## MINIMUM DATA SET (MDS) FOR SWING BED HOSPITALS

1	RESIDENT		15	DISCHARGE	Complete if Item 11a = 06 or 07	
١.	NAME		''	DATE	Somplete in item 11a = 50 or 57	
	AA1	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)	1	R4		
2.	GENDER		16	REENTRY	Complete if Item 11a = 09	
-	AA2	1. Male 2. Female		DATE	Complete ii itom 11a CC	
3.	BIRTHDATE		1			
	AA3			A4		
4.		1. Never Married 3. Widowed 5. Divorced		'	CLINICAL DATA	
	STATUS A5	2. Married 4. Separated	17	COMATOSE	Persistent vegetative state with no discernible consciousness	
-		·	-  ''	COMATOSE	If yes, skip to Item 23	
5.	RACE/ ETHNICITY	(Check all that apply)			0. No 1. Yes	
	Z I I I I I I I I	a. American Indian/Alaskan Native e. Native Hawaiian or other Pacific Islander	18			
		c. Black or African American	10	SHORT TERM MEMORY	1	
		d. Hispanic or Latino		B2a	0. Memory okay 1. Memory problem	
_			_  19		Makes decisions regarding tasks of daily life	
6.	ZIP CODE	Enter code for the pre-hospital residence		SKILLS	Independent	
				B4	Modified independence 3. Severely impaired	
	AB4		20	. MAKING SELF	Expressing information content – (however able)	
7.	RESIDENT	a. Social Security Number		UNDERSTOOD		
	SSN and MEDICARE			C4		
	NUMBERS		21		Code for indicators observed in the last 30 days,	
		b. Medicare or Railroad Insurance Number	-1	OF	regardless of the assumed cause	
				DEPRESSION	Indicator not exhibited in last 30 days	
<u>_</u>	AA5		$\dashv$		Indicator exhibited up to five days a week	
8.	RESIDENT MEDICAID	Enter + if pending or N if not a Medicaid recipient in first digit followed by blanks			2. Indicator exhibited daily or almost daily (6 or 7 days a week)	
	NUMBER	TOHOWER BY DIGITIES			a. Negative statements j. Unpleasant mood in	
	A A -				morning	Ш
_	FACILITY AA7		$\dashv$		b. Repetitive questions	
9.	PROVIDER	a. State Medicaid Provider Number			c. Repetitive verbalizations k. Insomnia/change in usual sleep pattern	
	NUMBER				usual sleep pattern	
					d. Persistent anger with self/others	
		b. Medicare Provider Number			self/others facial expression	
					e. Self deprecation m. Crying,tearfulness	
-	AA6a	L (L (MD) L C L	4			Ш
10.	ASSESSMENT REFERENCE	a. Last day of MDS observation period			f. Expression of unrealistic n. Repetitive physical movements	
	DATE				rears movements	
		b. Original (00) or correction	4		g. Recurrent statements o. Withdrawal from	
	A3a	(enter number of correction)			that something terrible activities of interest is about to happen.	
11	REASONS	a. Primary Reasons for Assessment	7		p. Reduced social	
ļ	FOR	00. PPS assessment for Medicare Payment	4		h. Repetitive health interaction	
	ASSESSMENT	06. Discharged–Return Not Anticipated			complaints	
		07. Discharged–Return Anticipated			i. Repetitive anxious	
		09. Reentry			complaints/concerns	
		11. Assessment–Not for Medicare payment		E1		
		b. PPS Scheduled Assessments	22		Behavioral symptom frequency in last 7 days	
		1. 5-day 4. 90-day 9. Other		SYMPTOMS	O Pohovior NOT exhibited in lest 7 days	
		2. 30-day 5. Readmission/Return			Behavior NOT exhibited in last 7 days     Behavior accurred 1 to 3 days in last 7 days.	
		3. 60-day 7. 14-day	╝		Behavior occurred 1 to 3 days in last 7 days     Behavior occurred 4 to 6 days, but less than daily	
		c. OMRA Assessment	1			
		0. No 1. Yes	$\dashv$		Behavior occurred daily	
		d. Clinical Change Assessment	7		a. Wandering (E4aA)	
		0. No 1. Yes	4		b. Verbally abusive behavioral symptoms (E4bA)	
		e. State-Required Assessment	71		b. verbally abusive beliaviolal symptoms (E4bA)	
		0. No 1. Yes	4		c. Physically abusive behavioral symptoms (E4cA)	L
		f. Assessment Needed for Other Reasons	41		d. Socially inappropriate/disruptive behavioral symptom (E4dA)	
		(e.g., HMOs, MSP, sanction situations, etc.)				
	440	0. No 1. Yes	7	E4	e. Resists care (E4eA)	
12	PRIOR ACUTE		<b>-</b> ∥23	. ADLs	(A) ADL Self-Performance—Code for resident's performance o	ver
'-	CARE STAY	Date of admission for prior qualifying hospital stay			all shifts during the last 7 days	
					0. Independent 3. Extensive assistance	
42	ADMISSION	Date of initial admission for extended care quing had convices	$\dashv$		1. Supervision 4. Total dependence	
13.	DATE	Date of initial admission for extended care swing bed services			2. Limited assistance 8. Activity did not occur	
					(B) ADL support provided—Code for most support provided over	er all
4.4	AB1	04 Drivete Hemelent with 06 Acute weit at another	$\dashv$		shifts during last 7 days	
14.	ADMISSION/ DISCHARGE	01. Private Home/apt with no home health care 06. Acute unit at another hospital			0. No setup or physical help 3. Two + persons physical assis	t
	STATUS	02. Private Home/apt with 07. Psychiatric hospital			Setup help only     8. Activity did not occur	
	CODE	home health care 08. Rehabilitation hospital			2 One person assist	Т-
		03. Board and Care/assisted living/group home 09. MR/DD facility 10. Hospice			A	В
		10. Hospice 04. Another nursing facility 11. Deceased			a. Bed Mobility (G1a)	
		05. Acute unit at own hospital 12. Other	╝		b. Transfer (G1b)	1
		a. Admitted From – Code with all records			S. Handioi (O1b)	$\perp$
		b. Discharge Status - Complete if Item 11a = 06 or 07	7		c. Eating (G1h)	
			$\parallel$		d. Toilet Use (G1i)	1
		c. Reentered From – Complete if Item 11a = 09	Ш	G1	aa.a. aaa (a 11)	1

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24.	TOILETING PROGRAMS	Check any that apply during the last 14 days		36.	TIME	Check appropriate time periods over the last 7 days the
		a. Any scheduled toileting plan			AWAKE	Resident was awake all or most of time (i.e., naps no more than one hour per time period) in the:
		b. Bladder retraining program				a. Morning c. Evening
25.	DISEASES	<b>Check only</b> those conditions/diseases that have a relationship to current ADL status, medical treatments, nursing	,		Na	b. Afternoon
		monitoring or risk of death. Do not code inactive diagnoses.	11	37	N1 INJECTIONS	Record the <b>number of days</b> injections of any type received
		a. Diabetes mellitus (I1a) d. Hemiplegia/hemiparesis (I1v)		٠. ا		in last 7 days. If none, enter "0".
		b. Aphasia (I1r) e. Multiple sclerosis (I1w)		38.	SPECIAL	a. SPECIAL CARE - Check treatments received during the
	14	c. Cerebral palsy (I1s) f. Quadriplegia (I1z)			TREATMENTS	the last 14 days
26	INFECTIONS	Check any that apply			AND PROCEDURES	a. Chemotherapy (P1aa) f. Suctioning (P1ai)
		a. Pneumonia (I2e) b. Septicemia (I2g)	-			b. Dialysis (P1ab) g. Tracheostomy care (P1aj)
27.	PROBLEM 12	Check all problems present in the last 7 days				c. IV medication (P1ac) h. Transfusions (P1ak) d. Oxygen therapy (P1ag) i. Ventilator or respirator (P1al)
21.	CONDITIONS	a. Dehydrated, output d. Hallucinations (J1i)	-			e. Radiation (P1ah)
		exceeds input (J1c)  e. Internal bleeding (J1j)				
		b. Delusions (J1e) f. Vomiting (J1o)				<b>b. THERAPIES</b> – Record the number of days and total minutes each of the following therapies was administered (for at
		c. Fever (J1h)				least 15 minutes a day) in the last 7 calendar days.
20	J1 WEIGHT	` '				Note: Count only therapies provided after admission for
	LOSS	Weight loss - 5% or more in last 30 days or 10% or more in the last 180 days				extended care swing bed services.
		0. No 1. Yes				(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in the last 7 days
20	K3a	Check all that apply in last 7 days				
	NUTRITIONAL APPROACHES	Check all that apply in last 7 days				DAYS MIN (A) (B)
		a. Parenteral/IV b. Feeding tube				a. Speech language pathology and audiology
30	K5 PARENTERAL	Skip to item 31 if neither 29a nor 29b is coded				
	OR ENTERAL	a. Code the proportion of total calories the resident received				b. Occupational therapy
	INTAKE	through parenteral or tube feedings in the last 7 days				c. Physical therapy
		0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100%				d. Respiratory therapy
		1. 1% to 25% 4. 76% to 100% 2. 26% to 50%			P1	
		b. Code the average fluid intake per day by IV or tube			NURSING REHABILITA-	Record the number of days each of the following was provided to the resident for more than or equal to 15 minutes per day in the
		feedings in last 7 days			TION/	last 7 days. (Enter 0 if none or less than 15 minutes per day.)
		0. None 3. 1001 to 1500 cc/day			RESTORATIVE	a. Range of motion(passive) f. Walking
	K6	1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day			CARE	b. Range of motion(active) g. Dressing or grooming
31.	ULCERS	Record the number of ulcers at each ulcer stage — regard-				c. Splint/Brace assistance h. Eating or swallowing
		less of cause. If none present at a stage, record "0".				d. Bed mobility i. Amputation/
		Code all that apply <b>during last 7 days</b> . Code 9 for 9 or more.				e. Transfer Prosthesis Care
		a. Stage 1 A persistent area of skin redness			P3	j. Communication
		b. Stage 2 A partial thickness loss of skin layers that		40.	PHYSICIAN	In the last 14 days (or since swing bed admission/
		presents clinically as an abrasion, blister, or			VISITS	readmission if less than 14 days in facility) how many days has the physician (or authorized assistant or
		shallow crater			P7	practitioner) examined the resident. (Enter 0 if none.)
		c. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues		41.	PHYSICIAN	In the last 14 days (or since swing bed admission/
		d. Stage 4 A full thickness of skin and subcutaneous			ORDERS	readmission if less than 14 days in facility) how many
	M1	tissue is lost, exposing muscle or bone.				days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not
	PRESSURE	Code pressure ulcers for the highest stage in the last			P8	include order renewals without change. (Enter 0 if none).
	ULCERS M2a	<b>7 days</b> (0=None, stages =1, 2, 3, or 4)		42.	ORDERED	Skip unless this is a PPS 5 day or PPS
	OTHER SKIN	Check all that apply in last 7 days			THERAPIES	Readmission/Return assessment.
	PROBLEMS OR	a. Burns (second or third degree) (M4b)				<ul> <li>a. Ordered Therapies: Has physician ordered any of the following therapy services to begin in the FIRST 14 days</li> </ul>
	LESIONS	b. Open lesions other than ulcers, rashes, cuts (M4c)				of stay — physical therapy, occupational therapy or
						speech pathology services. (T1b)
	M4	c. Surgical Wounds (M4g)				0. No 1. Yes If No, skip to item 45.
	SKIN	Check all that apply in last 7 days				b. <b>Through day 15</b> , provide an estimate of the number of
	TREATMENTS	a. Pressure relieving device(s) for chair				days when at least 1 therapy can be expected to be
		b. Pressure relieving device(s) for bed				delivered. (T1c)
		b. I lessure relieving device(s) for bed				c. Through day 15, provide an estimate of the number of therapy minutes (across the therapies)
		c. Turning/repositioning program			T1	that can be expected to be delivered. (T1d)
		d. Nutrition or hydration intervention to manage skin problems		43.	CASE MIX	Medicare State
		a Ullear Care			GROUP	
		e. Ulcer Care	<b></b>  -	44.	T3 HIPPS Code	
		f. Surgical wound care			5 5000	
		g. Application of dressings (with or without topical medications)		45.	SIGNATURE	a. Name/Signature of RN Coordinating Assessment
		other than to feet.			J.O.A. ONE	a
		h. Application of ointments/medications (other than to feet)				
	M5	·				
35.	FOOT CARE	Check all that apply in last 7 days				b. Date RN Assessment Coordinator signed as complete
	PROBLEMS	a. Infection of the foot – e.g., cellulitis, purulent drainage (M6b)				Signal do sompleto
	-	b. Open lesions on the foot (M6c)				
	MC	c. Application of dressings (with or without topical medications) (M6f)			DΩ	