

MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Part A PPS Discharge (NPE) Item Set

Section A	Identification Information
A0050. Type of Record	
Enter Code ☐	1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider
A0100. Facility Provider Numbers	
	A. National Provider Identifier (NPI): B. CMS Certification Number (CCN): C. State Provider Number:
A0200. Type of Provider	
Enter Code ☐	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed
A0310. Type of Assessment	
Enter Code ☐	A. Federal OBRA Reason for Assessment 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
Enter Code ☐	B. PPS Assessment PPS Scheduled 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 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
Enter Code ☐	C. PPS Other Medicare Required Assessment - OMRA 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code ☐	D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2 0. No 1. Yes
Enter Code ☐	E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? 0. No 1. Yes
A0310 continued on next page	

Section A	Identification Information
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A0310. Type of Assessment - Continued

Enter Code 	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code 	G. Type of discharge - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned
Enter Code 	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

A0410. Unit Certification or Licensure Designation

Enter Code 	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified
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A0500. Legal Name of Resident

	A. First name:		B. Middle initial:	
	C. Last name:		D. Suffix:	

A0600. Social Security and Medicare Numbers

[illegible]

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

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A0800. Gender

Enter Code	1. Male 2. Female
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A0900. Birth Date

	- - Month Day Year
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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

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

		-			-				
Month			Day			Year			

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

		-			-				
Month			Day			Year			

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

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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**

A2300. Assessment Reference Date

Observation end date:

		-			-				
Month			Day			Year			

A2400. Medicare Stay

Enter Code

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

0. **No** → Skip to GG0130, Self-Care
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

		-			-				
Month			Day			Year			

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

		-			-				
Month			Day			Year			

Section GG**Functional Abilities and Goals - Discharge (End of SNF PPS Stay)****GG0130. Self-Care** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

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

If activity was not attempted, code reason:

- 07. **Resident refused.**
- 09. **Not applicable.**
- 88. Not attempted due to **medical condition or safety concerns.**

**3.
Discharge
Performance**

Enter Code

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A. Eating: The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.

Enter Code

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B. Oral hygiene: The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]

Enter Code

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C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

Section GG**Functional Abilities and Goals - Discharge (End of SNF PPS Stay)****GG0170. Mobility** (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)**Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.****Coding:****Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.*Activities may be completed with or without assistive devices.*

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

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Codes in Boxes	
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	C. Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	D. Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
	E. Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair).
	F. Toilet transfer: The ability to safely get on and off a toilet or commode.
☐	H3. Does the resident walk? 0. No → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. Yes → Continue to GG0170J, Walk 50 feet with two turns
	J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐	Q3. Does the resident use a wheelchair/scooter? 0. No → Skip to J1800, Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent 1. Yes → Continue to GG0170R, Wheel 50 feet with two turns
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
☐	RR3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized
	S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
☐	SS3. Indicate the type of wheelchair/scooter used. 1. Manual 2. Motorized

Section J Health Conditions

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

Enter Code ☐	Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent? 0. No → Skip to M0210, Unhealed Pressure Ulcer(s) 1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)
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J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	A. No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	B. Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting 1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage
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M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister 1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of <u>these</u> 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
Enter Number ☐	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling 1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 2. Number of <u>these</u> 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
Enter Number ☐	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling 1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable - Non-removable dressing 2. Number of <u>these</u> 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

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 - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number 	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number 	G. Unstageable - Deep tissue injury: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0800, Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry 2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

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

Enter Number 	A. Stage 2
Enter Number 	B. Stage 3
Enter Number 	C. Stage 4

Section X**Correction Request****Complete Section X only if A0050 = 2 or 3**

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

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

Enter Code

☐**Type of provider**

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

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)**A. First name:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

C. Last name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

Enter Code

☐

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

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

				-				-											
Month						Day				Year									

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

				-				-											

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

Enter Code

☐**A. Federal OBRA Reason for Assessment**

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

Enter Code

☐**B. PPS Assessment****PPS Scheduled 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

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**

Enter Code

☐**C. PPS Other Medicare Required Assessment - OMRA**

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

X0600 continued on next page

Section X**Correction Request****X0600. Type of Assessment - Continued**

Enter Code ☐	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code ☐ ☐	F. Entry/discharge reporting 01. Entry tracking record 10. Discharge assessment- return not anticipated 11. Discharge assessment- return anticipated 12. Death in facility tracking record 99. None of the above
Enter Code ☐	H. Is this a SNF Part A PPS Discharge Assessment? 0. No 1. Yes

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

A. Assessment Reference Date (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99
- - Month Day Year
B. Discharge Date (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12
- - Month Day Year
C. Entry Date (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01
- - Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request**X0800. Correction Number**

Enter Number 	Enter the number of correction requests to modify/inactivate the existing record, including the present one
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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
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Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

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

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

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**A. Signature:****B. Date RN Assessment Coordinator signed assessment as complete:**

		-			-				
Month			Day			Year			

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