Skilled Nursing Facility | MDS 3.0 RAI v1.18.11

Quality Reporting Program

PRACTICE CODING REFERENCE PACKET

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Virtual Training

June 21, 2023

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Social Determinants of Health (SDOH) and New Data Elements in Section A

A1005. Ethnicity

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓	**Check all that apply**
☐	**A.** No, not of Hispanic, Latino/a, or Spanish origin
☐	**B.** Yes, Mexican, Mexican American, Chicano/a
☐	**C.** Yes, Puerto Rican
☐	**D.** Yes, Cuban
☐	**E.** Yes, another Hispanic, Latino/a, or Spanish origin
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

Practice Scenario 1

A resident was confused and unable to answer the question related to whether they are of Hispanic, Latino, or Spanish origin.

The resident's daughter stated that the resident was born in Brazil and has never considered themself as of Hispanic, Latino, or Spanish origin.

Practice Scenario 2

A resident was just admitted to the facility, and during their Admission assessment, when asked if they were of Hispanic, Latino/a, or Spanish origin, they declined to respond to the question of ethnic origin.

To reassure the resident, the assessor stated that they asked this question so that the treatment the resident receives is of the highest quality of care regardless of their ethnic background.

The resident still declined to answer the question.

A1010. Race

A1010. Race What is your race?	
↓	**Check all that apply**
☐	**A.** White
☐	**B.** Black or African American
☐	**C.** American Indian or Alaska Native
☐	**D.** Asian Indian
☐	**E.** Chinese
☐	**F.** Filipino
☐	**G.** Japanese
☐	**H.** Korean
☐	**I.** Vietnamese
☐	**J.** Other Asian
☐	**K.** Native Hawaiian
☐	**L.** Guamanian or Chamorro
☐	**M.** Samoan
☐	**N.** Other Pacific Islander
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond
☐	**Z.** None of the above

Practice Scenario 3

A resident was just admitted to the facility. Because they are in the late stages of dementia, their daughter assisted with answering some of the assessment information. The resident's daughter stated that their father is African American.

A1250. Transportation

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓	Check all that apply
☐	**A.** Yes, it has kept me from medical appointments or from getting my medications
☐	**B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	**C.** No
☐	**X.** Resident unable to respond
☐	**Y.** Resident declines to respond

Practice Scenario 4

The nurse asked the resident upon admission if, in the past 6 months to a year, lack of transportation kept them from medical appointments, meetings, work, or getting things needed for daily living.

The resident stated that over the last 6 months, they did not have difficulty getting things needed for daily living but did have difficulty getting to and from their medical appointments because they were living alone and did not have a way to get to appointments.

The resident reports that after discharge, they will not have difficulty getting to their doctor's appointments because their sister will be living with them.

Practice Scenario 5

A resident was asked about whether they had any lack of transportation per the questions provided.

The resident declined to answer any more questions and asked to be left alone. Even though the resident has a daughter who could respond to these questions, the resident asked that their daughter not be bothered.

B1300. Health Literacy

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

Practice Scenario 6

A resident was recently hospitalized after a heart attack with a subsequent diagnosis of atrial fibrillation and was admitted to your facility. During the 5-Day Prospective Payment System (PPS) assessment, you ask the resident, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

The resident states, "It was very difficult to comprehend the instructions that were given to me regarding my new warfarin medication. All the other discharge instructions, I understood without a problem. I rarely have a problem with medication instructions, pamphlets, or other written materials from doctors or pharmacies, but this medication requires testing and adjustments that I just don't understand, so I need help with that."

D0700. Social Isolation

D0700. Social Isolation

Enter Code ☐

How often do you feel lonely or isolated from those around you?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

Practice Scenario 7

A resident with early-stage dementia who has been in the facility for a year was asked during the observation period of their Annual assessment about how often they have felt lonely or isolated from those around them.

The resident stated that they did not want to answer any more questions. The resident's spouse, who happened to be in the room, offered that they have noticed that the resident rarely seems lonely since they have started to participate in more activities and have some new friends.

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge and A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Complete only if A0310H = 1 and A2105 = 02-12

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Complete only if A2121 = 1

↓ Check all that apply	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

Practice Scenario 8

A resident is being sent to an acute care hospital in a healthcare system that uses the same Electronic Health Record (EHR) as your facility. This means that the acute care hospital staff admitting the resident will be able to access this information as soon as it is transmitted.

The resident's reconciled medication list, progress notes, and transfer information are uploaded into the EHR by your facility at the time of discharge.

While the discharge nurse received a system message of successful transmission upon sending this information, there has been no confirmation that the acute care hospital staff have accessed the information.

A2123. Provision of Current Reconciled Medication List to Resident at Discharge and A2124. Route of Current Reconciled Medication List Transmission to Resident

A2123. Provision of Current Reconciled Medication List to Resident at Discharge

Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2124. Route of Current Reconciled Medication List Transmission to Resident

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.

Complete only if A2123 = 1

↓ Check all that apply	Route of Transmission
☐	A. **Electronic Health Record** (e.g., electronic access to patient portal)
☐	B. **Health Information Exchange**
☐	C. **Verbal** (e.g., in-person, telephone, video conferencing)
☐	D. **Paper-based** (e.g., fax, copies, printouts)
☐	E. **Other methods** (e.g., texting, email, CDs)

Practice Scenario 9

A resident had several medications discontinued during their PPS stay at the facility. At the time of discharge home, the resident still had an over-the-counter heartburn relief medication as well as numerous prescription medications.

The nurse verbally reviewed all medications and the resident confirmed understanding of each medication, how to take them, what dosage to take, and when.

The nurse handed a printed copy of the current reconciled medication list to the resident at the time of discharge. The resident also asked for a copy to give to their daughter.

Section D: Resident Mood Interview and Total Severity Score

D0150. Resident Mood Interview (PHQ-2 to 9©) and D0160. Total Severity Score

D0150. Resident Mood Interview (PHQ-2 to 9©)

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

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

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

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
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*	☐	☐

D0160. Total Severity Score

Enter Code ☐☐

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 required items).

Practice Scenario 1

Refer to video vignette with Mr. Mason. Mr Mason PHQ-2 to 9 with burned in captions.mp4 (vimeo.com).

Practice Scenario 2

Part 1:

The nurse is assessing a resident, Mr. K, and asks him, "Over the last 2 weeks, have you been bothered by any of the following problems: little interest or pleasure in doing things?"

Mr. K responds, "Maggie brings me lots of ice cream, but my favorite is vanilla."

The nurse checks to be sure that Mr. K can hear them and then proceeds to ask the question again. Mr. K shakes his head and says again, "My favorite is vanilla."

Part 2:

The nurse continues the Resident Mood Interview of Mr. K, asking him, "Over the last two weeks, have you been bothered by any of the following problems: feeling down, depressed, or hopeless?"

Mr. K looks away and does not respond. The nurse checks again to be sure that Mr. K. can hear them and proceeds to ask the question again.

Mr. K. remains silent and does not respond.

Practice Scenario 3

Part 1:

Mrs. M has been newly admitted to your facility. She is asked, "Over the last 2 weeks, have you been bothered by the following problems: little interest or pleasure in doing things?"

She states, "I have been in the hospital for over a week, and I feel that I am not getting any better. I am bothered that I have had no interest in reading or doing the things I enjoy."

The nurse shows the cue card and then asks, "Over the last 2 weeks, how often would you say you have been bothered by this: never or 1 day, 2-6 days, 7-11 days, or 12-14 days?"

Mrs. M responds, "7-11 days."

Part 2:

The nurse further questions Mrs. M, "Over the last two weeks, how often have you been bothered by any of the following problems: feeling down, depressed, or hopeless?"

Mrs. M responds, "Well, yes, I have been bothered by feeling a little down and hopeless, but I'm not depressed."

Then the nurse asks, "Over the last 2 weeks, how often would you say you have been bothered by this?"

Mrs. M. responds, "12-14 days; almost every day."

Section GG: Functional Abilities and Goals

GG0130. Self-Care

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

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 themself 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 and/or touching/steadying and/or contact guard 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** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes ↓	↓	
☐☐	☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐☐	B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	■■	I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0130. Self-Care (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the 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 themself 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 and/or touching/steadying and/or contact guard 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** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	3. Discharge Performance
Enter Codes in Boxes ↓	
☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Practice Scenario 1

Part 1:

A resident is admitted to the facility for a PPS stay. The resident indicates to the Certified Nursing Assistant (CNA) that in the hospital, they had difficulty with fatigue and weakness and needed help with some aspects of personal hygiene. The assessor identified that based on the resident's past independence at home with these tasks prior to hospitalization, and the resident's motivation, they could achieve their prior level of function by discharge.

While in the bathroom, the resident retrieved a face cloth from the towel rack and removed their personal hygiene items (comb, razor, and shaving cream) from their toiletry bag. The resident was able to wash and dry their face and hands but complained of arm fatigue after combing their hair.

The resident started to shave but required verbal cueing and steadying assistance of the resident's arm due to upper arm weakness.

After completing these personal hygiene tasks, the CNA returned the resident's personal care items to the toiletry bag and cleaned out the sink.

The resident requires this level of assistance each day for the next 3 days.

Part 2:

With therapy, the resident progressed throughout the stay in their ability to complete all personal hygiene tasks without any fatigue or arm weakness.

At discharge, the resident no longer required any assistance or supervision with personal hygiene, meeting their discharge goal.

GG0130. Self-Care

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, 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 themself 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 and/or touching/steadying and/or contact guard 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** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	5. OBRA/Interim Performance Enter Codes in Boxes ↓
A.	**Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
B.	**Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
C.	**Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
E.	**Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
F.	**Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
G.	**Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
H.	**Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
I.	**Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Practice Scenario 2

A nurse is in the process of completing a resident's Annual assessment. Below is a conversation between a CNA and the nurse regarding the resident's ability to complete personal hygiene tasks during the observation period.

The nurse asks, “Can you please describe how the resident washes and dries their face and hands, applies makeup, and grooms their hair in the morning?”

The CNA responds, “They can wash up once I set up a basin and the towels, but I usually have to make sure their face is dried. I also always have to brush their hair and apply makeup each day. Although they do attempt to do this, it is never complete. I usually put everything away when we’re done.”

GG0170. Mobility

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01. Complete columns 1 and 2 when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident’s usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason. Code the resident’s end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

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 themself 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 and/or touching/steadying and/or contact guard 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** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes ↓	↓	
☐☐	☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	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 move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	■■	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	☐☐	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.

GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the 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 themself 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 and/or touching/steadying and/or contact guard 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** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	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 move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	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.

Practice Scenario 3

Part 1:

On the first day of the Admission assessment period, a resident required assistance with a tub transfer. One CNA provided steadying assistance as the resident slowly sat on the side of the tub bench. Once seated, the resident was able to lift one leg at a time into the tub and position themselves in the center of the bench. After bathing was complete, the resident was able to lift both legs out of the tub and the CNA provided steadying assistance as the resident stood up.

On Day 3 of the assessment period, the CNA provided contact guard assistance for the resident as they sat on the tub bench and positioned themselves. The resident was able to swing both legs into and out of the tub and was provided with contact guard assistance to stand up. No other tub or shower transfers occurred during the observation period.

Part 2:

A month after the resident was admitted, the resident's family notified the facility that they are moving out of state and have found another facility for the resident near them so that they could continue to visit frequently.

3 days before discharge, the CNA reported to the discharging nurse that the resident was able to independently sit on the side of the tub bench and swing both legs into and out of the tub and position themself in the center of the bench. The CNA assisted by setting up the tub bench and bath supplies.

After bathing was complete, the resident was able to lift both legs out of the tub, put on a robe, and leave the bathroom. The CNA cleaned up the bath area and removed the tub bench. No other tub or shower transfers occurred during the observation period.

Practice Scenario 4

During the last 3 days of the observation period for a resident's Quarterly assessment, the resident was scheduled for a shower. The assessing nurse asked the resident's primary CNA if they can describe how the resident usually transfers in and out of the shower.

The CNA responds, "The resident can walk to the shower room using their walker, but I have to be nearby because sometimes they walk too fast, and I have to remind them to slow down. Once there, they can disrobe and enter the shower. I place the face cloth and soap on the shelf in the shower for them. To transfer into the shower, they use their walker. The resident then sits on the shower bench and is able to wash their body. Once they finish, they are able to stand up using their walker, put a towel on, and walk out of the shower. They pull the cord for me to come back to help them dry off, put their robe back on, and walk back to their room."

Section J: Pain Interview

J0510. Pain Effect on Sleep

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"***

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

Practice Scenario 1

A resident is admitted to the Skilled Nursing Facility (SNF) for continued care after a 10-day stay in the acute care hospital for repair of a right hip fracture resulting from a fall. A nurse is completing the Admission assessment.

The admitting nurse asks the resident, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

The resident responds, "The pain was unbearable at the hospital last week and I wasn't sleeping. I know that I was on a lot of medication there. But now I'm not sure what day it is. Is this Saturday?

The nurse replies, "Yes, today is Saturday. Can you recall when your most recent episode of pain was?"

The resident says, "No, I really cannot remember."

After indicating that they cannot recall when their most recent episode of pain was, the resident says that they do not want to discuss this any further.

Practice Scenario 2

Part 1:

A resident is preparing for discharge from the SNF after recovering from a major automobile accident and subsequent right lower lobe pneumonia.

During the discharge assessment, the nurse assessor asks the resident, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"

The resident responds, "Some nights I have a really hard time sleeping due to my pain – especially when I have done too much during the day. On those nights, I need to ask the nurse for additional pain medication before I can get back to sleep."

Part 2:

As a follow-up, the nurse asks the resident whether this pain occurred occasionally or frequently over the past 5 days.

The resident responds, "I guess I would say occasionally, since it only happens now and then."

J0520. Pain Interference with Therapy Activities

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your participation in rehabilitation therapy sessions due to pain?**"*

0. **Does not apply - I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

Practice Scenario 3

During the first week in the SNF, a nurse is completing the admission assessment and asks the resident, "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"

The resident reports, "I developed an infection in my foot and started intravenous (IV) antibiotics about 3 days ago. My doctor says that therapy will not start until this infection gets under control."

Practice Scenario 4

A resident with a history of osteoporosis has recovered from a spinal compression fracture and is about to be discharged from the SNF. The resident will be receiving outpatient therapy services after discharge. Staff have reported observing the resident experiencing a lot of pain during therapy sessions at the SNF.

The assessor reads the question and response choices as written.

The resident responds, "I have been able to go to therapy for most of my time here. I can recall only one instance in the past 5 days when the pain in my back was so severe that I had to limit my participation in therapy."

The assessor confirms, "The pain in your back limited your participation in therapy only one time in the past 5 days. If you had to choose an answer, would you say you have limited your participation in rehabilitation therapy sessions due to pain rarely or occasionally?"

The resident responds, "Rarely."

J0530. Pain Interference with Day-to-Day Activities

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?**"*

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

Practice Scenario 5

A resident is preparing for discharge after a prolonged SNF stay following a total knee replacement with subsequent joint infection.

During the discharge assessment, the nurse assessor asks the resident, "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"

The resident replies, "Most days I can do what I want to do, though I was disappointed that I couldn't attend the resident and staff Memorial Day celebration last week as I was having some pain on the day of the event. I still have pain in my knee from the surgery. Some days are good, and others are more difficult. I'm not sure… I would say that pain limits my day-to-day activities occasionally to frequently."

The assessor asks if the resident is able to narrow down their response choices, but the resident indicates that they are not.

Practice Scenario 6

A resident was transferred from the acute care hospital and has been in the SNF recovering from an episode of congestive heart failure. The resident also has severe rheumatoid arthritis.

The nurse is completing the admission assessment and asks the resident, “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?”

The resident replies, “I try to do as much as I can throughout the day and get out of my room, but I need to stop often to sit down and catch my breath. My feet are swollen and ache, and my joints hurt almost all the time, so it’s hard to walk.

Between my feet and joints, I always have pain that almost constantly limits my day-to-day activities. I don’t like taking the pain medication, so I tend to decline when the nurses offer it.”

Practice Scenario 7

A resident with a diagnosis of debility, Parkinson’s disease, and dementia was recently transferred to the SNF from an acute care hospital after experiencing a fall at home. The resident is sometimes able to respond to questions.

Staff report that the resident has seemed to be in a lot of pain since arriving. The resident’s daughter has also stated that their father seems to be experiencing a lot of pain since arriving to the facility.

The assessor completing the admission assessment asks the resident, “Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?”

The resident responds, “I want to go home.”

The assessor repeats the question in order to attempt to obtain a response. However, the resident repeatedly states that they want to go home and then becomes agitated. The assessor is unable to obtain a response from the resident.

The resident’s daughter, who is present during the assessment, reports that their father has frequently been complaining of pain.

Section K: Nutritional Approaches

K0520. Nutritional Approaches

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***
   Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
	↓ Check all that apply ↓			
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	[redacted]	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

Practice Scenario 1

A resident was admitted to the SNF for rehabilitation following a recent stroke.

On Day 5 they were placed on a low sodium diet (therapeutic diet) due to high blood pressure, which was exacerbated following news of a family tragedy.

On Day 7 of this PPS stay, the resident was temporarily placed on a mechanical soft diet due to a singular choking episode. Because the resident had no further choking episodes and requested a regular diet, the mechanical soft diet was discontinued on Day 13.

The high blood pressure improved with the low sodium diet and was continued throughout the stay. The low sodium diet was also ordered upon discharge to home.

Practice Scenario 2

Part 1:

A resident was admitted for a SNF PPS stay with a feeding tube after a long hospitalization.

They had been receiving tube feedings daily while receiving therapy to improve swallowing and progress to intake by mouth. The tube feedings were ordered to continue on admission.

The resident received 2 days of IV medication and fluids in the hospital and arrived with a peripheral line and orders to continue both for 5 more days. Upon reviewing the resident's transfer documentation, there is no supporting documentation indicating a need for additional fluid intake to support a need for hydration.

Part 2:

Over the 3-week stay (21 days), the resident slowly progressed on a mechanically altered diet and was placed on a regular diet on Day 10.

Their oral intake was nutritionally sufficient by the last week of the stay, so a decision was made to stop the tube feedings and remove the tube on Day 17, 4 days before discharge.

Section N: Medications

N0415. High-Risk Drug Classes: Use and Indication

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
A. **Antipsychotic**	☐	☐
B. **Antianxiety**	☐	☐
C. **Antidepressant**	☐	☐
D. **Hypnotic**	☐	☐
E. **Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. **Antibiotic**	☐	☐
G. **Diuretic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the above**	☐	

Practice Scenario 1

In the process of completing the resident's 5-Day PPS assessment, the nurse notes that the resident's medication documentation during the 7-day observation period reflects they are taking edoxaban and glipizide.

The documentation also indicates that the resident has type 2 diabetes and is taking glipizide to control their high blood sugar.

There is no indication documented for the edoxaban.

The resident received these medications daily during the last 7 days.

Practice Scenario 2

A resident was admitted for a SNF PPS stay 7 days ago.

When completing the 5-Day PPS assessment, the nurse reviewed the resident's medication record for the 7-day observation period. They noted that the resident is taking lisinopril for high blood pressure, levothyroxine for thyroid replacement, acetaminophen for arthritic pain, and low-dose aspirin for cardiovascular disease. They have also been taking lithium and clozapine for bipolar disorder for several years and are continuing to take these medications.

The nurse noted that the resident received these medications daily since admission.

Practice Scenario 3

A resident was admitted to the SNF from the hospital 5 days ago.

The nurse noted, while completing the 5-Day PPS assessment, that during the 7-day observation period the resident's medication record indicated that they are taking atenolol for hypertension, St. John's Wort (Hypericum perforatum) for depression, a daily multivitamin, and diphenhydramine for sleep.

The resident received these medications and the herbal supplement daily since admission.

Section O: Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

O0110. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***
c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐	[redacted]	☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐
Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐	[redacted]	☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐	[redacted]	☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐	[redacted]	☐
G3. CPAP	☐		☐
Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐	[redacted]	☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐

O0110 continued on next page

O0110. Special Treatments, Procedures, and Programs - Continued

Check all of the following treatments, procedures, and programs that were performed

a. **On Admission** Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
b. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***
c. **At Discharge** Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

	a. On Admission	b. While a Resident	c. At Discharge
	↓	Check all that apply ↓	↓
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐	[redacted]	☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care	[redacted]	☐	[redacted]
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐	[redacted]	☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

Practice Scenario 1

Part 1:

A resident was discharged from the hospital following an acute care inpatient stay for pneumonia.

On admission to the SNF for a PPS stay, the resident requires continuous oxygen (> 14 hours per day) via nasal canula and intravenous (IV) antibiotics via a peripheral line.

The resident received these treatments during the first 5 days of the stay.

Part 2:

Once the IV antibiotic course is completed on Day 5, the peripheral IV is discontinued.

By the end of week 2 (14 days), the resident is improving and requires oxygen only intermittently for 2 hours per day. By Day 17, there are no further supplemental oxygen needs.

The resident is discharged to home 4 days later, on Day 21.

Practice Scenario 2

Part 1:

A resident was discharged from the acute care hospital and admitted to the hospital swing bed (SNF) for a PPS stay following a pathologic vertebral fracture related to small cell lung cancer with bone metastasis.

While hospitalized, the resident was found to have a blood clot. IV heparin was administered via the previously placed central line port. The IV heparin continued to be administered during the first week of the PPS stay, until they were transitioned to subcutaneous heparin.

The resident also continued receiving oral chemotherapy medications as ordered throughout the stay.

Part 2:

Over the 2-week period of the SNF stay, the resident was placed on subcutaneous heparin and the IV anticoagulant was discontinued on Day 8. The port remained in place and was flushed daily by the nursing staff.

On discharge, the resident was referred for home health services for physical therapy and for nursing to continue to flush the port and teach the administration of a newly ordered oral anticoagulant. The discharge orders included the oral chemotherapy and returning for a follow up visit with the outpatient oncology team.

Practice Scenario 3

Part 1:

The resident was admitted to the SNF for a PPS stay after surgery for a fractured hip. Due to a history of renal failure, they receive hemodialysis 3 times per week. The contracted End Stage Renal Disease (ESRD) facility staff provided dialysis services at the SNF via the arteriovenous (AV) fistula while the resident was in for rehab.

Starting on the day of admission and throughout the stay, in addition to hemodialysis, the resident also received physical therapy and independently managed their continuous positive airway pressure (CPAP) for obstructive sleep apnea.

Part 2:

5 days before discharge, an infection developed at the surgical site resulting in the need for IV antibiotics via a peripheral line.

The resident wished to return home, so after 5 days of receiving the IV antibiotics, the resident was discharged with a saline lock to maintain access for the remaining doses of the IV antibiotics, which they would receive at home.

Discharge occurred on day 21.