '-' Dash if unable to assess.

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 individual: "What month are we in right now?" Enter '-' Dash if unable to assess.

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 individual: "What day of the week is today?" Enter '-' Dash if unable to assess.

Enter Code

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

C0400. Recall

Ask individual: "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 '-' Dash if unable to assess.

Enter Code

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

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

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

The sum of the scores for questions C0200–C0400. The sum should be a number (00–15)
A score of 99 indicates that the individual was unable to complete the interview
Section C  Cognitive Patterns

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

Enter [ ]

0.  No (individual was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium

1.  Yes (individual was unable to complete interview OR individual is less than 7 years of age) → Continue to C0700, Short-term Memory OK

Caregiver Assessment for Mental Status

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

C0700. Short-term Memory OK

Enter [ ]

0.  Seems or appears to recall after 5 minutes. Enter ‘+’ Dash if unable to assess OR individual is less than 2 years of age.

1.  Memory OK

1.  Memory problem

C0800. Long-term Memory OK

Enter [ ]

0.  Seems or appears to recall long past. Enter ‘+’ Dash if unable to assess OR individual is less than 2 years of age.

1.  Memory OK

1.  Memory problem

C0900. Memory/Recall Ability

↓ Check all that the individual was normally able to recall

A.  Current season

B.  Location of own room

C.  Caregiver names and faces

D.  That he or she is in their own home/room

Z.  None of the above were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter [ ]

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 Caregiver Assessment, and reviewing medical record

↓ Enter Codes in Boxes

Coding:

0.  Behavior not present

1.  Behavior continuously present, does not fluctuate

2.  Behavior present, fluctuates (comes and goes, changes in severity)

A.  Inattention – Did the individual have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?

B.  Disorganized thinking – Was the individual's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)? Enter ‘+’ Dash if unable to assess.

C.  Altered level of consciousness – Did the individual have altered level of consciousness (e.g., vigilant – started 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 individual 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 [ ]

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

0.  No

1.  Yes

.  No information/not assessed

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## Section D  Mood

### D0100. Should Individual Mood Interview be Conducted? – Attempt to conduct interview with the individual

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>(Individual is rarely/never understood) OR individual is less than 7 years of age → Skip to and complete D0500 -D0600, Caregiver Assessment of Individual Mood (PHQ-9-OV)</td>
</tr>
<tr>
<td>1. Yes</td>
<td>→ Continue to D0200, Individual Mood Interview (PHQ-9©)</td>
</tr>
</tbody>
</table>

### D0200. Individual Mood Interview (PHQ-9©)

**Say to individual: “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 individual: “About how often have you been bothered by this?”

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

#### 1. Symptom Presence

<table>
<thead>
<tr>
<th>No (enter 0 in column 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (enter 0-3 in column 2)</td>
</tr>
<tr>
<td>No response (leave column 2 blank)</td>
</tr>
</tbody>
</table>

#### 2. Symptom Frequency

<table>
<thead>
<tr>
<th>Never or 1 day</th>
</tr>
</thead>
<tbody>
<tr>
<td>2–6 days (several days)</td>
</tr>
<tr>
<td>7–11 days (half or more of the days)</td>
</tr>
<tr>
<td>12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

| ↓ 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

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-27). A score of 99 indicates that the individual was 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 individual self harm

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>
### Section D  Mood

**D0500. Caregiver Assessment of Individual Mood (PHQ-9-OV*)**

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

**Over the last 2 weeks, did the individual 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.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2–6 days (several days)</td>
</tr>
<tr>
<td></td>
<td>2. 7–11 days (half or more of the days)</td>
</tr>
<tr>
<td></td>
<td>3. 12–14 days (nearly every day)</td>
</tr>
</tbody>
</table>

↓ 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**

The sum of the scores for all frequency responses in Column 2, Symptom Frequency. The sum should be a number (00-30).

**D0650. Safety Notification** — Complete only if D050011 = 1 indicating possibility of individual self harm

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Was responsible caregiver, provider or appropriate entity informed that there is a potential for individual self harm?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

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### Section E  Behavior

#### E0100. Potential Indicators of Psychosis

Check all that apply:

- A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- B. **Delusions** (misperceptions 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

<table>
<thead>
<tr>
<th>Coding:</th>
<th>↓ Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. <strong>Behavior not exhibited</strong></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Behavior of this type occurred 1 to 3 days</strong></td>
<td>A. <strong>Physical behavioral symptoms directed toward others</strong> (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td>
</tr>
<tr>
<td>2. <strong>Behavior of this type occurred 4 to 6 days, but less than daily</strong></td>
<td>B. <strong>Verbal behavioral symptoms directed toward others</strong> (e.g., threatening others, screaming at others, cursing at others)</td>
</tr>
<tr>
<td>3. <strong>Behavior of this type occurred daily</strong></td>
<td>C. <strong>Other behavioral symptoms not directed toward others</strong> (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)</td>
</tr>
</tbody>
</table>

#### E0300. Overall Presence of Behavioral Symptoms

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No → Skip to E0800, Rejection of Care</td>
</tr>
<tr>
<td></td>
<td>1. Yes → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below</td>
</tr>
</tbody>
</table>

#### E0500. Impact on Individual

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did any of the identified symptom(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Put the individual at significant risk for physical illness or injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly interfere with the individual's care?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly interfere with the individual's participation in activities or social interactions?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

#### E0600. Impact on Others

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did any of the identified symptom(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Put others at significant risk for physical injury?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>B. Significantly intrude on the privacy or activity of others?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>C. Significantly disrupt care or living environment?</td>
</tr>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

#### E0800. Rejection of Care – Presence & Frequency

Did the individual reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual'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 individual or family), and determined to be consistent with individual values, preferences, or goals.

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Did the individual reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the individual's goals for health and well-being?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Behavior not exhibited</td>
</tr>
<tr>
<td></td>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td></td>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td></td>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>
## Section E | Behavior

### E0900. Wandering – Presence & Frequency

Has the individual 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

A. Does the wandering place the individual at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the residence/facility)?
- 0. No
- 1. Yes

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.

How does individual’s current behavior status, care rejection, or wandering **compare to prior assessment**?
- 0. Same
- 1. Improved
- 2. Worse
- 3. N/A because no prior assessment
# Section G  Functional Status

## G0110. Activities of Daily Living (ADL) Assistance

### 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 caregiver performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full caregiver 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 individual's performance - 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 caregiver performance every time

### Coding:

#### Activity Occurred 3 or More Times

- **Independent** - no help or caregiver oversight at any time
- **Supervision** - oversight, encouragement or cueing
- **Limited assistance** - individual highly involved in activity; caregiver provide guided maneuvering of limbs or other non-weight-bearing assistance
- **Extensive assistance** - individual involved in activity, caregiver provide weight-bearing support
- **Total dependence** - full caregiver performance every time during entire 7-day period

#### Activity Occurred 2 or Fewer Times

- **Activity occurred only once or twice** - activity did occur but only once or twice
- **Activity did not occur** - activity (or any part of the ADL) was not performed by individual or caregiver at all over the entire 7-day period

### A. Bed mobility
- how individual moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture

### B. Transfer
- how individual moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)

### C. Walk in room
- how individual walks between locations in room

### D. Walk in home
- how individual walks in home or community setting

### E. Locomotion in room
- how individual moves between locations in his/her room and adjacent hallway on same floor. If in wheelchair, self-sufficiency once in chair

### F. Locomotion in home
- how individual moves to and returns from distant areas in his/her home or community setting. If in wheelchair, self-sufficiency once in chair

### G. Dressing
- how individual 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 individual 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 individual 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 individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)

## 2. ADL Support Provided

Code for most support provided; code regardless of individual's self-performance classification

### Coding:

- **0. No setup or physical help from caregiver**
- **1. Setup help only**
- **2. One person physical assist**
- **3. Two+ persons physical assist**

8. ADL activity itself did not occur during entire period

---

### Enter Codes in Boxes

<table>
<thead>
<tr>
<th></th>
<th>1. Self-Performance</th>
<th>2. Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
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<tr>
<td>F</td>
<td></td>
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<tr>
<td>G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### G0120. Bathing

How individual 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Self-performance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. Independent – no help provided</td>
</tr>
<tr>
<td></td>
<td>1. Supervision – oversight help only</td>
</tr>
<tr>
<td></td>
<td>2. Physical help limited to transfer only</td>
</tr>
<tr>
<td></td>
<td>3. Physical help in part of bathing activity</td>
</tr>
<tr>
<td></td>
<td>4. Total dependence</td>
</tr>
<tr>
<td></td>
<td>8. Activity itself did not occur during the entire period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Support provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Bathing support codes are as defined in Item G0110 column 2, ADL Support Provided, above)</td>
</tr>
</tbody>
</table>

### G0300. Balance During Transitions and Walking

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

<table>
<thead>
<tr>
<th>Coding:</th>
<th>↓ Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Steady at all times</td>
<td>A. Moving from seated to standing position</td>
</tr>
<tr>
<td>1. Not steady, but able to stabilize without human assistance</td>
<td>B. Walking (with assistive device if used)</td>
</tr>
<tr>
<td>2. Not steady, only able to stabilize with human assistance</td>
<td>C. Turning around and facing the opposite direction while walking</td>
</tr>
<tr>
<td>8. Activity did not occur</td>
<td>D. Moving on and off toilet</td>
</tr>
</tbody>
</table>

### G0400. Functional Limitation in Range of Motion

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

<table>
<thead>
<tr>
<th>Coding:</th>
<th>↓ Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No impairment</td>
<td>A. Upper extremity (shoulder, elbow, wrist, hand)</td>
</tr>
<tr>
<td>1. Impairment on one side</td>
<td>B. Lower extremity (hip, knee, ankle, foot)</td>
</tr>
<tr>
<td>2. Impairment on both sides</td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Individual believes he or she is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>9. Unable to determine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Caregiver believes individual is capable of increased independence in at least some ADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0. No</td>
</tr>
<tr>
<td></td>
<td>1. Yes</td>
</tr>
<tr>
<td></td>
<td>- No information/not assessed</td>
</tr>
</tbody>
</table>
# Section H  Bladder and Bowel

## H0100. Appliances

- **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 continence promotion program or trial – Is an individualized continence promotion program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the individual's urinary continence?
  - 0. No
  - 1. Yes

## H0300. Urinary Continence

**Urinary continence** – Select the one category that best describes the individual

- 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 continent (no episodes of continent voiding)
- 9. Not rated, individual had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 7 days

## H0400. Bowel Continence

**Bowel continence** – Select the one category that best describes the individual

- 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, individual had an ostomy or did not have a bowel movement for the entire 7 days

## H0500. Bowel Continence Program

**Enter**

- **Code**
- **Is an individualized continence promotion program currently being used to manage the individual's bowel continence?**
  - 0. No
  - 1. Yes

## H0600. Bowel Patterns

**Enter**

- **Code**
- **Constipation present?**
  - 0. No
  - 1. Yes
## Section I  Active Diagnoses

### Active Diagnoses in the last 7 days – Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

#### Cancer
- **C0100. 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**
  - I0799a. Blood Pressure
  - [ ] 1
  - [ ] 2
  - [ ] 3
  - [ ] 4
  - [ ] 5

#### 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)
  - I2999. Blood Sugar Range
    - [ ] 1
    - [ ] 2
    - [ ] 3
    - [ ] 4
    - [ ] 5
- **I3100. Hyponatremia**
- **I3200. Hyperkalemia**
- **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto’s thyroiditis)
## 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.

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))</td>
<td></td>
</tr>
<tr>
<td>I3800. Osteoporosis</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>I3999. Contractures</td>
<td></td>
</tr>
<tr>
<td>I4000. Other Fracture</td>
<td></td>
</tr>
<tr>
<td>I4099. Scoliosis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I4200. Alzheimer's Disease</td>
<td></td>
</tr>
<tr>
<td>I4300. Aphasia</td>
<td></td>
</tr>
<tr>
<td>I4400. Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td>I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke</td>
<td></td>
</tr>
<tr>
<td>I4800. Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)</td>
<td></td>
</tr>
<tr>
<td>I4900. Hemiplegia or Hemiparesis</td>
<td></td>
</tr>
<tr>
<td>I5000. Paraplegia</td>
<td></td>
</tr>
<tr>
<td>I5100. Quadriplegia</td>
<td></td>
</tr>
<tr>
<td>I5199. Tremors</td>
<td></td>
</tr>
<tr>
<td>I5200. Multiple Sclerosis (MS)</td>
<td></td>
</tr>
<tr>
<td>I5250. Huntington's Disease</td>
<td></td>
</tr>
<tr>
<td>I5299. Muscular Dystrophy</td>
<td></td>
</tr>
<tr>
<td>I5300. Parkinson's Disease</td>
<td></td>
</tr>
<tr>
<td>I5350. Tourette's Syndrome</td>
<td></td>
</tr>
<tr>
<td>I5399. Hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>I5400. Seizure Disorder or Epilepsy</td>
<td></td>
</tr>
</tbody>
</table>

### I5499. Type of Seizure

↓ Check all that apply

A. Localized (partial or focal)

B. Generalized (absence, myclonic, clonic, tonic and atonic)

### I5499C. Average Frequency of Seizures in the last 7 days

Enter Code

- 0. No seizures
- 1. Less than 1 seizure/week
- 2. 1-6 seizures/week
- 3. 1 seizure/day
- 4. 2-5 seizures/day
- 5. 6-12 seizures/day
- 6. More than 12 seizures/day

| I5500. Traumatic Brain Injury (TBI) |  |
| I5599. Spina Bifida |  |
### Section I  Active Diagnoses

**Active Diagnoses in the last 7 days – Check all that apply**

<table>
<thead>
<tr>
<th>Nutritional</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I5600. Malnutrition (protein or calorie) or at risk for malnutrition</td>
</tr>
<tr>
<td>☐ I5699. At risk for dehydration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric/Mood Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I5700. Anxiety Disorder</td>
</tr>
<tr>
<td>☐ I5800. Depression (other than bipolar)</td>
</tr>
<tr>
<td>☐ I5900. Manic Depression (bipolar disease)</td>
</tr>
<tr>
<td>☐ I5950. Psychotic Disorder (other than schizophrenia)</td>
</tr>
<tr>
<td>☐ I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)</td>
</tr>
<tr>
<td>☐ I6100. Post Traumatic Stress Disorder (PTSD)</td>
</tr>
<tr>
<td>☐ I6199. ADHD Syndrome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)</td>
</tr>
<tr>
<td>☐ I6299. Cystic Fibrosis</td>
</tr>
<tr>
<td>☐ I6300. Respiratory Failure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I6500. Cataracts, Glaucoma, or Macular Degeneration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None of Above</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I7900. None of the above active diagnoses within the last 7 days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ I8000. Additional active diagnoses</td>
</tr>
</tbody>
</table>

Enter diagnosis description and ICD code.

A. ____________________________________________
B. ____________________________________________
C. ____________________________________________
D. ____________________________________________
E. ____________________________________________
F. ____________________________________________
G. ____________________________________________
H. ____________________________________________
I. ____________________________________________
J. ____________________________________________
Section J  Health Conditions

J0100. Pain Management – Complete for the individual, regardless of current pain level
At any time in the last 5 days, has the individual:

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Received scheduled pain medication regimen?</td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td></td>
</tr>
<tr>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td>B. Received PRN pain medications OR was offered and declined?</td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td></td>
</tr>
<tr>
<td>- Yes</td>
<td></td>
</tr>
<tr>
<td>C. Received non-medication intervention for pain?</td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td></td>
</tr>
<tr>
<td>- Yes</td>
<td></td>
</tr>
</tbody>
</table>

J0200. Should Pain Assessment Interview be Conducted? – Attempt to conduct interview with the individual.
If individual is comatose, skip to J1100, Shortness of Breath (dyspnea)

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (individual is rarely/never understood OR individual is less than 3 years of age) → Skip to J0800, Indicators of Pain or Possible Pain</td>
<td></td>
</tr>
<tr>
<td>1. Yes → Continue to J0300, Pain Presence</td>
<td></td>
</tr>
</tbody>
</table>

Pain Assessment Interview

J0300. Pain Presence

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask individual: “Have you had pain or hurting at any time in the last 5 days?”</td>
<td></td>
</tr>
<tr>
<td>0. No → Skip to J1100, Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>1. Yes → Continue to J0400, Pain Frequency</td>
<td></td>
</tr>
</tbody>
</table>

J0400. Pain Frequency

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask individual: “How much of the time have you experienced pain or hurting over the last 5 days?”</td>
<td></td>
</tr>
<tr>
<td>1. Almost constantly</td>
<td></td>
</tr>
<tr>
<td>2. Frequently</td>
<td></td>
</tr>
<tr>
<td>3. Occasionally</td>
<td></td>
</tr>
<tr>
<td>4. Rarely</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>

J0500. Pain Effect on Function

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ask individual: “Over the past 5 days, has pain made it hard for you to sleep at night?”</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
<tr>
<td>B. Ask individual: “Over the past 5 days, have you limited your day-to-day activities because of pain?”</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Enter</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Numeric Rating Scale (00–10)</td>
<td></td>
</tr>
<tr>
<td>Ask individual: “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 individual 00 -10 pain scale)</td>
<td></td>
</tr>
<tr>
<td>Enter two-digit response. Enter 99 if unable to answer.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Verbal Descriptor Scale</td>
<td></td>
</tr>
<tr>
<td>Ask individual: “Please rate the intensity of your worst pain over the last 5 days.” (Show individual verbal scale)</td>
<td></td>
</tr>
<tr>
<td>1. Mild</td>
<td></td>
</tr>
<tr>
<td>2. Moderate</td>
<td></td>
</tr>
<tr>
<td>3. Severe</td>
<td></td>
</tr>
<tr>
<td>4. Very severe, horrible</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>
### Section J  Health Conditions

#### J0700. Should the Caregiver Assessment for Pain be Conducted?

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.</td>
<td>No (J0400=1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)</td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td>Yes (J0400=9) → Continue to J0800, Indicators of Pain or Possible Pain</td>
</tr>
</tbody>
</table>

#### Caregiver Assessment for Pain

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

- [ ] 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

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Code</th>
<th>Description</th>
</tr>
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<tr>
<td></td>
<td>1.</td>
<td><strong>Indicators of pain</strong> or possible pain observed 1 to 2 days</td>
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<tr>
<td></td>
<td>2.</td>
<td><strong>Indicators of pain</strong> or possible pain observed 3 to 4 days</td>
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<tr>
<td></td>
<td>3.</td>
<td><strong>Indicators of pain</strong> or possible pain observed daily</td>
</tr>
</tbody>
</table>

#### Other Health Conditions

**J1000. Shortness of Breath (dyspnea)**

- [ ] 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**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Code</th>
<th>Description</th>
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<tbody>
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<td></td>
<td>0.</td>
<td>No</td>
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<td></td>
<td>1.</td>
<td>Yes</td>
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</table>

**J1550. Problem Conditions**

- [ ] A. **Fever**
- [ ] B. **Vomiting**
- [ ] C. **Dehydrated**
- [ ] D. **Internal bleeding**
- [ ] E99. **Syncope**
- [ ] Z. None of the above
Section J | Health Conditions

J1700. Fall History

Enter A. Did the individual have a fall any time in the last month?
   0. No
   1. Yes
   9. Unable to determine

Enter B. Did the individual have a fall any time in the last 2–6 months?
   0. No
   1. Yes
   9. Unable to determine

Enter C. Did the individual have any fracture related to a fall in the last 6 months?
   0. No
   1. Yes
   9. Unable to determine

J1900. Number of Falls in the last 6 months with or without injury
Complete only if J1700A or J1700B = 1

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

| Enter Codes in Boxes |
|---|---|
| A. No injury – no evidence of any pain, injury or change in the individual's behavior after the fall as reported by the individual/caregiver. |
| B. Injury (except major) – skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the individual to complain of pain |
| C. Major injury – bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma |

Section K | Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

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

K0200. Height and Weight – 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. |
| 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.). Enter `-.` Dash if unable to assess. |

K0300. Weight Loss
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 |
### Section K  Swallowing/Nutritional Status

#### K0310. Weight Gain

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

#### K0510. Nutritional Approaches

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

- 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

#### K0710. Percent Intake by Artificial Route – Complete K0710 only if K0510A or K0510B is checked

| **A.** Proportion of total calories the individual received through parenteral or tube feeding during entire 7 days |
| 1. 25% or less |
| 2. 26–50% |
| 3. 51% or more |

| **B.** Average fluid intake per day by IV or tube feeding during entire 7 days |
| 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
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. Individual 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 individual at risk of developing pressure ulcers?
0. No
1. Yes

M0210. Unhealed Pressure Ulcer(s)

Enter Code
Does this individual have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
0. No → skip to M0300, Number of Venous and Arterial Ulcers
1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number
A. Number of Stage 1 pressure ulcers

Stage 1: Intact skin with non-bleachable 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
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

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown

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

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

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

1. Number of unstageable pressure ulcers due to non-removable dressing/device

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

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

Enter Number
G. Unstageable – Deep tissue: Suspected deep tissue injury in evolution

1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution
Section M  Skin Conditions

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 individual has one or more unhealed 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:

<table>
<thead>
<tr>
<th>Length (cm)</th>
<th>Width (cm)</th>
<th>Depth (cm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

A. **Pressure ulcer length**: Longest length from head to toe

B. **Pressure ulcer width**: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

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)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Epithelial tissue</strong> – new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</td>
</tr>
<tr>
<td></td>
<td><strong>Granulation tissue</strong> – pink or red tissue with shiny, moist, granular appearance</td>
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<td></td>
<td><strong>Slough</strong> – yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</td>
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<td></td>
<td><strong>Eschar</strong> – black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</td>
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<tr>
<td></td>
<td><strong>None of the Above</strong></td>
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</tbody>
</table>

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

Div 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)

G. **Skin tear(s)**

H. **Moisture Associated Skin Damage (MASD)** (i.e. incontinence (IAD), perspiration, drainage)

None of the Above

Z. **None of the above** were present
Section M  Skin Conditions

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. Pressure 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

Section N  Medications

N0300. Injections

Enter Days

Record the number of days that injections of any type were received during the last 7 days
If 0 → Skip to N0410, Medications Received

N0350. Insulin

Enter Days

A. Insulin injections – Record the number of days that insulin injections were received during the last 7 days

Enter Days

B. Orders for insulin – Record the number of days the physician (or authorized assistant or practitioner) changed the individual's insulin orders during the last 7 days

N0410. Medications Received

Indicate the number of DAYS the individual received the following medications during the last 7 days.
Enter "0" if medication was not received by the individual during the last 7 days.

Enter Days

A. Antipsychotic

Enter Days

B. Antianxiety

Enter Days

C. Antidepressant

Enter Days

D. Hypnotic

Enter Days

E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)

Enter Days

F. Antibiotic

Enter Days

G. Diuretic
### 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

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<th>Check all that apply</th>
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<td>A. Chemotherapy</td>
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<td>B. Radiation</td>
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<td><strong>Respiratory Treatments</strong></td>
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<td>C. Oxygen therapy</td>
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<td>D. Suctioning</td>
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<td>E. Tracheostomy care</td>
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<td>F. Ventilator or respirator</td>
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<td>G. BiPAP/CPAP</td>
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<td><strong>Other</strong></td>
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<td>H. IV medications</td>
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<td>I. Transfusions</td>
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<td>K. Hospice care</td>
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<td>L. Respite care</td>
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<tr>
<td>M. <strong>Isolation or quarantine for active infectious disease</strong> (does not include standard body/fluid precautions)</td>
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<td>N99. Psychiatric care</td>
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<tr>
<td>Z. None of the above</td>
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MN and LOC 3.0 V.15 23 of 32
Section O  
Special Treatments, Procedures, and Programs

<table>
<thead>
<tr>
<th>O0400. Therapies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Speech-Language Pathology and Audiology Services</strong></td>
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<td>Enter Number of Minutes</td>
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<tr>
<td>Enter Number of Days</td>
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</tbody>
</table>

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, ➔ skip to O0400B, Occupational Therapy

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 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 last assessment) started

   ![Date Format](Month - Day - Year)

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

   ![Date Format](Month - Day - Year)

<table>
<thead>
<tr>
<th>B. Occupational Therapy</th>
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<tbody>
<tr>
<td>Enter Number of Minutes</td>
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<tr>
<td>Enter Number of Days</td>
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</tbody>
</table>

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, ➔ skip to O0400C, Physical Therapy

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 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 last assessment) started

   ![Date Format](Month - Day - Year)

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

   ![Date Format](Month - Day - Year)

O0400 continued on next page

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**Section O**  
Special Treatments, Procedures, and Programs

**O0400. Therapies - Continued**

<table>
<thead>
<tr>
<th>C. Physical Therapy</th>
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<tbody>
<tr>
<td>Enter Number of Minutes</td>
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<td>Enter Number of Days</td>
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</tbody>
</table>

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

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

3. **Group minutes** - record the total number of minutes this therapy was administered to the individual as **part of a group of individuals** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the individual in co-treatment sessions in the last 7 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 last assessment) started

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
<td>Year</td>
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<table>
<thead>
<tr>
<th>D. Respiratory Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Number of Minutes</td>
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<td>Enter Number of Days</td>
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</tbody>
</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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

<table>
<thead>
<tr>
<th>E. Psychological Therapy (by any licensed mental health professional)</th>
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<tbody>
<tr>
<td>Enter Number of Minutes</td>
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<tr>
<td>Enter Number of Days</td>
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</tbody>
</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual 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

<table>
<thead>
<tr>
<th>F. Recreational Therapy (includes recreational and music therapy)</th>
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</thead>
<tbody>
<tr>
<td>Enter Number of Minutes</td>
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<td>Enter Number of Days</td>
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</table>

1. **Total minutes** - record the total number of minutes this therapy was administered to the individual in the last 7 days

If zero, → skip to O0420, Distinct Calendar Days of Therapy

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
**Section O  Special Treatments, Procedures, and Programs**

**O0420. Distinct Calendar Days of Therapy**

Enter Number of Days

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

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

**O0600. Physician Examinations**

Enter Days

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

**O0700. Physician Orders**

Enter Days

Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the individual'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 individual’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Used in Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Not used</td>
<td>A. Bed rail</td>
</tr>
<tr>
<td>1. Used less than daily</td>
<td>B. Trunk restraint</td>
</tr>
<tr>
<td>2. Used daily</td>
<td>C. Limb restraint</td>
</tr>
<tr>
<td></td>
<td>D. Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
<th>Used in Chair or Out of Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Not used</td>
<td>E. Trunk restraint</td>
</tr>
<tr>
<td>1. Used less than daily</td>
<td>F. Limb restraint</td>
</tr>
<tr>
<td>2. Used daily</td>
<td>G. Chair prevents rising</td>
</tr>
<tr>
<td></td>
<td>H. Other</td>
</tr>
</tbody>
</table>

### Section Q  Participation in Assessment and Goal Setting

**Q0100. Participation in Assessment**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Individual participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Family or significant other participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. No family or significant other available</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>C. Guardian or legally authorized representative participated in assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. No guardian or legally authorized representative available</td>
<td></td>
</tr>
</tbody>
</table>

**Q0300. Individual's Overall Expectation**

Complete only if A0310A = 01

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Select one for individual’s overall goal established during assessment process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Expects to be discharged to the home (i.e. currently in ALF)</td>
</tr>
<tr>
<td>2.</td>
<td>Expects to remain in the home</td>
</tr>
<tr>
<td>3.</td>
<td>Expects to be transferred to a facility/institution</td>
</tr>
<tr>
<td>9.</td>
<td>Unknown or uncertain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>B. Indicate information source for Q0300A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Individual</td>
</tr>
<tr>
<td>2.</td>
<td>If not individual, then family or significant other</td>
</tr>
<tr>
<td>3.</td>
<td>If not individual, family, or significant other, then guardian or legally authorized representative</td>
</tr>
<tr>
<td>9.</td>
<td>Unknown or uncertain</td>
</tr>
</tbody>
</table>
## Section Z

**Assessment Administration**

<table>
<thead>
<tr>
<th>Z0500. Signature of RN Completing Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Signature</strong></td>
</tr>
<tr>
<td><strong>B. Date Assessment Completed:</strong></td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>

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MN and LOC 3.0 V.15
### LTC Medicaid Information

#### S1. Medicaid Information

| S1a | Medicaid Client Indicator 1. Medicaid |
| S1b | Individual Address |
| S1c | City |
| S1d | State |
| S1e | ZIP Code |
| S1f | Phone |

#### S2. Claims Processing Information

| S2a | DADS Vendor/Site ID Number |
| S2b | Contract/Provider Number |
| S2d | NPI Number |
| S2e | Region |
| S2f | Purpose Code |
| S2g | HHA License # |
| S2h | HHA License # Expiration Date |

#### S3. Primary Diagnosis

| S3a | Primary Diagnosis ICD Code |
| S3b | Primary Diagnosis ICD Description |

#### S4. For DADS use only

| S4a | MN |
| S4b | RUG |
| S4c | Effective Date |
| S4d | Expiration Date |
| S4e | County |
| S4f | DADS RN Signature |
| S4g | Signature Date |

#### S5. Licenses

**Certification**: To the best of my knowledge, I certify to the accuracy and completeness of this information.

| S5a | HHA RN Last Name |
| S5b | HHA RN License # |
| S5c | HHA RN License State |
| S5d | DADS RN Last Name |
| S5e | DADS RN License # |
| S5f | DADS RN License State |
| S5g | DADS RN Signature Date |
| S5h | PACE RN Last Name |
| S5i | PACE RN License # |
| S5j | PACE RN License State |
| S5k | HMO RN Last Name |
| S5l | HMO RN License # |
| S5m | HMO RN License State |

#### S6. Additional MN Information

| S6a | Tracheostomy Care 1. Less than once a week 2. 1 to 6 times a week 3. Once a day 4. Twice a day 5. 3 - 11 times a day 6. Every 2 hours 7. Hourly / continuous |
| S6b | Ventilator/Respirator 1. Less than once a week 2. 1 to 6 times a week 3. Once a day 4. Twice a day 5. 3 - 11 times a day 6. 6 - 23 hours 7. 24-hour continuous |
**LTC Medicaid Information**

<table>
<thead>
<tr>
<th>S6c</th>
<th>Number of hospitalizations in the last 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>S6d</td>
<td>Number of emergency room visits in the last 90 days</td>
</tr>
</tbody>
</table>
| S6e | Oxygen Therapy  
1. Less than once a week  
2. 1 to 6 times a week  
3. Once a day  
4. Twice a day  
5. 3 - 11 times a day  
6. 6 - 23 hours  
7. 24-hour continuous |
| S6f | Special Ports/Central Lines/PICC Y/N/U |
| S6g | At what developmental level is the individual functioning?  
1. < 1 Infant  
2. 1 - 2 Toddler  
3. 3 - 5 Pre-School  
4. 6 - 10 School age  
5. 11 - 15 Young Adolescence  
6. 16 - 20 Older Adolescence  
7. Unknown or unable to assess |
| S6h | Enter the number of times this individual has fallen in the last 90 days |
| S6i | In how many of the falls listed above was the person physically restrained prior to the fall? |
| S6j | In the falls listed in S6h above, how many had the following contributory factors? (More than one factor may apply to a fall. Indicate the number of falls for each contributory factor.)  
1. Environmental (debris, slick or wet floors, lighting, etc.)  
2. Medication(s)  
3. Major Change in Medical Condition (Myocardial Infarction (MI/Heart Attack), Cerebrovascular Accident (CVA/Stroke), Syncope (Fainting), etc.)  
4. Poor Balance/Weakness  
5. Confusion/Disorientation  
6. Assault by Individual or Caregiver |

**S7. Physician's Evaluation & Recommendation**

| S7a | Did an MD/DO certify that this individual requires nursing facility services or alternative community based services under the supervision of an MD/DO? Y/N |
| S7b | Did a military physician providing healthcare according to requirements stipulated in 10 US Code 1094 provide the evaluation and recommendation for this individual? Y/N |
| S7c | MD/DO Last Name |
| S7d | MD/DO License # |
| S7e | MD/DO License State |
| S7f | MD/DO First Name |
| S7g | MD/DO Address |
| S7h | MD/DO City |
| S7i | MD/DO State |
| S7j | MD/DO ZIP Code |
| S7k | MD/DO Phone |

The following MD/DO information is required if MD/DO is not licensed in Texas.
LTC Medicaid Information

S9. Medications

List all medications that the individual received during the last 30 days. Include scheduled medications that are used regularly, but less than weekly.

☐ **Medication Certification:** I certify this individual is taking no medications OR the medications listed below are correct.

<table>
<thead>
<tr>
<th>1. Medication Name and Dose Ordered</th>
<th>2. RA</th>
<th>3. Freq</th>
<th>4. PRN-n</th>
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<tbody>
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</table>
LTC Medicaid Information

S10. Comments

S11. Advance Care Planning

| S11a | Does the individual/caregiver report having a legally authorized representative? | Y/N |
| S11b | Does the individual/caregiver report having a Directive to Physicians and Family or Surrogates? | Y/N |
| S11c | Does the individual/caregiver report having a Medical Power of Attorney? | Y/N |
| S11d | Does the individual/caregiver report having an Out-of-Hospital Do Not Resuscitate Order? | Y/N |

S12. LAR Address

Required if individual/caregiver has reported having a legally authorized representative.

| S12a | LAR First Name |
| S12b | LAR Last Name |
| S12c | Address |
| S12d | City |
| S12e | State |
| S12f | ZIP Code |
| S12g | Phone |