

## MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Part A PPS Discharge (NPE) Item Set

<b>Section A</b>	<b>Identification Information</b>
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**A0050. Type of Record**

Enter Code <input style="width: 100%;" type="text"/>	<ol style="list-style-type: none"> <li>1. <b>Add new record</b> → Continue to A0100, Facility Provider Numbers</li> <li>2. <b>Modify existing record</b> → Continue to A0100, Facility Provider Numbers</li> <li>3. <b>Inactivate existing record</b> → Skip to X0150, Type of Provider</li> </ol>
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**A0100. Facility Provider Numbers**

	<p><b>A. National Provider Identifier (NPI):</b></p> <p><b>B. CMS Certification Number (CCN):</b></p> <p><b>C. State Provider Number:</b></p>
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**A0200. Type of Provider**

Enter Code <input style="width: 100%;" type="text"/>	<p><b>Type of provider</b></p> <ol style="list-style-type: none"> <li>1. <b>Nursing home (SNF/NF)</b></li> <li>2. <b>Swing Bed</b></li> </ol>
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**A0310. Type of Assessment**

Enter Code <input style="width: 100%;" type="text"/>	<p><b>A. Federal OBRA Reason for Assessment</b></p> <ol style="list-style-type: none"> <li>01. <b>Admission</b> assessment (required by day 14)</li> <li>02. <b>Quarterly</b> review assessment</li> <li>03. <b>Annual</b> assessment</li> <li>04. <b>Significant change in status</b> assessment</li> <li>05. <b>Significant correction to prior comprehensive</b> assessment</li> <li>06. <b>Significant correction to prior quarterly</b> assessment</li> <li>99. <b>None of the above</b></li> </ol>
Enter Code <input style="width: 100%;" type="text"/>	<p><b>B. PPS Assessment</b></p> <p><b>PPS Scheduled Assessments for a Medicare Part A Stay</b></p> <ol style="list-style-type: none"> <li>01. <b>5-day</b> scheduled assessment</li> <li>02. <b>14-day</b> scheduled assessment</li> <li>03. <b>30-day</b> scheduled assessment</li> <li>04. <b>60-day</b> scheduled assessment</li> <li>05. <b>90-day</b> scheduled assessment</li> </ol> <p><b>PPS Unscheduled Assessments for a Medicare Part A Stay</b></p> <ol style="list-style-type: none"> <li>07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment)</li> </ol> <p><b>Not PPS Assessment</b></p> <ol style="list-style-type: none"> <li>99. <b>None of the above</b></li> </ol>
Enter Code <input style="width: 100%;" type="text"/>	<p><b>C. PPS Other Medicare Required Assessment - OMRA</b></p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Start of therapy</b> assessment</li> <li>2. <b>End of therapy</b> assessment</li> <li>3. <b>Both Start and End of therapy</b> assessment</li> <li>4. <b>Change of therapy</b> assessment</li> </ol>
Enter Code <input style="width: 100%;" type="text"/>	<p><b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if A0200 = 2</p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>
Enter Code <input style="width: 100%;" type="text"/>	<p><b>E. Is this assessment the first assessment</b> (OBRA, Scheduled PPS, or Discharge) <b>since the most recent admission/entry or reentry?</b></p> <ol style="list-style-type: none"> <li>0. <b>No</b></li> <li>1. <b>Yes</b></li> </ol>

**A0310 continued on next page**

<b>Section A</b>	<b>Identification Information</b>
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**A0310. Type of Assessment - Continued**

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

**A0410. Unit Certification or Licensure Designation**

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. <b>Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State</b></li> <li>2. <b>Unit is neither Medicare nor Medicaid certified but MDS data is required by the State</b></li> <li>3. <b>Unit is Medicare and/or Medicaid certified</b></li> </ol>
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**A0500. Legal Name of Resident**

	<b>A. First name:</b> _____	<b>B. Middle initial:</b> _____
	<b>C. Last name:</b> _____	<b>D. Suffix:</b> _____

**A0600. Social Security and Medicare Numbers**

	<b>A. Social Security Number:</b> _____ - _____ - _____
	<b>B. Medicare number</b> (or comparable railroad insurance number): _____

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

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**A0800. Gender**

Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"> <li>1. <b>Male</b></li> <li>2. <b>Female</b></li> </ol>
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**A0900. Birth Date**

	_____ - _____ - _____ Month                  Day                  Year
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**A1000. Race/Ethnicity**

↓ Check all that apply

<input type="checkbox"/>	<b>A. American Indian or Alaska Native</b>
<input type="checkbox"/>	<b>B. Asian</b>
<input type="checkbox"/>	<b>C. Black or African American</b>
<input type="checkbox"/>	<b>D. Hispanic or Latino</b>
<input type="checkbox"/>	<b>E. Native Hawaiian or Other Pacific Islander</b>
<input type="checkbox"/>	<b>F. White</b>

**Section A****Identification Information****A1100. Language**

Enter Code

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

- 0. **No** → Skip to A1200, Marital Status
- 1. **Yes** → Specify in A1100B, Preferred language
- 9. **Unable to determine** → Skip to A1200, Marital Status

**B. Preferred language:****A1200. Marital Status**

Enter Code

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

**A1300. Optional Resident Items****A. Medical record number:****B. Room number:****C. Name by which resident prefers to be addressed:****D. Lifetime occupation(s) - put "/" between two occupations:****Most Recent Admission/Entry or Reentry into this Facility****A1600. Entry Date**

\_\_\_\_\_ - \_\_\_\_\_  
 Month                  Day                  Year

**A1700. Type of Entry**

Enter Code

- 1. **Admission**
- 2. **Reentry**

**A1800. Entered From**

Enter Code

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

<b>Section A</b>	<b>Identification Information</b>
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<b>A1900. Admission Date (Date this episode of care in this facility began)</b>	
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	-                      - Month                  Day                      Year
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<b>A2000. Discharge Date</b> Complete only if A0310F = 10, 11, or 12	
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	-                      - Month                  Day                      Year
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<b>A2100. Discharge Status</b> Complete only if A0310F = 10, 11, or 12	
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Enter Code <input style="width:50px; height:20px;" type="text"/>	01. <b>Community</b> (private home/apt., board/care, assisted living, group home) 02. <b>Another nursing home or swing bed</b> 03. <b>Acute hospital</b> 04. <b>Psychiatric hospital</b> 05. <b>Inpatient rehabilitation facility</b> 06. <b>ID/DD facility</b> 07. <b>Hospice</b> 08. <b>Deceased</b> 09. <b>Long Term Care Hospital (LTCH)</b> 99. <b>Other</b>
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<b>A2300. Assessment Reference Date</b>	
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	<b>Observation end date:</b>  -                      - Month                  Day                      Year
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<b>A2400. Medicare Stay</b>	
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Enter Code <input style="width:50px; height:20px;" type="text"/>	<b>A. Has the resident had a Medicare-covered stay since the most recent entry?</b> 0. <b>No</b> → Skip to GG0130, Self-Care 1. <b>Yes</b> → Continue to A2400B, Start date of most recent Medicare stay  <b>B. Start date of most recent Medicare stay:</b>  -                      - Month                  Day                      Year  <b>C. End date of most recent Medicare stay</b> - Enter dashes if stay is ongoing:  -                      - Month                  Day                      Year
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**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.**

<b>3.</b>	
<b>Discharge Performance</b>	
Enter Code <input type="text"/>	<b>A. Eating:</b> 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 <input type="text"/>	<b>B. Oral hygiene:</b> 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 <input type="text"/>	<b>C. Toileting hygiene:</b> 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.**

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

**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 <b>had any falls since admission/entry or reentry or the prior assessment</b> (OBRA or Scheduled PPS), whichever is more recent?
<input type="checkbox"/>	0. <b>No</b> → Skip to M0210, Unhealed Pressure Ulcer(s)
<input type="checkbox"/>	1. <b>Yes</b> → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

**J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent**

↓ Enter Codes in Boxes		
<b>Coding:</b> 0. <b>None</b> 1. <b>One</b> 2. <b>Two or more</b>	<input type="checkbox"/>	<b>A. No injury</b> - 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
	<input type="checkbox"/>	<b>B. Injury (except major)</b> - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/>	<b>C. Major injury</b> - 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	<b>Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</b>
<input type="checkbox"/>	0. <b>No</b> → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting
<input type="checkbox"/>	1. <b>Yes</b> → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

**M0300. Current Number of Unhealed Pressure Ulcers at Each Stage**

Enter Number	<b>B. Stage 2:</b> 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
<input type="checkbox"/>	<b>1. Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3
Enter Number	<b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<input type="checkbox"/>	
Enter Number	<b>C. Stage 3:</b> 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
<input type="checkbox"/>	<b>1. Number of Stage 3 pressure ulcers</b> - If 0 → Skip to M0300D, Stage 4
Enter Number	<b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<input type="checkbox"/>	
Enter Number	<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
<input type="checkbox"/>	<b>1. Number of Stage 4 pressure ulcers</b> - If 0 → Skip to M0300E, Unstageable - Non-removable dressing
Enter Number	<b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<input type="checkbox"/>	

**M0300 continued on next page**

**Section M****Skin Conditions****M0300. Current Number of Unhealed Pressure Ulcers at Each Stage - Continued**

Enter Number <input type="text"/>	<p><b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device</p> <p><b>1. Number of unstageable pressure ulcers due to non-removable dressing/device</b> - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</p> <p><b>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/>	<p><b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p><b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> - If 0 → Skip to M0300G, Unstageable - Deep tissue injury</p> <p><b>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/>	<p><b>G. Unstageable - Deep tissue injury:</b> Suspected deep tissue injury in evolution</p> <p><b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → Skip to M0800, Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry</p> <p><b>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</p>
<b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry</b>	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> 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 <input type="text"/>	<b>A. Stage 2</b>
Enter Number <input type="text"/>	<b>B. Stage 3</b>
Enter Number <input type="text"/>	<b>C. Stage 4</b>



**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	<b>Type of provider</b>
<input type="text"/>	1. <b>Nursing home (SNF/NF)</b>
	2. <b>Swing Bed</b>

**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. <b>Male</b>
<input type="text"/>	2. <b>Female</b>

**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)

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

Enter Code	<b>A. Federal OBRA Reason for Assessment</b>
<input type="text"/>	01. <b>Admission</b> assessment (required by day 14)
	02. <b>Quarterly</b> review assessment
	03. <b>Annual</b> assessment
	04. <b>Significant change in status</b> assessment
	05. <b>Significant correction to prior comprehensive</b> assessment
	06. <b>Significant correction to prior quarterly</b> assessment
	99. <b>None of the above</b>

Enter Code	<b>B. PPS Assessment</b>
<input type="text"/>	<b>PPS Scheduled Assessments for a Medicare Part A Stay</b>
	01. <b>5-day</b> scheduled assessment
	02. <b>14-day</b> scheduled assessment
	03. <b>30-day</b> scheduled assessment
	04. <b>60-day</b> scheduled assessment
	05. <b>90-day</b> scheduled assessment
	<b>PPS Unscheduled Assessments for a Medicare Part A Stay</b>
	07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment)
	<b>Not PPS Assessment</b>
	99. <b>None of the above</b>

Enter Code	<b>C. PPS Other Medicare Required Assessment - OMRA</b>
<input type="text"/>	0. <b>No</b>
	1. <b>Start of therapy</b> assessment
	2. <b>End of therapy</b> assessment
	3. <b>Both Start and End of therapy</b> assessment
	4. <b>Change of therapy</b> assessment

**X0600 continued on next page**

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

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

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

	<b>A. Assessment Reference Date</b> (A2300 on existing record to be modified/inactivated) - Complete only if X0600F = 99  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
	<b>B. Discharge Date</b> (A2000 on existing record to be modified/inactivated) - Complete only if X0600F = 10, 11, or 12  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
	<b>C. Entry Date</b> (A1600 on existing record to be modified/inactivated) - Complete only if X0600F = 01  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>—</span> <span>—</span> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

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

<b>Enter Number</b> <input type="text"/>	<b>Enter the number of correction requests to modify/inactivate the existing record, including the present one</b>
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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**

<input type="checkbox"/>	<b>A. Transcription error</b>
<input type="checkbox"/>	<b>B. Data entry error</b>
<input type="checkbox"/>	<b>C. Software product error</b>
<input type="checkbox"/>	<b>D. Item coding error</b>
<input type="checkbox"/>	<b>E. End of Therapy - Resumption (EOT-R) date</b>
<input type="checkbox"/>	<b>Z. Other error requiring modification</b> 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**

<input type="checkbox"/>	<b>A. Event did not occur</b>
<input type="checkbox"/>	<b>Z. Other error requiring inactivation</b> If "Other" checked, please specify: _____

<b>Section X</b>	<b>Correction Request</b>
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<b>X1100. RN Assessment Coordinator Attestation of Completion</b>
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	<b>A. Attesting individual's first name:</b>
	<b>B. Attesting individual's last name:</b>
	<b>C. Attesting individual's title:</b>
	<b>D. Signature</b>
	<b>E. Attestation date</b>
	Month      Day      Year

**Section Z****Assessment Administration****Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting**

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

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

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

—                      —

Month                      Day                      Year

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