MDS Assessment Cheat Sheet

This cheat sheet contains the codes for completing a Minimum Data Set (MDS) Assessment (version 3.0).

Section title	Intent	Subsection	Codes	
A - Identification information	Obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident, potential care needs, including access to transportation and the home in which they reside.	A0050: Type of record	Code 1: Add new record	
			Code 2: Modify existing record	
		A0100: Facility provider numbers	A. National Provider Identifier (NPI). B. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank. C. State Provider Number (optional).	
		A0200: Type of provider	Code 1: Nursing home (SNF/NF)	
			Code 2: Swing bed	
		A0310: Type of assessment	A0310A	01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior comprehensive assessment 06. Significant correction to prior quarterly assessment 99. None of the above
			A0310B	01. 5-day scheduled assessment 08. IPA-Interim Payment Assessment 99. None of the above
			A0310E	Code 0: No
				Code 1: Yes
			A0310F	01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. None of the above
			A0310G	Code 1: Planned discharge
				Code 2: Unplanned discharge
			A0310G1	Code 0: No
				Code 1: Yes (did resume SNF care in the same SNF within the interruption window)
		A0410: Unit certification or licensure designation	Code 1: Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State	
			Code 2: Unit is neither Medicare nor Medicaid certified but MDS data is required by the State	
			Code 3: Unit is Medicare and/or Medicaid certified	
		A0500: Legal name of resident	A. First Name B. Middle Initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name) C. Last Name D. Suffix (e.g., Jr./Sr.)	
		A0600: Social security and Medicare numbers	A. Social security number	
			B. Medicare number	
		A0700: Medicaid number	“+” if pending, “N” if not a Medicaid recipient	

Section title	Intent	Subsection	Codes
A - Identification information		A0800: Gender	Code 1: Male
			Code 2: Female
		A0900: Birthdate	Month/Day/Year
		A1005: Ethnicity	Code X: Resident unable to respond
			Code Y: Resident declines to respond
		A1010: Race	Code X: Resident unable to respond
			Code Y: Resident declines to respond
			Code Z: None of the above
		A1110B: Language	Code 0: No
			Code 1: Yes
			Code 9: Unable to determine
		A1200: Marital status	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced
		A1250: Transportation	Code A: Yes, it has kept me from medical appointments or from getting my medications
			Code B: Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
			Code C: No
			Code X: Resident unable to respond
			Code Y: Resident declines to respond
		A1500: Preadmission screening and resident review (PASRR)	Code 0: No
			Code 1: Yes
			Code 9: Not a medicaid-certified unit
		A1510: Level II PASRR conditions	Code A: Serious mental illness
			Code B: Intellectual disability
			Code C: Other related conditions
		A1550: Conditions related to intellectual disability/developmental disability (ID/DD) status	Code A: Down syndrome
			Code B: Autism
			Code C: Epilepsy
			Code D: Other organic condition
			Code E: ID/DD, but no specific condiitons
			Code Z: ID/DD not present
		A1700: Type of entry	Code 1: Admission
			Code 2: Re-entry
		A1805: Entered from AND A2105: Discharge status AND A2121	Code 1: Home/community
			Code 2: Nursing home
			Code 3: Skilled nursing facility (SNF)
			Code 4: Short-term general hospital
			Code 5: Long-term care hospital
			Code 6: Inpatient rehablitation facility
			Code 7: Inpatient psychiatric facility

Section title	Intent	Subsection	Codes
A - Identification information		A1805: Entered from AND A2105: Discharge status AND A2121	Code 8: Intermediate care facility
			Code 9: Hospice
			Code 10: Hospice (institutional)
			Code 11: Critical access hospital
			Code 12: Organized home health service
			Code 13: Deceased
			Code 99: Not listed
		A2123: Provision of current reconciled medication list to resident at discharge	Code 0: No
			Code 1: Yes
		A2400A	Code 0: No
			Code 1: Yes
B - Hearing, speech and vision	To document whether the resident is comatose, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, and the resident's ability to see objects nearby in their environment.	B0100: Comatose	Code 0: No
			Code 1: Yes
		B0200: Hearing	Code 0: Adequate
			Code 1: Minimal difficulty
			Code 2: Moderate difficulty
			Code 3: Highly impaired
		B0300: Hearing aid	Code 0: No
			Code 1: Yes
		B0300: Speech clarity	Code 0: Clear speech
			Code 1: Unclear speech
			Code 2: No speech
		B0700: Makes self understood	Code 0: Understood
			Code 1: Usually understood
			Code 2: Sometimes understood
			Code 3: Rarely or never understood
		B0800: Understands others	Code 0: Understands
			Code 1: Usually understands
			Code 2: Sometimes understands
			Code 3: Rarely/never understands
		B1000: Vision	Code 0: Adequate
			Code 1: Impaired
			Code 2: Moderately impaired
			Code 3: Highly impaired
			Code 4: Severely impaired
		B1200: Corrective lenses	Code 0: No
			Code 1: Yes
		B1300: Health literacy	Code 0: Never
			Code 1: Rarely
			Code 2: Sometimes
			Code 3: Often
			Code 4: Always

Section title	Intent	Subsection	Codes	
B - Hearing, speech and vision		B1300: Health literacy	Code 7: Declines to respond	
			Code 8: Unable to respond	
C - Cognitive patterns	To determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions.	C0100: Should a brief interview for mental status be conducted?	Code 0: No	
			Code 1: Yes	
		C0200: Repetition of three words	Code 0: None	
			Code 1: One	
			Code 2: Two	
			Code 3: Three	
		C0300: Temporal orientation	C0300A	Code 0: Missed by >5 years/no answer
				Code 1: Missed by 2-5 years
				Code 2: Missed by 1 year
				Code 3: Correct
			C0300B	Code 0: Missed by >1 month/no answer
				Code 1: Missed by 6 days-1 month
				Code 2: Accurate within 5 days
		C0400: Recall	Code 0: Could not recall	
			Code 1: Yes, after cueing	
			Code 2: Yes, no cueing required	
		C0500: BIMS summary score	Code 99: Unable to complete	
		C0600: Should the staff assessment for mental status be conducted?	Code 0: No	
			Code 1: Yes	
		C0700: Short-term memory OK	Code 0: Memory OK	
			Code 1: Memory problem	
		C0800: Long-term memory OK	Code 0: Memory OK	
			Code 1: Memory problem	
		C1000: Cognitive skills for daily decision-making	Code 0: Independent	
			Code 1: Modified independence	
			Code 2: Moderately impaired	
			Code 3: Severely impaired	
		C1310: Signs and symptoms of delirium	C1310A	Code 0: No
				Code 1: Yes
			C1310B	Code 0: Behavior not present
				Code 1: Behavior continuously present, did not fluctuate
				Code 2: Behavior present, fluctuates
			C1310C	Code 0: Behavior not present
				Code 1: Behavior continuously present, did not fluctuate
				Code 2: Behavior present, fluctuates
			C1310D	Code 0: Behavior not present
				Code 1: Behavior continuously present, did not fluctuate
				Code 2: Behavior present, fluctuates

Section title	Intent	Subsection	Codes	
D - Mood	The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies.	D0150: Resident mood interview AND D0500: Staff assessment of resident mood	Column 1 presence	Code 0: No
				Code 1: Yes
				Code 9: No response
			Column 2 frequency	Code 0: Never or 1 day
				Code 1: 2-6 days (several days)
				Code 2: 7-11 days (half or more of the days)
				Code 3: 12-14 days (nearly every day)
		D0700: Social isolation	Code 0: Never	
			Code 1: Rarely	
			Code 2: Sometimes	
			Code 3: Often	
			Code 4: Always	
			Code 7: Declines to respond	
			Code 8: Unable to respond	
E - Behavior	The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident themself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.	E0200: Behavioral symptom	Code 0: Behavior not exhibited	
			Code 1: Behavior of this type occurred 1-3 days	
			Code 2: Behavior of this type occurred 4-6 days, but less than daily	
			Code 3: Behavior of this type occurred daily	
		E0300: Overall presence of behavioral symptoms	Code 0: No	
			Code 1: Yes	
		E0500: Impact on resident	E0500A	Code 0: No
				Code 1: Yes
			E0500B	Code 0: No
				Code 1: Yes
			E0500C	Code 0: No
				Code 1: Yes
		E0600: Impact on others	E0600A	Code 0: No
				Code 1: Yes
			E0600B	Code 0: No
				Code 1: Yes
			E0600C	Code 0: No
				Code 1: Yes

Section title	Intent	Subsection	Codes	
E - Behavior		E0800: Rejection of care- presence and frequency AND E0900: Wandering - presence and frequency	Code 0: Behavior not exhibited	
			Code 1: Behavior of this type occurred 1-3 days	
			Code 2: Behavior of this type occurred 4-6 days, but less than daily	
			Code 3: Behavior of this type occurred daily	
		E1000: Wandering - impact	E1000A	Code 0: No
				Code 1: Yes
			E1000B	Code 0: No
				Code 1: Yes
		E1100: Change in behavior or other symptoms	Code 0: Same	
			Code 1: Improved	
			Code 2: Worse	
			Code 3: N/A	
F - Preferences for customary routine and activities	The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences.	F0300: Should interview for daily and activity preferences be conducted?	Code 0: No	
			Code 1: Yes	
		F0400: Interview for daily preferences (A-H) AND F0500: Interview for activity preferences (A-H)	Code 1: Very important	
			Code 2: Somewhat important	
			Code 3: Not very important	
			Code 4: Not important at all	
			Code 5: Important, but can't do or no choice	
			Code 9: No response or non-responsive	
		F0600: Daily and activity preferences primary respondent	Code 1: Resident	
			Code 2: Family or significant other	
			Code 9: Interview could not be completed	
		F0700: Should the staff assessment of daily and activity preferences be conducted	Code 0: No	
			Code 1: Yes	
GG - Functional abilities	This section includes items about functional abilities. It includes items focused on prior function, admission and discharge performance, performance throughout a resident's stay, mobility device use, and range of motion. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.	GG0100	Code 3: Independent	
			Code 2: Needed some help	
			Code 1: Dependent	
			Code 8: Unknown	
			Code 9: N/A	
		GG0115: Functional limitation in range of motion	Code 0: No impairment	
			Code 1: Impairment on one side	
			Code 2: Impairment on both sides	
		GG0130: Self-care AND GG0170: Mobility	Code 6: Independent	
			Code 5: Set up or clean up assistance	
			Code 4: Supervision or touching assistance	
			Code 3: Partial/moderate assistance	
			Code 2: Substantial/maximal assistance	
			Code 1: Dependent	
			Code 7: Resident refused	
			Code 9: N/A	
			Code 10: Not attempted due to environmental limitations	
			Code 88: Not attempted due to medical condition or safety concerns	

Section title	Intent	Subsection	Codes	
H - Bladder and bowel	To gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.	H0200: Urinary toileting program	H0200A AND H0200C	Code 0: No
				Code 1: Yes
				Code 9: Unable to determine
			H0200B	Code 0: No improvement
				Code 1: Decreased wetness
				Code 2: Completely dry
				Code 9: Unable to determine
		H0300: Urinary continence AND H0400: Bowel continence	Code 0: Always continent	
			Code 1: Occasionally incontinent	
			Code 2: Frequently incontinent	
			Code 3: Always incontinent	
			Code 9: Not rated	
		H0500: Bowel toileting program AND H0600: Bowel patterns	Code 0: No	
			Code 1: Yes	
I - Active diagnoses	To code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.	I0020: Primary medical condition	Code 1: Stroke	
			Code 2: Non-traumatic brain dysfunction	
			Code 3: Traumatic brain dysfunction	
			Code 4: Non-traumatic spinal cord dysfunction	
			Code 5: Traumatic spinal cord dysfunction	
			Code 6: Progressive neurological conditions	
			Code 7: Other neurological conditions	
			Code 8: Amputation	
			Code 9: Hip and knee replacement	
			Code 10: Fractures and other multiple trauma	
			Code 11: Other orthopedic conditions	
			Code 12: Debility, cardiorespiratory conditions	
			Code 13: Medically complex conditions	
J - Health conditions	To document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the management of pain, the presence of pain, pain frequency, effect of pain on sleep, and pain interference with therapy and day-to-day activities. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.	J0100: Pain management AND J0200: Should pain assessment interview be conducted?	Code 0: No	
			Code 1: Yes	
		J0300: Pain presence	Code 0: No	
			Code 1: Yes	
			Code 9: Unable to answer	
		J0410: Pain frequency AND J0510: Pain affect on sleep	Code 1: Rarely or not at all	
			Code 2: Occasionally	
			Code 3: Frequently	
			Code 4: Almost constantly	
			Code 9: Unable to answer	
		J0520: Pain interference with therapy activities	Code 0: Does not apply	
			Code 1: Rarely or not at all	
			Code 2: Occasionally	
			Code 3: Frequently	
			Code 4: Almost constantly	
			Code 8: Unable to answer	

Section title	Intent	Subsection	Codes
J - Health conditions		J0530: Pain interference with day-to-day activities	Code 1: Rarely or not at all
			Code 2: Occasionally
			Code 3: Severe
			Code 4: Almost constantly
			Code 8: Unable to answer
		J0600: Pain intensity	Code 1: Mild
			Code 2: Moderate
			Code 3: Severe
			Code 4: Very severe, horrible
			Code 9: Unable to answer
		J0700: Should staff assessment for pain be conducted	Code 0: No
			Code 1: Yes
		J0850: Frequency of indicator of pain or possible pain	Code 1: The resident complained or showed evidence of pain 1 to 2 days
			Code 2: The resident complained or showed evidence of pain 3 to 4 days
			Code 3: The resident complained or showed evidence of pain on a daily basis
		J1300: Current tobacco use AND J1400: Prognosis	Code 0: No
			Code 1: Yes
		J1700: Fall history on admission/re-entry	Code 0: No
			Code 1: Yes
			Code 9: Unable to determine
		J1800: Any falls since admission/entry or re-entry or prior assessment	Code 0: No
			Code 1: Yes
		J1900: Number of falls since admission/entry or re-entry or prior assessment	Code 0: None
			Code 1: One
			Code 2: Two or more
		J2000: Prior surgery AND J2100: Recent surgery requiring active SNF care	Code 0: No
			Code 1: Yes
			Code 8: Unknown
K - Swallowing/ nutritional status	To assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.	K0300: Weight loss	Code 0: No, or unknown
			Code 1: Yes on physician-prescribed weight-loss regimen
			Code 2: Yes, not on physician-prescribed weight-loss regimen
		K0310: Weight gain	Code 0: No, or unknown
			Code 1: Yes on physician-prescribed weight-gain regimen
			Code 2: Yes, not on physician-prescribed weight-gain regimen

Section title	Intent	Subsection	Codes
M - Skin conditions	To document the risk, presence, appearance, and change of pressure ulcers/ injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.	M0150: Risk of pressure ulcers/injuries AND M0210: Unhealed pressure ulcers/injuries	Code 0: No
			Code 1: Yes
N - Medications	To record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/ or select medications were received by the resident.	N2003: Medication follow-up	Code 0: No
			Code 1: Yes
		N2005: Medication intervention	Code 0: No
			Code 1: Yes
			Code 9: N/A
O - Special treatment, procedures and programs	To identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods	O0250: Influenza vaccine	Code 0: No
			Code 1: Yes
		O0300: Pneumococcal vaccine	Code 0: Not eligible
			Code 2: Offered and decline
			Code 3: Not offered
P - Restraints and alarms	To record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.	P0100: Physical restraints AND P0200: Alarms	Code 0: Not used
			Code 1: Used less than daily
			Code 2: Used daily

Section title	Intent	Subsection	Codes	
Q - Participation in assessment and goal setting	To record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)).	Q0110: Participation in assessment and goal setting	Code A: Resident	
			Code B: Family	
			Code C: Significant other	
			Code D: Legal guardian	
			Code E: Other legally authorized representative	
			Code Z: None of the above	
		Q0310: Resident's overall goal	Q0310A	Code 1: Discharge to the community
				Code 2: Remain in the facility
				Code 3: Discharge to another facility
				Code 9: Unknown/uncertain
			Q0310B	Code A: Resident
				Code B: Family
				Code C: Significant other
				Code D: Legal guardian
				Code E: Other legally authorized representative
				Code Z: None of the above
		Q0400: Discharge plan	Code 0: No	
			Code 1: Yes	
		Q0490: Residents documented preference to avoid being asked Q0500B	Code 0: No	
			Code 1: Yes	
		Q0500: Return to community	Q0500B	Code 0: No
				Code 1: Yes
				Code 9: Uncertain or unknown
			Q0500C	Code A: Resident
				Code B: Family
				Code C: Significant other
				Code D: Legal guardian
				Code E: Other legally authorized representative
				Code Z: None of the above
		Q0550: Resident's preference to avoid being asked question Q0500B	Q0550A	Code 0: No
				Code 1: Yes
				Code 8: Information not available
			Q0550C	Code A: Resident
				Code B: Family
				Code C: Significant other
				Code D: Legal guardian
				Code E: Other legally authorized representative
				Code Z: None of the above
		Q0610: Referral	Code 0: No	
			Code 1: Yes	

Section title	Intent	Subsection	Codes	
Q - Participation in assessment and goal setting		Q0620: Reason referral to local contact agency	Code 1: LCA unknown	
			Code 2: Referral previously made	
			Code 3: Referral not wanted	
			Code 4: Discharge date 3 or fewer months away	
			Code 5: Discharge date more than 3 months away	
X - Correction request	To identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must 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 Internet Quality Improvement and Evaluation System (iQIES).	X0150: Type of provider	Code: 1: Nursing home (SNF)	
			Code 2: Swing bed	
		X0600: Type of assessment/tracking	X0600F	Code 1: Entry tracking record
				Code 10: Discharge assessment-return not anticipated
				Code 11: Discharge assessment-return anticipated
				Code 12: Death in facility tracking record
				Code 99: None of the above
			X0600H	Code 0: No
				Code 1: Yes

Centers for Medicare & Medicaid Services. (2024). *Long-Term care facility resident assessment instrument 3.0 user's manual.* Version 1.19 .1. https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf