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MDS Basics
June 2019

Objectives

- Objectives:
- Examine RAI Manual steps for assessment and coding for key MDS sections G, H, I, J, M, N, O, P.
- Discuss requirements for conducting the MDS interviews. The Pain Interview will be used as an example.

State Information

Virginia

RAI Coordinator

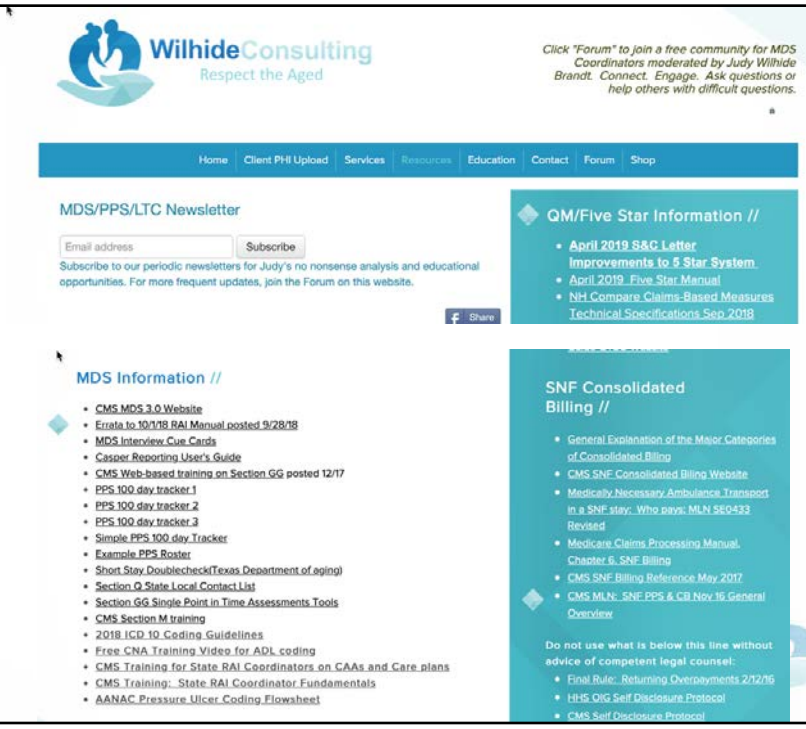
- Diana Marsh
- 804-367-2141
- diana.marsh@vdh.virginia.gov

No case mix auditors in Virginia, but subject to review by Department of Medical Assistance (DMAS)

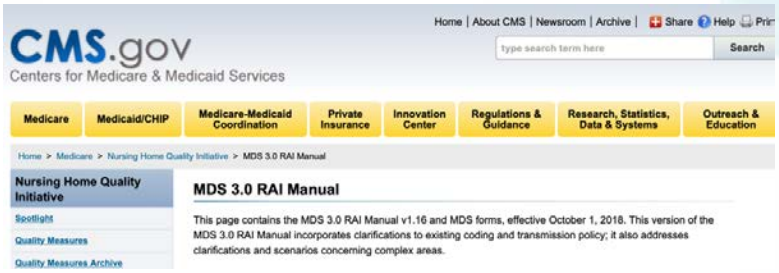
- http://www.dmas.virginia.gov/Content_pgs/pr-nursing.aspx
- Va Section S required on all assessments

Resources

www.JudyWilhide.com



RAI Manual



RAI: Resident Assessment Instrument = Comprehensive MDS

RAI Process:

1. MDS: Minimum Data Set
2. CAA: Care Area Assessment Process
3. Utilization Guidelines (Content of RAI Manual & Survey regulations)

MDS

- Core set of
  - screening,
  - clinical, and
  - functional status elements

Forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.

- Meant to standardize communication about resident problems and conditions within & between nursing homes, and between nursing homes and outside agencies.

Page 1 - 6

Care Area Assessment (CAA) Process

- Assists to systematically interpret information recorded on the **comprehensive MDS**.
  - Admission, Annual, Significant Change
- If care area has been triggered, we conduct an assessment of the potential problem and ***determine whether or not to care plan for it.***
- Helps focus on key issues so that decisions as to whether and how to intervene can be explored with the resident.

F641 §483.20(g) Accuracy of Assessment

- The assessment must accurately reflect the resident's status.

GUIDANCE §483.20(g)

- *"Accuracy of Assessment"* means appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).
- *Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.*

F641: Accuracy of Assessment: *GUIDANCE* ***§483.20(g)*** continued

- The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident.
- Includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.

F641: Accuracy of Assessment: *GUIDANCE §483.20(g)* continued

- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS.
  - The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.
- The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.

PROBES §483.20(g): Questions for surveyors to answer about their investigation of MDS Accuracy

- *Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?*
- *Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?*

F642

§483.20(h) Coordination.

- A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

§483.20(i) Certification.

- (1) A registered nurse must sign and certify that the assessment is completed.
- (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

§483.20(j) Penalty for Falsification.

- (1) Under Medicare and Medicaid, an individual who willfully and knowingly—
  - (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
  - (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.

F642 *GUIDANCE §483.20(h)-(j)*

- **Each individual assessor is responsible for certifying the accuracy of responses** relative to the resident's condition and discharge or entry status.
- When MDS forms are completed directly on the facility's computer, then each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the portion(s) they completed.
- Facilities that are not capable of maintaining the MDS signatures electronically must have handwritten signatures

F642 *GUIDANCE §483.20(h)-(j)*

- **Backdating Completion Dates** is not acceptable – note that recording the actual date of completion is not considered backdating.
  - For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.
- Patterns of MDS Assessment and Submissions: MDS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. ***A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures***.
- All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

F642 *GUIDANCE §483.20(h)-(j)*

- A pattern of clinical documentation or of MDS assessment/reporting practices that result in:
  - Higher Resource Utilization Group (RUG) scores
  - Untriggering Care Area Assessments (CAAs)
  - Unflagging Quality Measures (QMs)

  where the information **does not accurately reflect the resident's status**, may be indicative of payment fraud or attempts to avoid reporting negative quality measures.

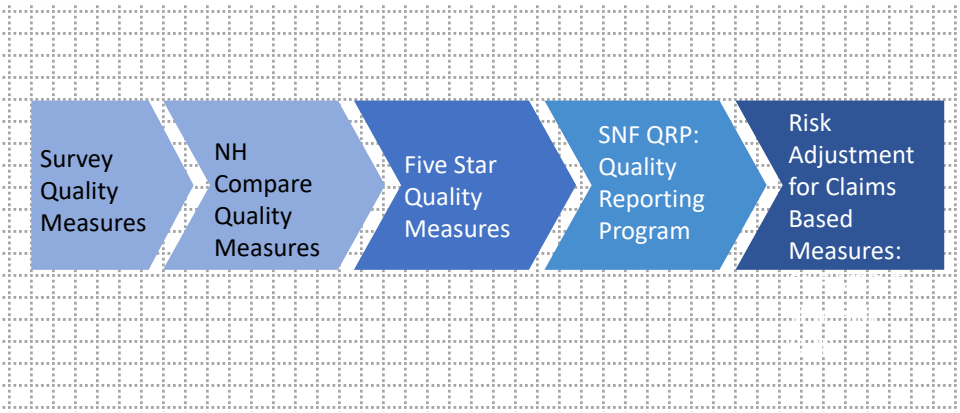
F642 *GUIDANCE §483.20(h)-(j)*

- Such practices may include, but are not limited to, a pattern or high prevalence of the following:
  - Submitting inaccurate MDS Assessments
  - Submitting correction(s) to previously submitted MDS data , where corrected information is inaccurate per medical record
  - Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error
  - Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met
  - Delaying or withholding MDS Assessments from the QIES ASAP system.
    - *Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP): MDS national repository*

Additional Uses of the MDS

- Medicare and Medicaid Payment Systems
  - Contains items that reflect the acuity level of the resident, including diagnoses, treatments, & functional status.
  - Data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups).
    - Medicare RUG-IV 66 Groups
    - PDPM Oct 2019
    - Virginia Medicaid RUG IV-48 Grouper

Additional Uses of the MDS: Quality Monitoring



RAI Manual

Chapter 1: General overview, background

Chapter 2:

- Assessment types and definitions
- OBRA and PPS scheduling
- Tracking forms & Discharge assessments
- Timing requirements
- Imperative to understand this chapter for OBRA and PPS scheduling, combinations, etc.

Chapter 3: Line by line coding instructions: Required to complete the MDS

Chapter 4: CAAs and Care Planning: Instructions for working CAAs and completing care plans

Chapter 5: Modifications, Inactivations, Transmittal rules and links to the qtso.com website

Chapter 6:

- PDPM grouper
- Medicare rules
- PPS payment rules
- Rules for non-compliance with PPS schedule

RAI Manual

- Appendix A: Glossary
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (When Administered In Writing)
- Appendix F: Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Item Sets

Assessment Reference Date (ARD): The last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period.

- The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.
- Most items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59PM should be included for MDS 3.0 coding Page 2-9

Observation (Look Back) Period: Time period over which resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS. Page 2-14

Assessment Reference Date (ARD) A2300

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21 ARD
22	23	24	25	26	27	28

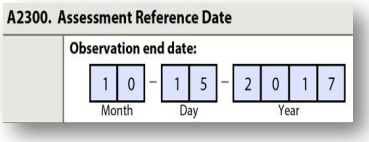
When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS. 2-14

Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

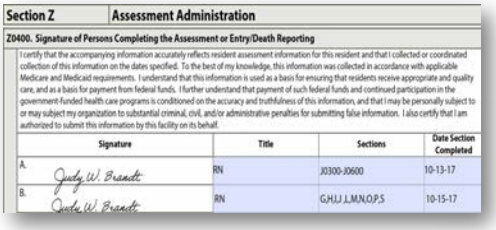
- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.
- Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

Timeframes for Completion Non-comprehensive

End-point for look-back



Signature attesting to accuracy



RN attesting to completion

Section Completion Z0400

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.	*Judy Wilhide Brandt*	*Dietitian*	K	August 7, 2015
B.				

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Z-6

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. ***Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response***. Each person completing a section or portion of a section of the MDS *is required* to sign the Attestation Statement.

The importance of accurately completing and submitting the MDS cannot be over-emphasized.

Z-6

Z0500 MDS Completion Z-8

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature: Judy Brandt, RN

B. Date RN Assessment Coordinator signed assessment as complete: 01 – 06 – 2015 (Month – Day – Year)

Item Rationale: Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.
2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Coding Instructions

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date will generally be later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.

- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Coding Tips

- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.
- Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to ***protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.***

Coding Tips

- Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
- Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a copy document and not the original.

CAA & Care Plan Completion

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☒	☒	See CAA Summary on Review of Indicators 1/2/15
02. Cognitive Loss/Dementia	☒	☒	See nursing notes by J. Brandt 1/3/15
03. Visual Function	☒	☐	See MD progress note 1/3/15, Nsg note 1/4/15
04. Communication	☐	☐	
05. ADL Fu[illegible]habilitation?	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature: Judy W. Brandt, RN
2. Date: 01 (Month) – 17 (Day) – 2015 (Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature: Sally Smith, LPN
2. Date: 01 (Month) – 20 (Day) – 2015 (Year)

Coding Instructions for V0200A, CAAs

- For each triggered care area, use the CAA process to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. ***Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.***
- **The Care Planning Decision column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed**.
- For each triggered care area, indicate the date and location of the CAA documentation in the Location and Date of CAA Documentation column. ***Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.***

V-5

Coding Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed

V0200B1, Signature

- Signature of the RN coordinating the CAA process.

V0200B2, Date

- Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI.

V-5

Coding Instructions for V0200C, Signature of Person Completing Care Plan Decision and Date Signed

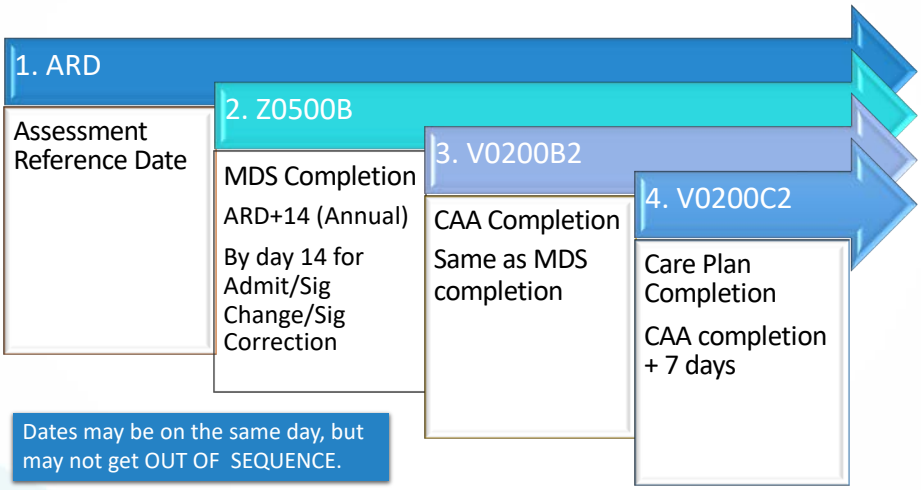
V0200C1, Signature

- Signature of the staff person facilitating the care planning decision-making. Person signing does not have to be an RN.

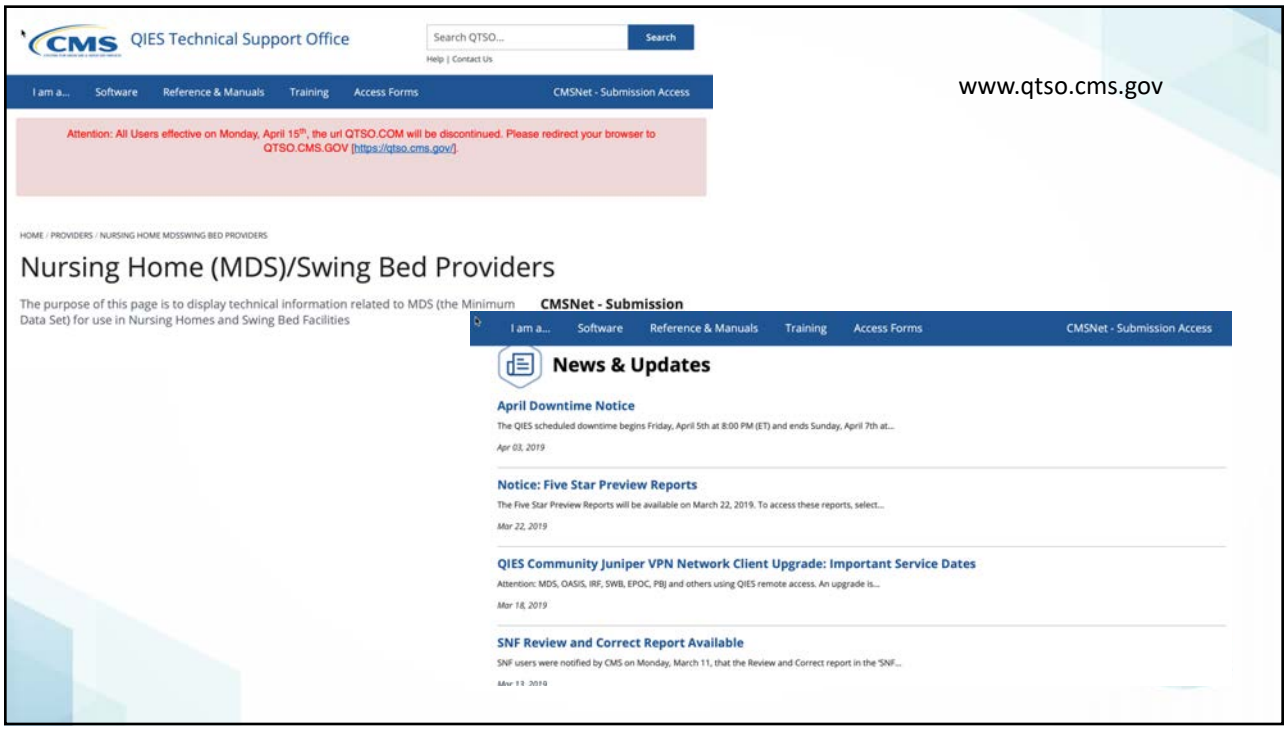
V0200C2, Date

- The date on which a staff member completes the Care Planning Decision column (V0200A, Column B), which is done *after the care plan is completed*. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and CAAs), as indicated by the date in V0200B2.

Timeframes for Comprehensive



Dates may be on the same day, but may not get OUT OF SEQUENCE.



www.qtso.cms.gov

Reference & Manuals

w.qtso.cms.gov

CASPER Reporting User's Guide For MDS Providers

- Cover (v1.02 posted 01/2019)
- Section 1 - Introduction (v1.02 posted 05/2017)
- Section 2 - Functionality (updated 08/2014)
- Section 3 - Utility Reports (updated 11/2012)
- Section 6 - MDS 3.0 Nursing Home Provider Reports (v1.04 posted 09/2016)
- Section 7 - MDS 3.0 Nursing Home Final Validation Report (v1.02 posted 09/2016)
- Section 8 - MDS 3.0 Swing Bed Provider Reports (v1.01 posted 09/2018)
- Section 9 - MDS 3.0 Swing Bed Final Validation Report (v1.01 posted 09/2016)
- Section 10 - MDS 3.0 Submitter Validation Report (v1.01 posted 09/2016)
- Section 11 - MDS 3.0 Quality Measure (QM) Reports (v1.03 posted 01/2019)
- Section 12 - Payroll Based Journal (PBJ) Reports (v1.07 posted 07/2018)
- Section 13 - SNF Quality Reporting Program (v1.05 posted 03/2019)
- Appendix A - Quick Reference (v1.02 posted 09/2016)

Mar 11, 2019

MDS 3.0 Provider User's Guide

- Cover
- Table of Contents (v1.01 Posted 09/2016)
- Section 1- Introduction (v1.00 Posted 09/2015)
- Section 2 - Overview (v1.01 Posted 02/2018)
- Section 3 - Functionality (v1.01 Posted 02/2018)
- Section 4 - Reports (v1.00 Posted 09/2016)
- Section 5 - Error Messages (v1.04 posted 09/2018)
- Section 6 - Glossary
- Appendix A- Quick Reference (v1.02 Posted 09/2016)
- Appendix B - Resident Match (Posted 12/2014)

Feb 01, 2018

Example Error Messages

Error ID	Sev	Error Message	Error Description
-1038	Warn	Assessment Completed Late: An OBRA comprehensive assessment with the Care Area Assessment (Section V) is due every year unless the resident is no longer in the facility. A prior record with an ARD (A2300) within 366 days of the submitted record could not be found.	**Cause:** The submitted assessment was not completed according to CMS timing guidelines. There should be no more than 366 days between OBRA comprehensive assessments with Care Area Assessment (Section V) completed. The 366 days is calculated from A2300 (Assessment Reference Date) to A2300. **Tip:** Timing edits are not performed on records where A0410 = 2. Timing edits are not performed on any two records where the value of A0410 is not the same. Medicare PPS only assessments (A0310A = 99 and A0310B = 01, 02, 03, 04, 05, 06, or 07) are excluded from CMS timing guideline edits. **Action:** To avoid this warning in the future, review the assessment schedule and verify that all assessments are completed in a timely manner. No action is required.
-1040	Warn	Assessment Completed Late: An OBRA assessment (comprehensive or quarterly) is due every quarter unless the resident is no longer in the facility. A prior record with an ARD (A2300) within 92 days of the submitted record could not be found.	**Cause:** The submitted assessment was not completed according to CMS timing guidelines. There should be no more than 92 days between OBRA assessments. The 92 days is calculated from A2300 (Assessment Reference Date) to A2300 for OBRA assessments. **Tip:** Medicare PPS only assessments (A0310A = 99 and A0310B = 01, 02, 03, 04, 05, 06, or 07) are excluded from CMS timing guideline edits. Timing Edits are not performed on records where A0410 = 2. Timing edits are not performed on any two records where the value of A0410 is not the same. **Action:** To avoid this warning in the future, review the assessment schedule and verify that all assessments are completed in a timely manner. No action is required.

Coding Major Sections of the MDS

Chapter 3 RAI Manual

A2300: Assessment Reference Date

- Designates the end of the look-back period.
- Serves as the reference point for determining what care and services are captured on the MDS assessment.
- Look-back period includes observations and events through midnight of the ARD,
  - including LOA if specific MDS item instructions permit.
- When resident dies/is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.

A2300. Assessment Reference Date	
	Observation end date: ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

ARD Example

1	2	3	4	5	6	7
8	9	10	11 **ARD**	12	13	14
15	16	17	18	19	20	21

Anything that happens
- After the ARD, or
- Before the lookback period

Will not be captured on the MDS.

Preadmission Data is not captured unless the specific MDS item allows it.

Lookback is 7 days unless specific MDS item instructions designate different timeframe.

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**

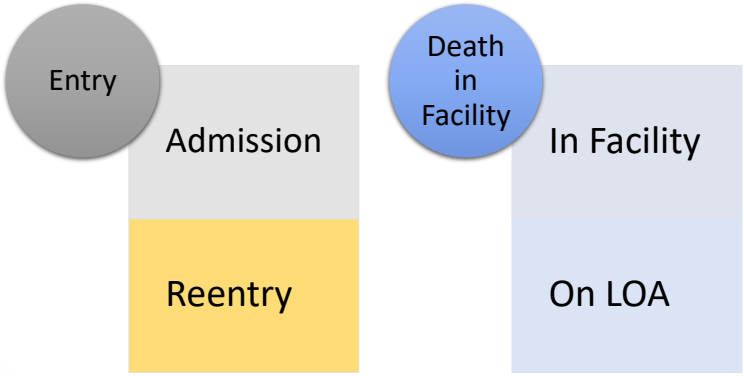
Very important to code correctly!

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

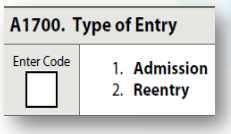
Month – Day – Year

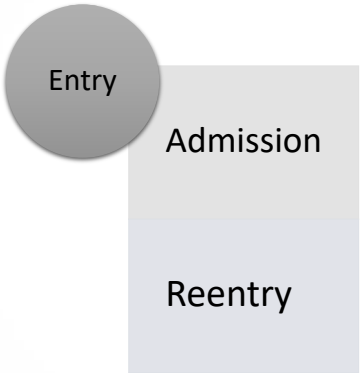
First, we need to explain tracking records and discharge assessment

Tracking Records



Tracking Records





- Contains:
  - Demographic information
  - Date entered
  - "Entered From"
  - Medicare Part A stay dates
- Must be:
  - Completed NLT 7 days from entry
  - Transmitted NLT 14 days from entry

OBRA Discharge assessment: Used to Track Quality, shorter than Quarterly

Return Anticipated

- Completed when resident is discharged and expected to return in 30 days.
  - Hospital
  - Respite

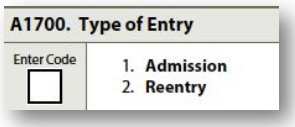
Return Not Anticipated

- Completed when resident is discharged and not expected to return in 30 days.

Must be competed (Z0500b) within 14 days of discharge date.
Must be submitted within 14 days of completion.

2-37

Rules for Entry Tracking Form



First Admission

Return after DCRNA

Return > 30 days after DCRA

A1700 = 1 Admission

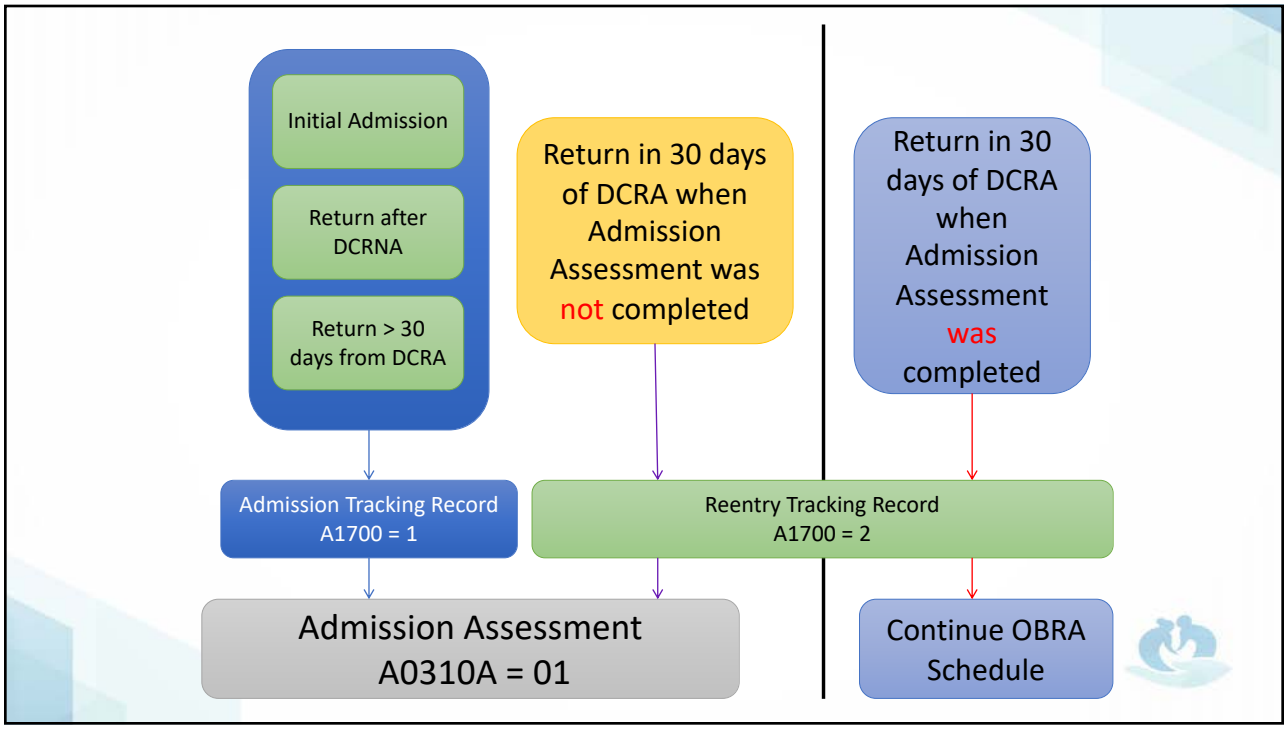
DCRNA = DC return not anticipated

DCRA = DC return anticipated

Return within 30 days of DCRA, even if DC prior to completion of OBRA Admission Assessment

A1700 = 2 Reentry

2-33



New Episode starts with entry tracking record coded as "Admission A1700 = 1"

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

10 – 15 – 2014 (Month – Day – Year)

A1700. Type of Entry

Enter Code: 1

1. Admission
2. Reentry

A1800. Entered From

Enter Code: 03

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

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

10 – 15 – 2014 (Month – Day – Year)

New Episode

Episode continues after DCRA out ≤ 30 days

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

01 – 15 – 2015 (Month – Day – Year)

A1700. Type of Entry

Enter Code: 2

1. Admission
2. Reentry

A1800. Entered From

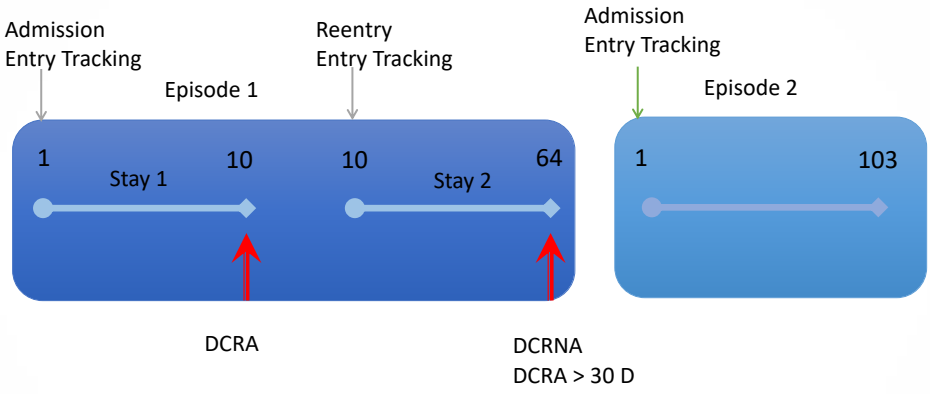
Enter Code: 03

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

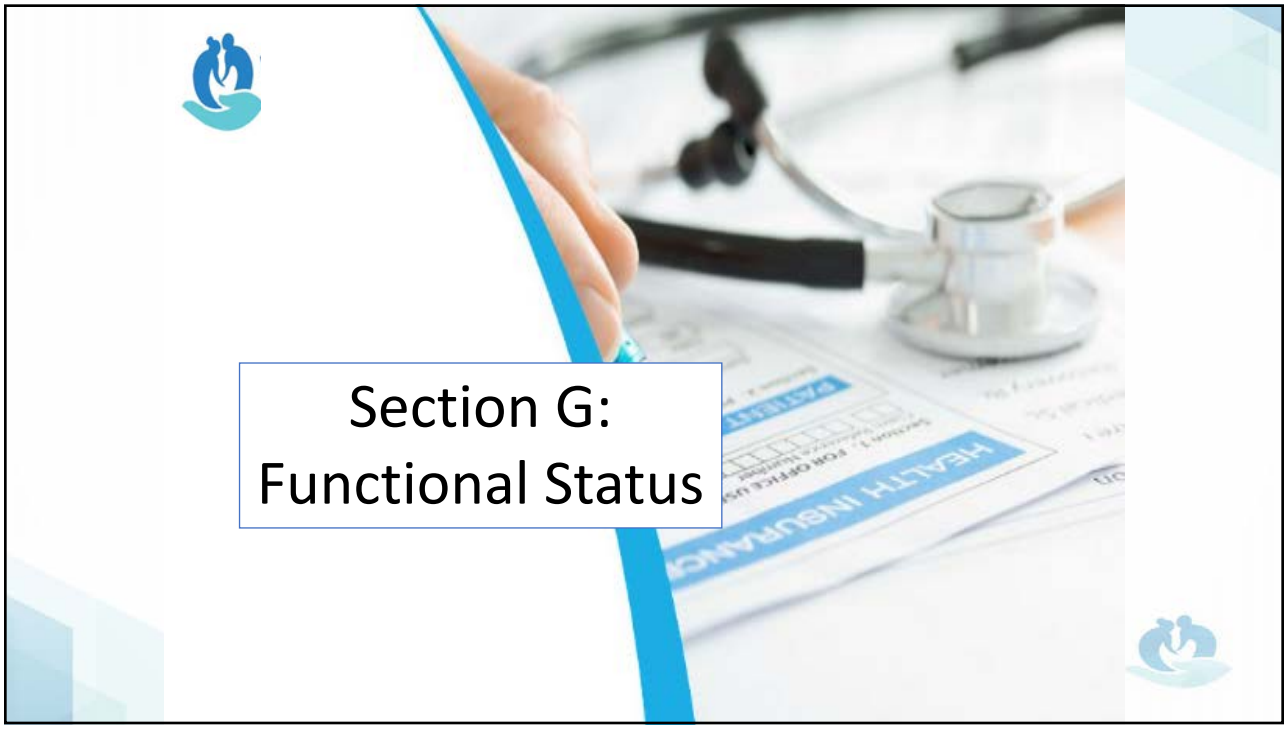
A1900. Admission Date (Date this episode of care in this facility began)

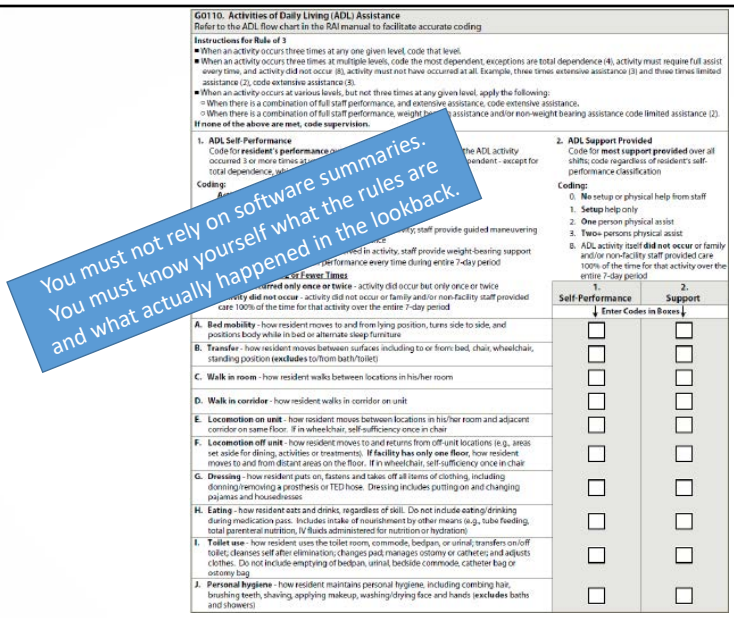
10 – 15 – 2014 (Month – Day – Year)

Quality Measures (Why A1700 matters)



Cumulative Days in Facility:
≤ 100 = Short Stay
> 100 = Long Stay



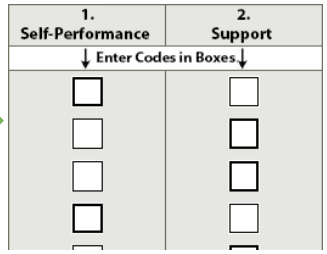


You must not rely on software summaries.
You must know yourself what the rules are
and what actually happened in the lookback.

CMS YouTube video: https://www.youtube.com/watch?v=t-6e5NV4j6k&feature=youtu.be

G-1

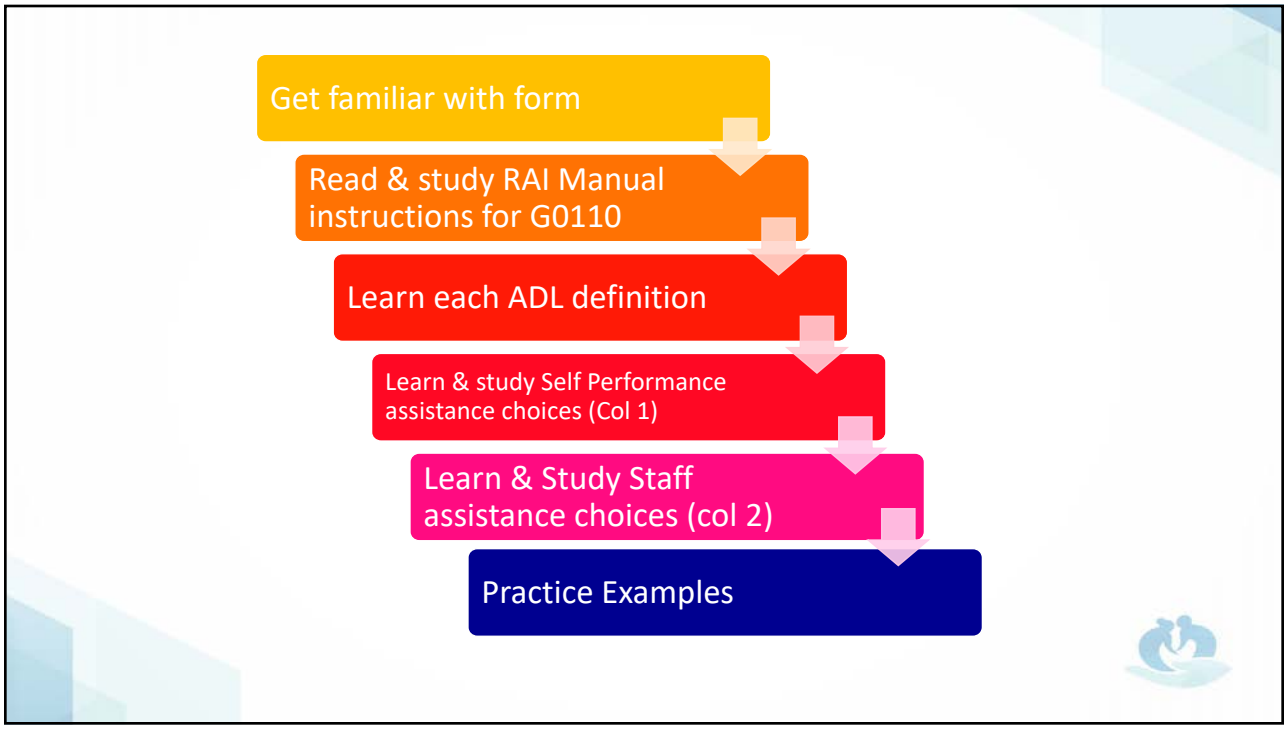
ADL SELF-PERFORMANCE
Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

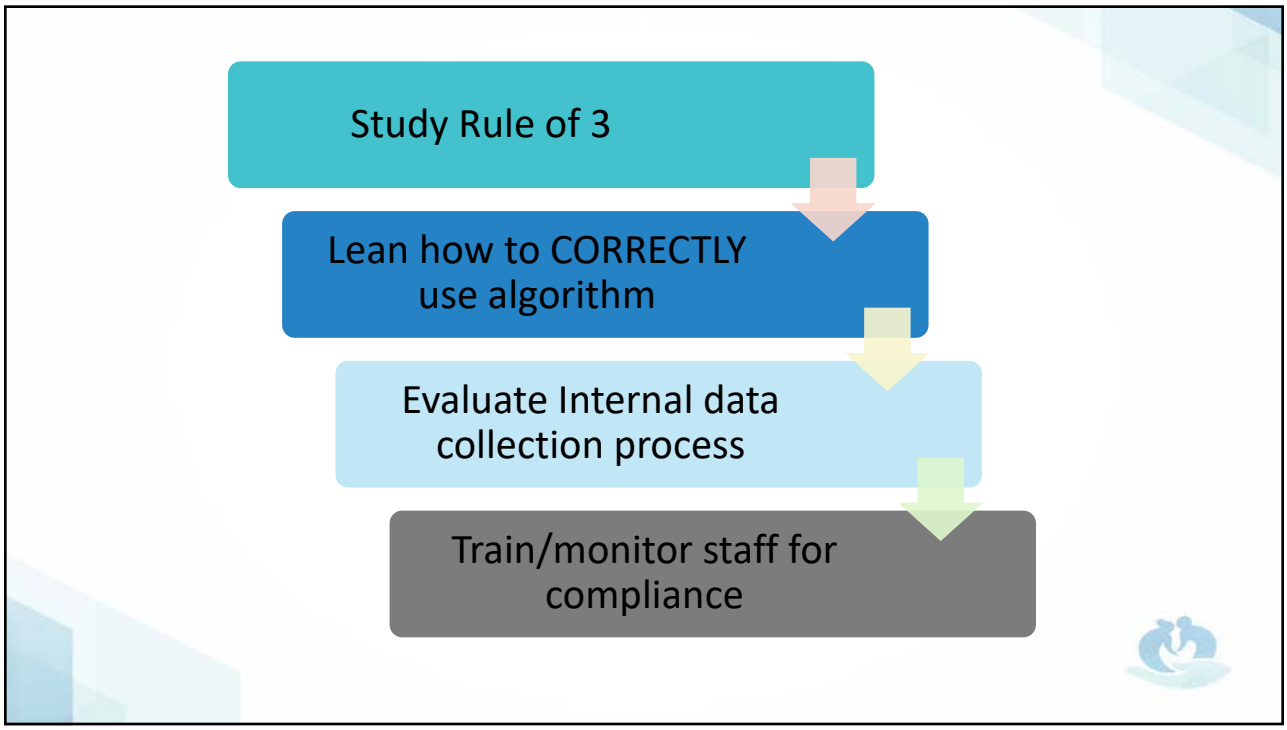


ADL ASPECTS
Components of an ADL activity. These are listed next to the activity in the item set. For example, the components of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition and IV fluids for hydration.

ADL SUPPORT PROVIDED
Measures the most support **provided by staff** over the last 7 days, even if that level of support only occurred once.

G-2&3


Get familiar with form
Read & study RAI Manual instructions for G0110
Learn each ADL definition
Learn & study Self Performance assistance choices (Col 1)
Learn & Study Staff assistance choices (col 2)
Practice Examples


Study Rule of 3
Lean how to CORRECTLY use algorithm
Evaluate Internal data collection process
Train/monitor staff for compliance

Definitions:

Bed Mobility: How resident moves to and from a lying position, turns side to side, and positions body while in bed or alternate sleep furniture.

- How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting. (G-10 coding tip)

Examples:

- Going from lying down to sitting up on side of bed
  - And sitting up to lying down
  - Lifting legs up into/down out of bed
- Pulling up at night
- Rolling head/foot of bed
- Pillow under head
- Readjusting positioning devices
  - Floating heels
- Turn/Reposition
  - Dressing changes
  - Changing briefs, getting on bedpan, using urinal
- Bed mobility in therapy or restorative

MDS Form and Page G-4

Definitions:

Transfer: How resident moves between surfaces, including to or from: bed, chair, wheelchair, standing position. Excludes to/from bath and toilet. G-4

- Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer. (G-9 coding tip)
- Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support. (G-10 coding tip)
- When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use. (G-10 coding tip)

Examples of transfers:

- Bed to chair
- Wheelchair to chair in DR/day room
- Sit to stand/stand to sit
- Transfer after fall
- Transfers in therapy, activities, dining room, restorative

- Walk in room: How resident walks between locations in his/her room.
- Walk in corridor: How resident walks in corridor on unit.
  - Location specific
  - Includes assistance by any facility staff (eg: therapy/activities/restorative) as long as the walking occurred in these specific locations only
- **Walking anywhere else does not count here.**
  - ~~**In therapy room**~~
  - ~~**Outside**~~
  - ~~**Anywhere in unit that is not the room or corridor**~~
  - ~~**Anywhere off the unit**~~

MDS Form and Page G-4

Locomotion on unit: How resident moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, self-sufficiency once in the chair.

- *Note: Walking in room/corridor is included in this activity.*

Locomotion off unit: How resident moves to and returns from off-unit locations (areas set aside for dining, activities, or treatments). If the facility has only one floor, how the resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in the chair.

- *Note: Don't include wheelchair transfer. Begin evaluating locomotion on/off unit once locomotion begins.*

MDS Form and Page G-4

Dressing: How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedress.

Don't forget:

- Outerwear (sweater/coat)
- Socks/shoes
- Hose
- Undressing when changing clothes, bathing, at night, etc.

MDS Form and Page G-4

Eating: How the resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).

- Between meal snacks/drinks
- Water/fluids in bed
- Food-related activities(parties, etc)
- Early morning/late at night

MDS Form and Page G-4

Toilet Use: How the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag, or ostomy bag. (G-4)

Personal Hygiene: How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands. Excludes baths and showers.

G0110 ADLs: Self Performance

- **Code 7, activity occurred only once or twice:** if the activity occurred **fewer than three times**.
- **Code 0, independent:** if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- **Code 1, supervision:** if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.

Begins on G-5

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- **Code 2, limited assistance:** if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.

- **Code 3, extensive assistance:** if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
  - Weight-bearing support provided **three or more times, OR**
  - Full staff performance of activity **three or more times** during part but not all of the last 7 days.

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- **Code 4, total dependence:** if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity **and the activity occurred three or more times.** The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.

- **Code 8, activity did not occur:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period. (or since admission)
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.

G-3

Rule of Three

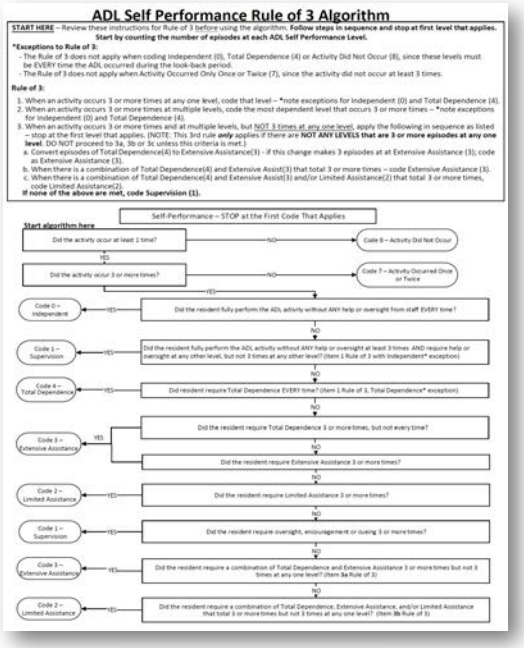
- The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.

Exceptions to the Rule of 3:

- **Code 0, Independent** – Coded only if resident completed the ADL activity with no help or oversight **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
- **Code 4, Total dependence –** Coded only if resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
- **Code 7, Activity occurred only once or twice** – Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period.
- **Code 8, Activity did not occur –** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

G-6

67



G-8

START HERE – Review these instructions for Rule of 3 before using the algorithm. **Follow steps in sequence and stop at first level that applies.**

Start by counting the number of episodes at each ADL Self-Performance Level.

*** Exceptions to Rule of 3:**

- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

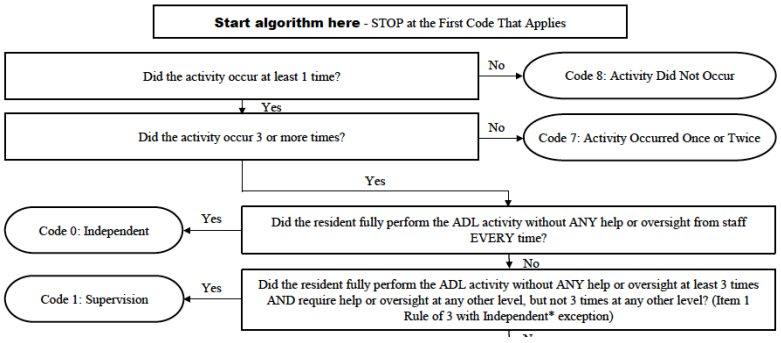
G-7

Rule of 3:

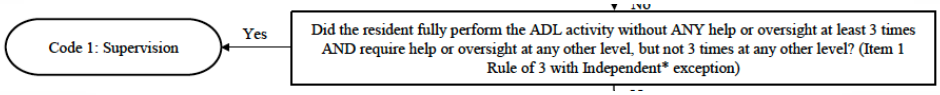
1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).

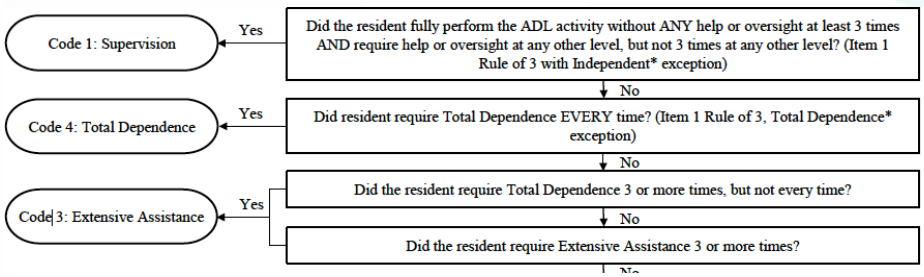
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed –stop at the first level that applies: (NOTE: This 3rd rule ***only*** applies if there are **NOT ANY LEVELS that are 3 or more episodes at any one level**. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3) – if this change makes 3 episodes at Extensive Assistance (3), code as Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

If none of the above are met, code Supervision (1).



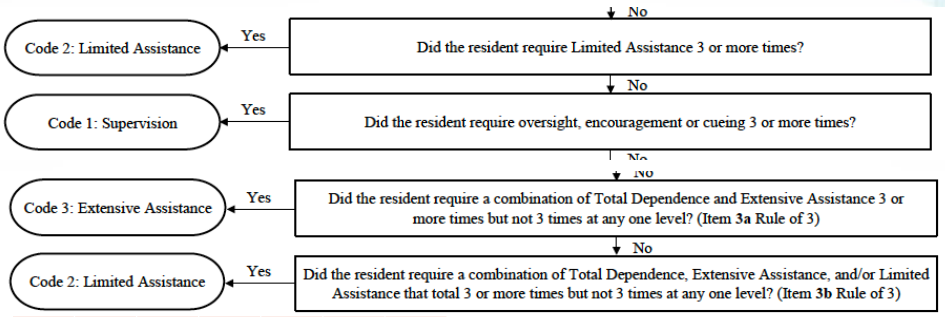
0	0	0	1	1	2	2
3	3	4	4	8	8	8
0	0	0	0	0	0	0





0	0	0	1	1	2	2
3	4	4	4	8	8	8
0	0	0	0	0	0	0

0	0	0	1	1	2	3
3	3	4	4	8	8	8
0	0	0	0	0	0	0



0	0	8	1	1	2	2
3	4	4	8	8	8	8
8	8	8	8	8	8	8

0	0	8	1	1	2	3
8	4	8	8	8	8	8
8	8	8	8	8	8	8

More examples:

CODE 2

4	**4**	**3**	**0**	**0**	**0**	**3**
2	**1**	**1**	**2**	**2**	**2**	**2**
0	**0**	**8**	**8**	**8**	**0**	**0**

CODE 3

4	**4**	**4**	**0**	**0**	**0**	**0**
0	**1**	**1**	**2**	**2**	**0**	**0**
0	**0**	**8**	**8**	**8**	**0**	**0**

76

Code 3

4	4	3	3	0	0	3
1	1	1	2	2	2	2
0	0	8	8	8	0	0

Code 3:

4	4	3	3	8	8	8
1	1	8	8	8	2	2
8	8	8	8	8	0	0

4	3	0	0	0	0	8
1	1	4	3	8	2	2
8	8	8	8	8	0	0

Code: Supervision

Staff Support: Column 2 G-9

*Code for the **most** support provided over all shifts. Code regardless of how Column I ADL Self-Performance is coded.*

- **Code 0, no setup or physical help from staff:** if resident completed activity with no help or oversight.
- **Code 1, setup help only:** if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- **Code 2, one person physical assist:** if the resident was assisted by one staff person.
- **Code 3, two+ person physical assist:** if the resident was assisted by two or more staff persons.
- **Code 8, ADL activity itself did not occur during the entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Tips and Special Populations

Differentiating between guided maneuvering and weight-bearing assistance:

- For example, if staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is weight-bearing assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.

G-9

Coding Tips and Special Populations

- Do **NOT** record the type and level of assistance that the resident should be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. **Record what actually happened**. G-9
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff).
  - Does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration.
  - Does not include, for example, hospice staff, nursing/CNA students, etc.
  - Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents. G-5

G-9

Coding Tips and Special Populations

- **Supervision**
  - **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
- General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.

G-10

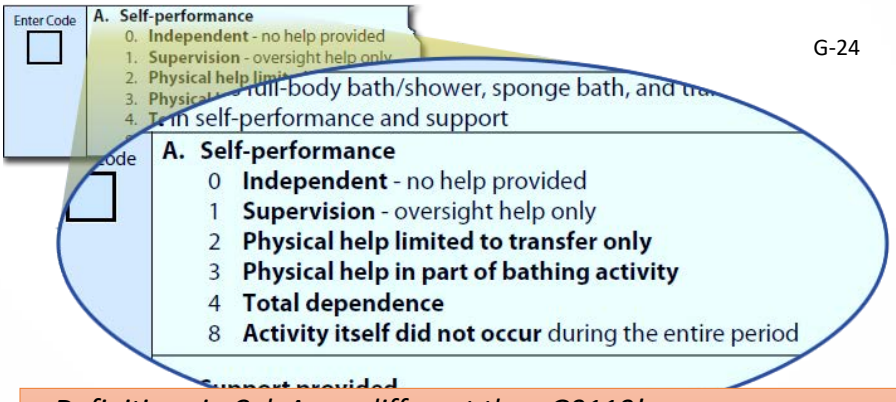
Coding Tips and Special Populations

Residents with tube feeding, TPN, or IV fluids

- **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
- **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

G-11

Bathing: How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.

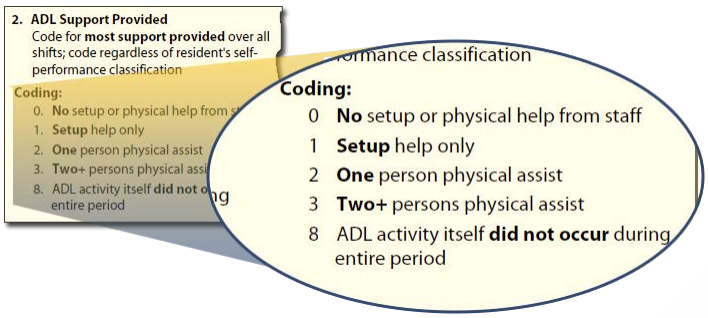


G-24

- *Definitions in Col. A are different than G0110!*
- Code for the ***most dependent*** in self-performance and support.

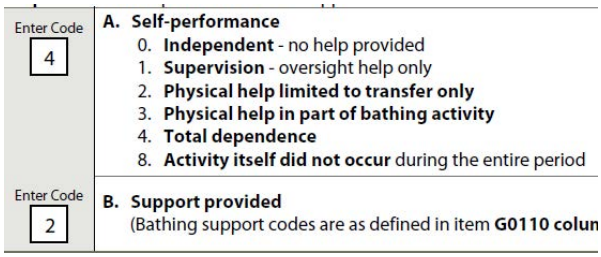
G0120B Support Provided

- Col. 2 definitions are same as Col. 2 G0110



G0120 Practice

- For one bath, the resident received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one staff member.



G0300: Balance during Transitions and Walking

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:	Enter Codes in Boxes	
0. Steady at all times 1. Not steady, but able to stabilize without human assistance 2. Not steady, only able to stabilize with human assistance 8. Activity did not occur	☐	A. **Moving from seated to standing position**
	☐	B. **Walking** (with assistive device if used)
	☐	C. **Turning around** and facing the opposite direction while walking
	☐	D. **Moving on and off toilet**
	☐	E. **Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

- Individuals with impaired balance/unsteadiness during transitions and walking face several potential issues.
  - Are at increased risk for falls.
  - Often are afraid of falling.
  - May limit their physical and social activity.
  - May become socially isolated and depressed about limitations.
  - Can become increasingly immobile.

G-26

Balance Categories:

- Moving from Seated to Standing Position
- Walking (with Assistive Device if Used)
- Turning Around and Facing the Opposite Direction while Walking
- Moving on and off Toilet
- Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)
- *Detailed instructions for coding each of these with examples start on G-28*
  - *Read all of them*

Steps for Assessment

1. Complete this assessment for all residents.
2. Throughout the 7-day look-back period, interdisciplinary team members should carefully observe and document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair (for residents who use a wheelchair).

- If staff have not systematically documented the resident's stability in these activities at least once during the 7-day look-back period, use the following process to code these items:

Test for G0300:

- Start sitting up on the edge of bed, in chair or wheelchair.
- Ask resident to stand up and stay still for 3-5 seconds.
- Ask resident to walk approximately 15 feet using his or her usual assistive device.
- Ask resident to turn around.
- Ask resident to walk or wheel from a starting point in his or her room into the bathroom, prepare for toileting as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet.
- If using a wheelchair for mobility, ask resident to transfer from a seated position in the wheelchair to a seated position on the bed.

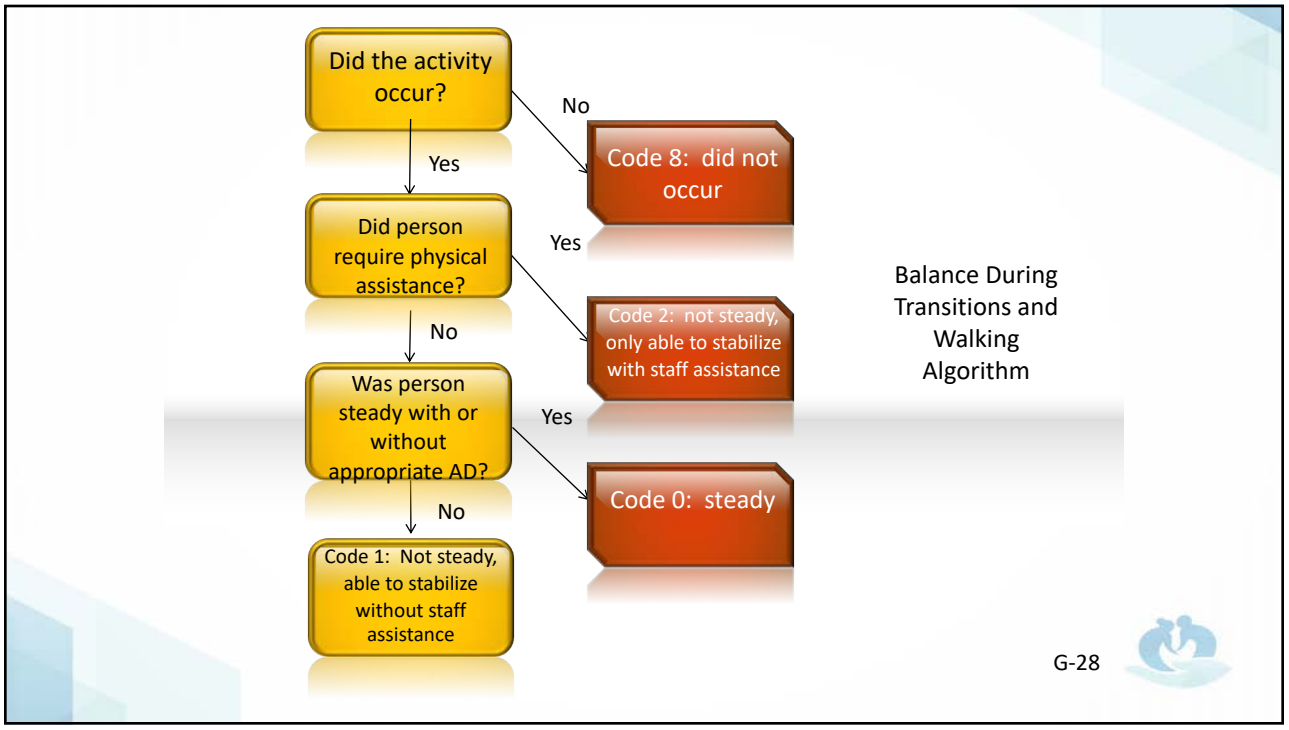
G0300 Coding Instructions

- Code for the least steady episode, using an assistive device if applicable.
- Unsteady is characterized by resident appearing unbalanced or moving with a sway or with uncoordinated or jerking movements.

Coding:

0. **Steady at all times**
1. **Not steady, but <u>able</u> to stabilize without staff assistance**
2. **Not steady, <u>only</u> <u>able</u> to stabilize with staff assistance**
8. **Activity did not occur**

Look at G-27



G0400: Functional Limitation in ROM

G0400. Functional Limitation in Range of Motion	
Code for limitation that interfered with daily functions or placed resident at risk of injury	
Coding: 0. **No impairment** 1. **Impairment on one side** 2. **Impairment on both sides**	↓ **Enter Codes in Boxes** ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand) ☐ **B. Lower extremity** (hip, knee, ankle, foot)

- Definition:
  - Limited ability to move a joint that interferes with daily functioning (particularly activities of daily living) or places the resident at risk for injury.
  - If resident unable to initiate movement, code impairment.

G-36

Steps for Assessment

1. Review the medical record for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a 3 step process:
   1. Test the resident's upper and lower extremity ROM.
   2. If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
   3. Code G0400 A/B as appropriate based on the above assessment.

Amputations

- Amputation does not automatically mean coding limited ROM.
- He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that there is a limitation in completing ADLs or injury risk.
- Many amputees function extremely well and can complete all activities of daily living either with or without the use of prosthetics.
- If resident with an amputation does have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate.
- Item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

G-38

G0600 Mobility Devices G-39

G0600. Mobility Devices	
↓ Check all that were normally used	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

Check G0600C, wheelchair (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. **Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs**. G-40

Steps for Assessment

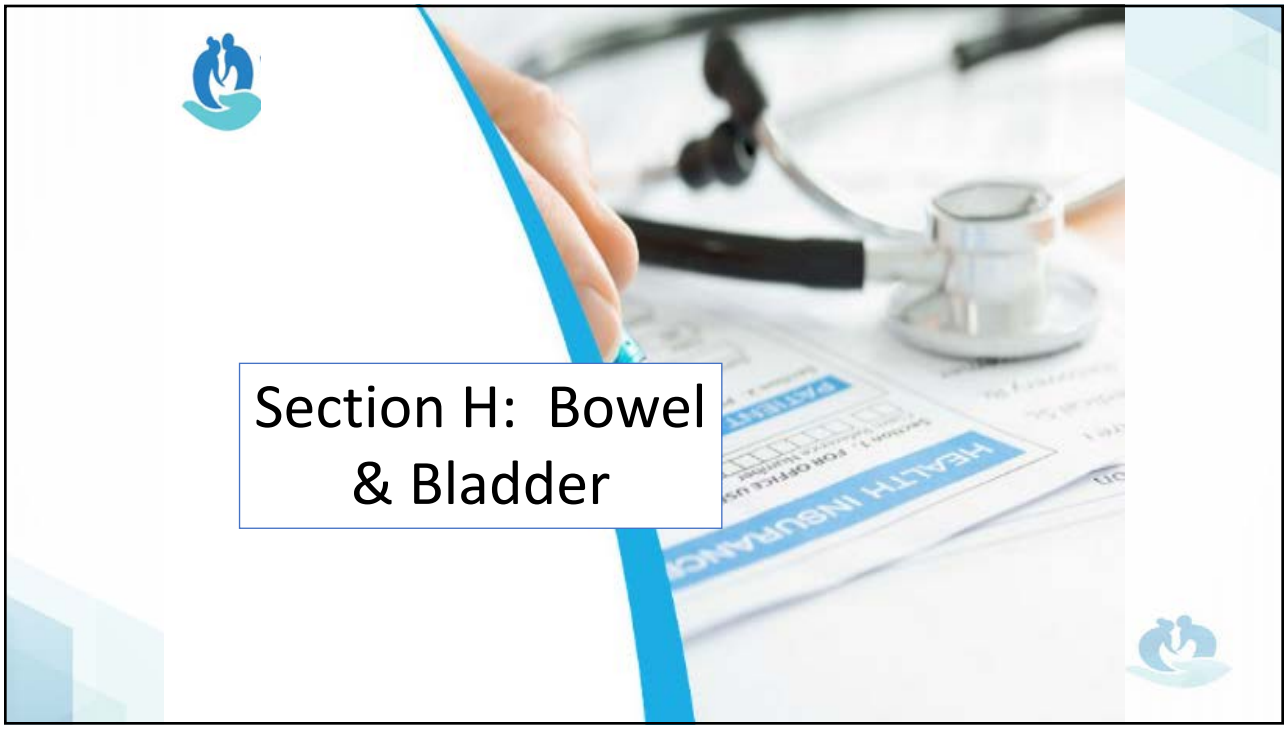
1. Review the medical record for references to locomotion during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the look-back period.
3. Observe the resident during locomotion.

Steps for Assessment: Interview Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the resident thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the resident believes, even if it appears unrealistic.
   - It is sometimes helpful to have a conversation with the resident that helps him/her break down this question. For example, you might ask the resident what types of things staff assist him with and how much of those activities the staff do for the resident. Then ask the resident, "Do you think that you could get to a point where you do more or all of the activity yourself?"

Steps for Assessment for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. Discuss in interdisciplinary team meeting.
2. Ask staff who routinely care for or work with the resident if they think he or she is capable of greater independence in at least some ADLs.



Nephrostomy tube is coded as indwelling catheter, not ostomy

Ostomy = excretory only

H0100. Appliances	
↓ Check all that apply	
☐	A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☐	B. **External catheter**
☐	C. **Ostomy** (including urostomy, ileostomy, and colostomy)
☐	D. **Intermittent catheterization**
☐	Z. **None of the above**

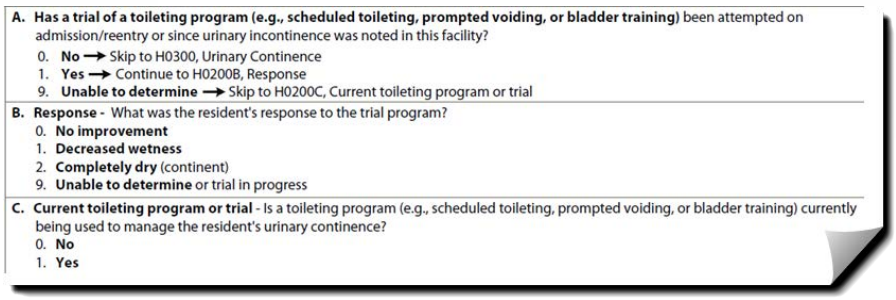
Self-catheterizations that are performed by the resident in the facility should be coded as intermittent cath. Self-cath using clean technique counts

Do not include one time catheterization for urine specimen during look back period as intermittent catheterization.

Urinary pouch is coded as external catheter

Section H = 7 day lookback or since last entry.

H0200 Urinary Toileting Program



A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

B. Response - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

- Captures 3 aspects of a toileting program:
  A. Whether a toileting program has been attempted
  B. Resident's response to any trial program
  C. Whether a toileting program is being used now to manage incontinence

Toileting: Defined

- Toileting program refers to a specific approach:
  - Organized, planned, documented, monitored, and evaluated.
  - Consistent with nursing home policies and procedures and current standards of practice.
- Toileting program does not refer to:
  - Simply tracking continence status.
  - Changing pads or wet garments.
  - Random assistance with toileting or hygiene.

H0200A: Urinary Toileting Trial Attempted

- Review record for evidence of a trial of an individualized, resident-centered toileting program.
  - Should include observations of at least 3 days of toileting patterns with **prompting to toilet** and of recording results in a bladder record or voiding diary.
  - Simply tracking continence status using a bladder record or voiding diary **should not be** considered a trial of an individualized, resident-centered toileting program.

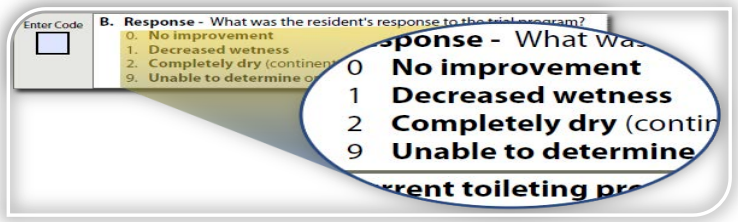
H-4

PROMPTED VOIDING

- Prompted voiding includes
  - (1) regular monitoring with encouragement to report continence status,
  - (2) using a schedule and prompting the resident to toilet, and
  - (3) praise and positive feedback when the resident is continent and attempts to toilet.

H0200B Response to Trial

- Code **0.** if incontinence did not decrease.
- Code **1.** if frequency decreased but still incontinent.
- Code **2.** if resident becomes completely continent of urine.
- Code **9.** if no information or trial is in progress.



No quantitative definition of improvement. However, the improvement should be clinically meaningful.

H0300 Urinary Continence: Definition

Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

H0300 Urinary Continence

- Code 0, always continent: No episodes of incontinence
- Code 1, occasionally incontinent: Incontinent less than 7 episodes.
- Code 2, frequently incontinent: Incontinent during ≥ 7 episodes but had at least 1 continent void.
- Code 3, always incontinent: No continent voids.
- Code 9, not rated: if the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output for the entire 7 days.
  - If intermittent catheterization is used to drain the bladder, code continence level based on continence **between catheterizations.**

H0400: Bowel Continence

- Code 0, always continent: No episodes of incontinence.
- Code 1, occasionally incontinent: Incontinent of stool once.
- Code 2, frequently incontinent: Incontinent of bowel more than once, but had at least one continent BM
- Code 3, always incontinent: No continent BMs
- Code 9, not rated: Resident had an ostomy or did not have BM for the entire 7 days

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code ☐	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

- Look for documentation showing:
  - Implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
  - Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
  - Notations of the resident's response to the toileting program and subsequent evaluations, as needed.

H0600. Bowel Patterns	
Enter Code ☐	Constipation present? 0. No 1. Yes

- Constipation:
  - ≤ 2 BMs during e 7-day look-back period or
  - if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).
- If unaddressed, constipation can lead to fecal impaction.

Section I: Diagnoses

- *There are two look-back periods for this section:*
  - Diagnosis identification (Step 1) is **a 60-day look-back period.**
  - Diagnosis status: Active or Inactive (Step 2) is a **7-day look-back period**
    - (except for Item I2300 UTI, which has it's own coding rules and lookback period)

Steps for Assessment

1. **Identify diagnoses:** The disease conditions in this section require a physician/NPP documented diagnosis in the **last 60 days.** Medical record sources:
   - progress notes,
   - most recent history and physical
   - transfer documents
   - discharge summaries
   - diagnosis/ problem list
   - other resources as available.
- If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

Steps for Assessment

- Diagnoses communicated verbally ***must be documented in the medical record by the physician*** to ensure follow-up.
- Diagnostic information, including past history obtained from family members and close contacts, ***must also be documented in the medical record by the physician*** to ensure validity and follow-up.

Steps for Assessment

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.**
   - Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
   - Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

Steps for Assessment

Examples of diseases are included for some disease categories.

- Diseases to be coded in these categories are not meant to be limited to only those listed in the examples
- For example, **I0200, Anemia,** includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- Check off each active disease. Check all that apply
- If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis

Indicators of Active Diagnosis:

- Specific Documentation of Active Diagnosis in medical record by MD/NPP
- In the absence of specific documentation:
  - Recent onset or acute exacerbation indicated by a positive study, test, or procedure, hospitalization for acute S/S, and/or recent changes in therapy.
  - Symptoms and abnormal signs indicating ongoing or decompensated disease.
    - Must be specifically attributable to a disease
  - Ongoing therapy w/meds or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potential adverse effects.

Signs and Symptoms that indicate active disease

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
- For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease.
- Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease.
  - For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

Diagnoses Checkboxes

Cancer

- **I0100,** cancer (with or without metastasis)

Heart/Circulation

- **I0200,** anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- **I0300,** atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- **I0400,** coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500,** deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)
- **I0600,** heart failure (e.g., congestive heart failure [CHF], pulmonary edema)
- **I0700,** hypertension
- **I0800,** orthostatic hypotension
- **I0900,** peripheral vascular disease or peripheral arterial disease

Diagnoses Checkboxes

Gastrointestinal

- **I1100,** cirrhosis
- **I1200,** gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)
- **I1300,** ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

- **I1400,** benign prostatic hyperplasia (BPH)
- **I1500,** renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550,** neurogenic bladder
- **I1650,** obstructive uropathy

Diagnoses Checkboxes

Infections

- **I1700,** multidrug resistant organism (MDRO)
- **I2000,** pneumonia
- **I2100,** septicemia
- **I2200,** tuberculosis
- **I2300,** urinary tract infection (UTI) (last 30 days)
- **I2400,** viral hepatitis (e.g., hepatitis A, B, C, D, and E)
- **I2500,** wound infection (other than foot)

Diagnoses Checkboxes

Metabolic

- **I2900,** diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)
- **I3100,** hyponatremia
- **I3200,** hyperkalemia
- **I3300,** hyperlipidemia (e.g., hypercholesterolemia)
- **I3400,** thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Diagnoses Checkboxes

Musculoskeletal

- **I3700,** arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])
- **I3800,** osteoporosis
- **I3900,** hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)
- **I4000,** other fracture

Neurological

- **I4200,** Alzheimer's disease
- **I4300,** aphasia
- **I4400,** cerebral palsy
- **I4500,** cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800,** dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- **I4900,** hemiplegia or hemiparesis
- **I5000,** paraplegia
- **I5100,** quadriplegia
- **I5200,** multiple sclerosis (MS)
- **I5250,** Huntington's disease
- **I5300,** Parkinson's disease
- **I5350,** Tourette's syndrome
- **I5400,** seizure disorder or epilepsy
- **I5500,** traumatic brain injury (TBI)

Section I5100: Quadriplegia

Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.

Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.

Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

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Diagnoses Checkboxes

Nutritional

- **I5600,** malnutrition (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- **I5700,** anxiety disorder
- **I5800,** depression (other than bipolar)
- **I5900,** manic depression (bipolar disease)
- **I5950,** psychotic disorder (other than schizophrenia)
- **I6000,** schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- **I6100,** post-traumatic stress disorder (PTSD)

Diagnoses Checkboxes

Pulmonary

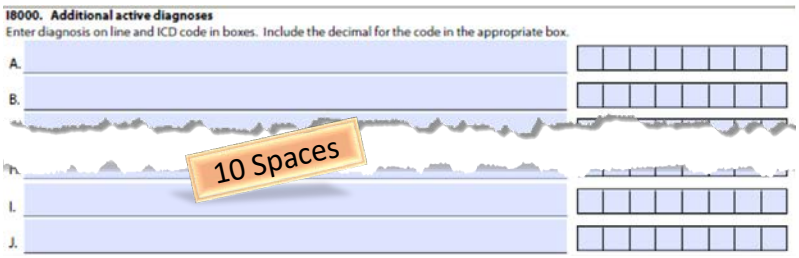
- **I6200,** asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6300,** respiratory failure

Vision

- **I6500,** cataracts, glaucoma, or macular degeneration
- **None of Above**
- **I7900,** none of the above active diagnoses within the past 7 days

I8000 Additional Active Diagnoses

- Use if a disease or condition is not specifically listed



Section I: UTI Definition

Item I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days.

- **Code only if both of the following are met in the last 30 days:**

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

AND

2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

Section I: UTI Definition

- Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.
- Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.
- **Resources for evidence-based UTI criteria:**
  - Loeb criteria: https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-_Care_Facilities_Results_of_a_Consensus_Conference
  - Surveillance Definitions of Infections in LTC (updated McGeer criteria): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/
  - National Healthcare Safety Network (NHSN):
  - https://www.cdc.gov/nhsn/ltc/uti/index.html

I-8

- If UTI Dx was made prior to the resident's admission, entry, or reentry into the facility, it is **not** necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.
- When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

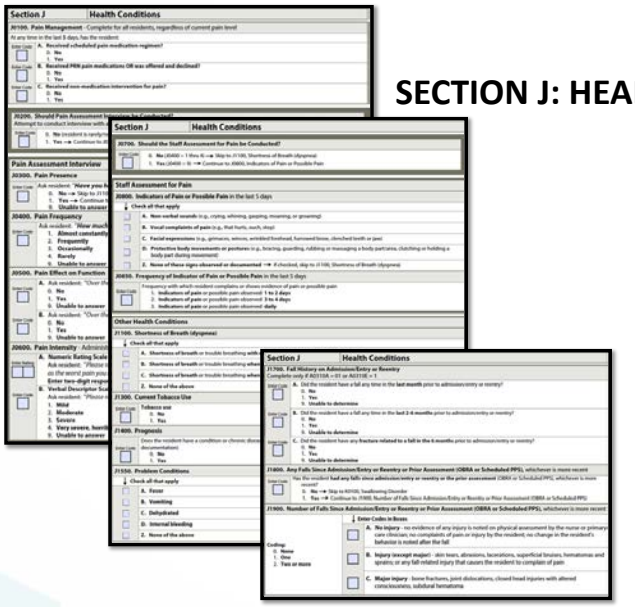
I-9 Revised

Examples I-9

- The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. The resident is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.
- **Coding: Cerebrovascular Vascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be **checked**.
- **Rationale:** The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

Examples:

- Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.
- **Coding: Hip Fracture** item (I3900), would **not be checked.**
- **Rationale:** Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.



SECTION J: HEALTH CONDITIONS

J0100: Pain Management

J0100. Pain Management - Complete for all residents, regardless of current pain level	
At any time in the last **5** days, has the resident:	
Enter Code ☐	**A. Received scheduled pain medication regimen?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Received PRN pain medications OR was offered and declined?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Received non-medication intervention for pain?** 0. **No** 1. **Yes**

- Received PRN
  - Yes if PRN med was either received OR ***was offered & declined.***
- Non-med intervention
  - Yes if scheduled as part of the care plan and documented that intervention was actually received and assessed for efficacy.

J0100 Pain Management

PAIN MEDICATION REGIMEN: Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments by lead to pain reduction.

J-1

J0100 Instructions

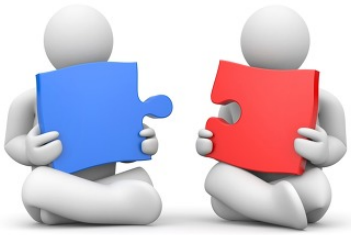
SCHEDULED PAIN MEDICATION REGIMEN: Pain medication order that defines dose and specific time interval for pain medication administration. For example, once a day, every 12 hours.

PRN PAIN MEDICATIONS
Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as every 4 hours as needed for pain or every 6 hours as needed for pain.

NON-MEDICATION PAIN INTERVENTION: Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.

J-2

MDS Interviews: Background



Attempting the interviews

D-1

MDS interview principles:

All residents capable of **any communication** should be asked to provide information regarding what **they** consider to be **the most important** facets of their lives.

MDS interview principles:

Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident regarding these specific topic areas; however, resident interview/inquiry should become part of a supportive care environment that helps residents fulfill their choices over aspects of their lives.

D-1

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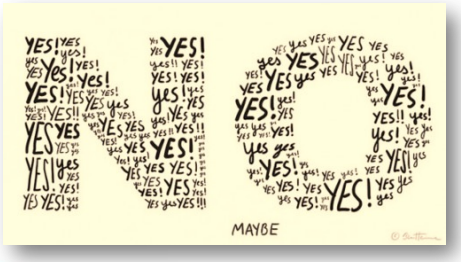
MDS Interviews:

- Standardized, structured, scripted
  - Not chats
- May be done verbally, in writing or both
- Cue cards recommended
- Appendix D Review



140

MDS Interviews:

- Attempt interview with everyone, unless:
  - Rarely/never understood or
  - Resident needs or wants an interpreter (A1100) and one is not available for the interview.
    - *When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.* *p. A-11*
- Stop interview after a certain amount of nonsensical /no responses & more to Staff Assessment.
  - Rules differ depending on particular interview.
- Additional interview techniques specific to the particular interview provided in coding instructions.

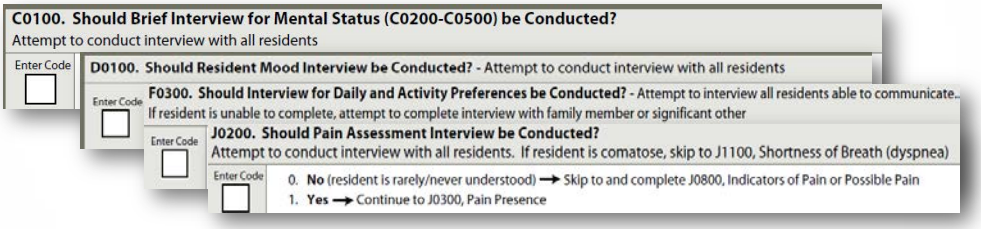
From gateway question for each interview

141

Note on Interviews:

- *Attempt to conduct interview with all residents*

- Determine if the resident is rarely/never understood.
- *Review **Language*** item (A1100), to determine whether the resident needs or wants an interpreter.
- *Code 0 – No only if resident is rarely/never understood or needs an interpreter and one is not available on the day of the interview.*



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B0700: Makes Self Understood: Definition

- Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these.
- Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

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B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

Steps for Assessment

Assess using the resident's preferred language or method of communication.	Interact with the resident. Be sure he or she can hear you. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.	Observe his or her interactions with others in different settings and circumstances.	Consult with the primary nurse assistant (over all shifts), if available, the resident's family, and speech-language pathologist.

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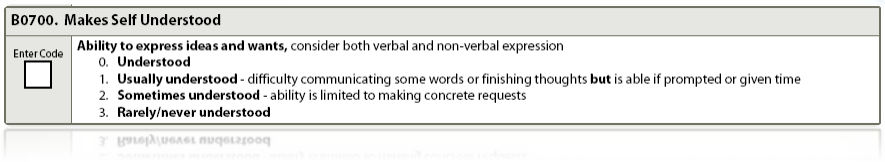

B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

0. Understood: Expresses requests and ideas clearly.

1. Usually understood: Has difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood.

2. Sometimes understood: Has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

3. Rarely or never understood: if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

B-4

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B0700 Instruction:

Coding Tips and Special Populations

- This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.
- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.

B-7

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Identical Instructions for Three Interviews: BIMS, PHQ-9, Pain

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

C-1
D-2
J-4

147

Instructions for Preferences

- Determine whether or not resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.
- If resident is rarely/never understood and a family member or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.

F-1

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Instructions for Preferences

7. Conduct the interview during the observation period.
8. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.

F-1

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Identical Coding Tips & Special Populations (for all interviews):

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident needs an interpreter, every effort should be made to have an interpreter present for the [type] interview. If it is not possible for a needed interpreter to be present on the day of the interview, code [gateway question "interview should not be attempted"] to indicate that an interview was not attempted and complete items [staff assessment]
- Includes residents who use American Sign Language (ASL).

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Identical Coding Tips & Special Populations:

- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item [gateway] must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment items if the resident interview should have been conducted, but was not done.

Note: The "preferences" interview does not have "preferably the day before or the day of the ARD"

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Look back periods

3.3 Coding Conventions

- There are several standard conventions to be used when completing the MDS assessment, as follows.
- The standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.
- **With the exception of certain items (e.g., some items in Sections K and O), the look-back period does not extend into the preadmission period unless the item instructions state otherwise.** In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise.

3-4

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Look back periods:

BIMS	7 days (Page 3-4)
PHQ-9	14 days (Page D-5)
Preferences	7 days (Page 3-4)
Pain	5 days (Page J-8)

All, except Preferences: The interview is conducted in the lookback period, preferable on the ARD or the day prior to the ARD.

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- Introduce yourself to the resident.
- Be sure the resident can hear what you are saying.
- Do not mumble or rush
- Ask if resident owns a communication device. Use it. Ensure it is operational.
- Assessor may need to offer headphones
- Ask about interpreter as needed.
- Find a quiet, private area where you are not likely to be interrupted or overheard.
- Sit where the resident can see you clearly and you can see his or her expressions.
- Establish rapport and respect.
- Explain the purpose of the questions to the resident.
- Say and show the item responses in large, clear print.
- Ask the questions as they appear in the questionnaire

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- Break the question apart if necessary
- Clarify using echoing.
- Repeat the response options as needed.
- Move on to another question if unable to answer.
- Try to complete an entire interview in one sitting. Be willing to come back later for other interviews.
- Do not try to talk a resident out of an answer.
- Record actual response, not what you think they should have said.
- Sympathetically respond to feelings.
- Resident preferences can be challenging to discern.

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Factors to Consider:

- Who does the resident best respond to?
- Who is the resident most comfortable talking with?
- Would one person doing all the interviews be appropriate for some residents?
- Are the interviews seen as an important building block for care planning?
- Does the boss check?
- Does your organization want to know the resident's responses? Are you willing to change schedules, approaches, physical environment?

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Each has a lookback period. There is NOT one or two days in which the interview must be done.

Each must* be done no later than the ARD. Stand-alone OMRAs are an exception

You may not substitute a staff assessment for an interview when the resident is interviewable and the interview just wasn't done by the ARD.

Each interview has a process to follow when the resident is being interviewed and the result is a certain number of no answer or nonsensical answers.

Each must be done in an environment where the resident can see and hear you with distractions minimized

Each has a structured method of delivery from which there can be no deviation.

The interviewer must seek clarification from the resident whenever the interviewer is not clear on which answer to code on the MDS

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Section Completion Z0400

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.	Judy Wilhide Brandt	Dietitian	K	August 7, 2015
B.				

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

Interview attestation must use the date of the interview.

Summary

- Attempting interviews earlier in the lookback facilitates:
  - More interviews completed
  - Ability to come back later if it's a bad time for the resident

Pain interview

Nuts and bolts

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Health-related Quality of Life

Pain is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems

Some limit activities to avoid pain. Report of lower pain frequency may reflect avoidance of activity more than it reflects adequate pain management.

Effects of unrelieved pain include functional decline, skin breakdown and infections.

Self-report is the most reliable way to detect pain. You can't tell by looking at a person if he or she is in pain.

Pain adversely affects a person's quality of life

Regular and objective use of self-report pain scales enhances residents' willingness to report.

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Pain Assessment Interview Guidelines

- The look-back period for all pain interview items is **5 days**.
- Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
- Ask each question in order and as written.
- Code **9** if the resident is unable to answer, chooses not to answer or gives nonsensical answer and move on to the next question.
- Use other terms for pain or follow-up discussion if resident seems unsure or hesitant.

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Pain Assessment Interview Guidelines

- If the resident is unsure about whether pain occurred during the look-back period:
  - Prompt resident to think about the most recent episode.
  - Try to determine whether it occurred during the look-back period.
- The interview is considered complete if:
  - Resident answers No to J0300 Pain Presence.

  OR
  - Resident answers Yes to J0300 and answers J0400 Pain Frequency.

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Pain Interview Instructions

- Attempt unless rarely/never understood or interpreter desired and unavailable.
- If unable to answer primary question on pain presence, skip to the Staff Assessment for Pain.
- If unable to answer Pain Frequency item, continue interview and complete Staff Assessment for Pain.

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Give an introduction before starting the interview. Suggested language: “I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.”

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Pain Interview Instructions:

Read the question and item choices slowly.

- While reading, may use cue card.

The resident may provide

- verbal response,
- point to the written response, or
- both.

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Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐

Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐

A. Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐

B. Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. Numeric Rating Scale (00-10)
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. Verbal Descriptor Scale
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

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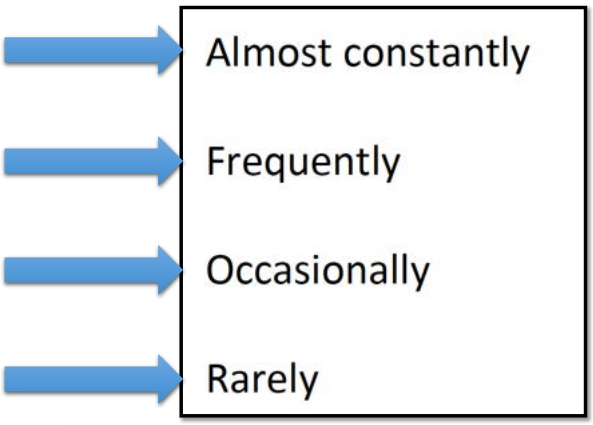
Cue Cards: How much of the time have you experienced pain or hurting over the last five days?



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J0500. Pain Effect on Function	
Enter Code ☐	A. Ask resident: *"Over the past 5 days,* ***has pain made it hard for you to sleep at night?"*** 0. **No** 1. **Yes** 9. **Unable to answer**
Enter Code ☐	B. Ask resident: *"Over the past 5 days,* ***have you limited your day-to-day activities because of pain?"*** 0. **No** 1. **Yes** 9. **Unable to answer**

If the resident's response does not lead to a clear "yes" or "no" answer, repeat the resident's response and then try to narrow the focus of the response. For example, if the resident responded to the question, "Has pain made it hard for you to sleep at night?" by saying, "I always have trouble sleeping," then the assessor might reply, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?

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Pain Intensity

Select either numeric or verbal descriptor scale.

Try to use the same scale used on prior assessments.

If unable to answer using one scale, the other scale should be attempted.

This is not an open ended chat.
Don't add to the interview or take away from the interview.
You may ask any other questions after this scripted five question interview.

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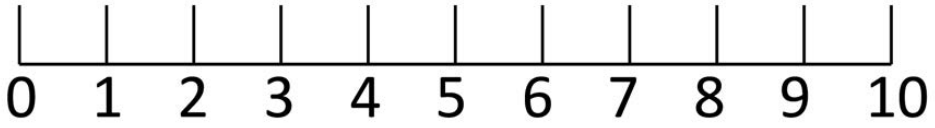
Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.



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Please rate the intensity of your worst pain over the last 5 days.

1. Mild
2. Moderate
3. Severe
4. Very severe, horrible

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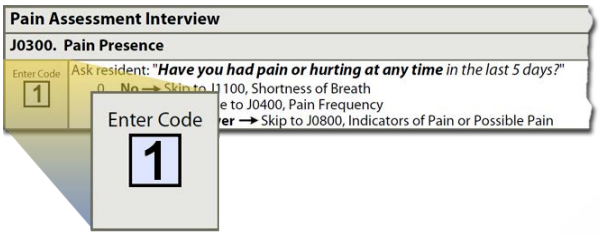
J0300 Practice

- When asked about pain, Mr. T. responds, No pain, but I have had a terrible burning sensation all down my leg.



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J0400 Pain Frequency

- Do not offer definitions of response options.
- Resident's response should be based on the resident's interpretation of the frequency options.
- Use echoing to help clarify the preferred option if the resident does not respond according to the response scale.

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J0400 Practice

- When asked about pain, Mr. J. responds:
  - I don't know if it is frequent or occasional.
  - My knee starts throbbing every time they move me from the bed or the wheelchair.
- The interviewer says:
  - Your knee throbs every time they move you.
  - If you had to choose an answer, would you say that you have pain frequently or occasionally
- Mr. J. is still unable to choose between frequently and occasionally.

J0400. Pain Frequency

Enter Code: 2

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

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Pain Interview Completion

- Pain Interview Completed in these 2 scenarios:

J0300. Pain Presence

Enter Code: 0

Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"

0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

If the resident chooses not to answer a particular item, accept his/her refusal, **code 9**, and move on to the next item.

Anything except 9 →

J0300. Pain Presence

Enter Code: 1

Ask resident: "***Have you had pain or hurti***

0. **No** → Skip to J1100, Shortness of Br
1. **Yes** → Continue to J0400, Pain Freq
9. **Unable to answer** → Skip to J0800,

J0400. Pain Frequency

Enter Code: 2

Ask resident: "***How much of the time hav***

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

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J0700 Coding Instructions

- **Code 0. No.**
  - Resident completed the Pain Assessment Interview.
  - Skip to J1100 Shortness of Breath (dyspnea).
- **Code 1. Yes.**
  - Resident unable to complete the Pain Assessment Interview.
  - Continue to J0800 Indicators of Pain or Possible Pain.

J0700. Should the Staff Assessment for Pain be Conducted?	
Enter Code ☐	0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea) 1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

J0800: Indicators of Pain or Possible Pain: 5 day lookback

Staff Assessment for Pain	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ **Check all that apply**	
☐	**A. Non-verbal sounds** (crying, whining, gasping, moaning, or groaning)
☐	**B. Vocal complaints of pain** (that hurts, ouch, stop)
☐	**C. Facial expressions** (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	**D. Protective body movements or postures** (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement
☐	**Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days	
Enter Code ☐	Frequency with which resident complains or shows evidence of pain or possible pain 1. **Indicators of pain** or possible pain observed **1 to 2 days** 2. **Indicators of pain** or possible pain observed **3 to 4 days** 3. **Indicators of pain** or possible pain observed **daily**

Staff Assessment of Pain

- Residents who cannot verbally communicate about their pain are at particularly high risk for under detection and under treatment of pain.
- Severe cognitive impairment may affect ability of residents to communicate verbally.
  - Limits availability of self-reported information about pain.
  - Fewer complaints may not mean less pain.
- Individuals unable to communicate verbally may be more likely to use alternative methods of expression to communicate pain.

J1100 & J1300

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

Check all that apply

- ☐ A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ B. **Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ C. **Shortness of breath** or trouble breathing **when lying flat**
- ☐ Z. **None of the above**

J1300. Current Tobacco Use

Enter Code ☐ **Tobacco use**
0. **No**
1. **Yes**

Shortness of Breath

Steps for Assessment

- Interview resident. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.
- If the resident is not experiencing SOB during interview, ask if SOB occurs when he or she engages in certain activities.
- Review the medical record….Interview staff, family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
- Observe for SOB or trouble breathing. If observed, note whether it occurs with certain positions or activities.

Shortness of Breath

- For SOB with exertion:
  - If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- For SOB lying flat:
  - Also code this as present if the resident avoids lying flat because of shortness of breath.

SOB does not have to actually happen during the lookback in these cases.

J1400 Prognosis

Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months (Requires physician documentation)

0. No
1. Yes

Code 1, yes: if the medical record includes physician documentation:

1) that the resident is terminally ill; or
2) the resident is receiving hospice services.

J1400

Steps for Assessment

1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record.
3. Review the medical record to determine whether the resident is receiving hospice services.

TERMINALLY ILL

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

HOSPICE SERVICES

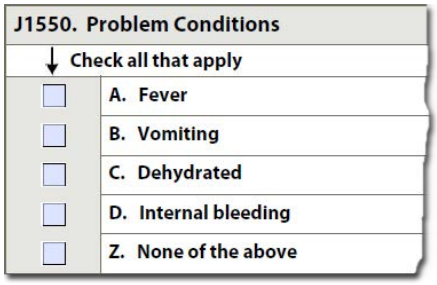
A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

DEFINITION

CONDITION OR CHRONIC DISEASE THAT MAY RESULT IN A LIFE EXPECTANCY OF LESS THAN 6 MONTHS

In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months.

This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.



Fever: 2.4 above baseline, or **100.4 upon admission** (prior to baseline establishment)

Internal Bleeding: Nose bleeds that are easily controlled, **menses, or a urinalysis that shows a small amount of red blood cells** should not be coded as internal bleeding.

Dehydration

- Dehydration requires at least two of the following indicators:
  1. Takes in less than 1,500 ml of fluids daily.
  2. Has one or more clinical signs of dehydration.
  3. Fluid loss exceeds amount of fluids residents takes in.

J1700/1800/1900: Falls & Injury

J1700. Fall History on Admission/Entry or Reentry
Complete only if A0310A = 01 or A0310E = 1

Admission or 1st assessment since entry

Enter Code ☐ **A.** Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐ **B.** Did the resident have a fall any time in the **last 2-6 months** p… entry?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐ **C.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry
0. **No**
1. **Yes**
9. **Unable to determine**

Do not count PPS assessment not transmitted (Not original Med A)

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

Enter Code ☐ Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → 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

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Definition of a Fall

- Unintentional change in position coming to rest on the ground, floor, or next lower surface.
- May be witnessed, reported by resident or identified by finding resident on the floor or ground.
- Not a result of overwhelming external force.
- Intercepted fall where resident catches himself or herself or is intercepted by another person is still considered a fall.
- Challenging a resident's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention. Anticipated losses of balance that occur during supervised therapeutic interventions are not coded here as intercepted falls.

J-27

INJURY RELATED TO A FALL

Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

INJURY (EXCEPT MAJOR)

Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY

Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

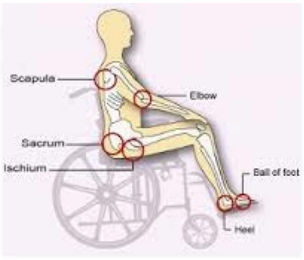
Steps for Assessment – J1900

1. If this is the first assessment/entry or reentry (A0310E = 1), review medical record for time period from the admission date to the ARD.
2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last OBRA or scheduled PPS MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.

Steps for Assessment – J1900

4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.
6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

- **Coding Tip**
- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.



Common Locations of Pressure Ulcers

Section M: Skin Conditions

Risk of Pressure Ulcers/Injuries

Check all that have occurred **in the 7 day lookback period.**

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
☐	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
☐	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
☐	C. Clinical assessment
☐	Z. None of the above

M0150. Risk of Pressure Ulcers	
Enter Code ☐	Is this resident at risk of developing pressure ulcers? 0. No 1. Yes

Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer.

PRESSURE ULCER

A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. ***You must code the MDS according to the instructions in this manual.***

- **HEALED PRESSURE ULCER:** Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, **even if** the area continues to have some surface discoloration.
- **EPITHELIAL TISSUE:** New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
- **GRANULATION TISSUE:** Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

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Actual Pressure Ulcers: 7 day lookback

M0210. Unhealed Pressure Ulcer(s)	
Enter Code ☐	**Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → Skip to M0900, Healed Pressure Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

- if an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- PU with flap graft is surgical wound, if graft fails, continue to code as surgical wound until healed.
- Surgically debrided PU is still a PU (M-34)

Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.

- A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change.
  - Eschar is dead tissue. Scab is evidence of wound healing.

M-5

Actual Pressure Ulcers: 7 day lookback

Code based on the presence of any pressure ulcer(regardless of stage) in the past 7 days.

- **Code 0, no:** if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Items M0300–M0800.
- **Code 1, yes:** if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period.

Coding Tips for M0210: Unhealed Pressure Ulcers/Injuries

- Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.
- The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

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Coding Tips for M0210: Unhealed Pressure Ulcers/Injuries

- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.
- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.

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What to Include as a 'current ulcer':

- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.

M-6

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.

M-7

Steps for completing M0300A-G

3. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
4. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool.

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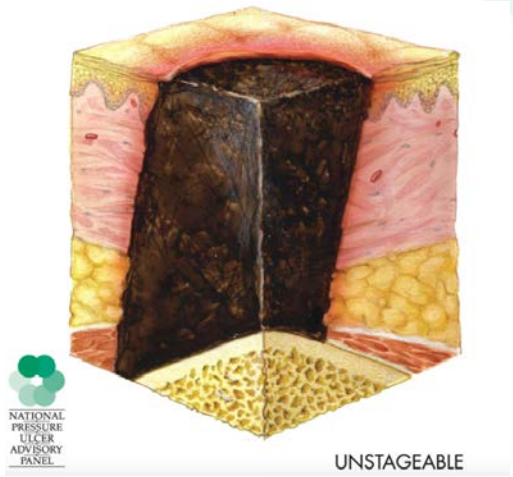
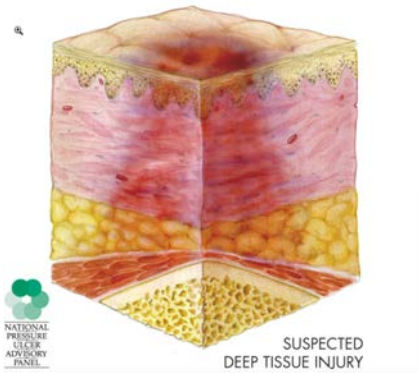
Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.

3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable.



4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
5. A pressure *injury* with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure *injury*. It should be coded as unstageable.



6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device .

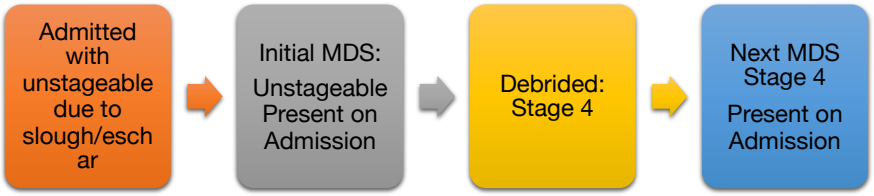
Step 3: Determine “Present on Admission”

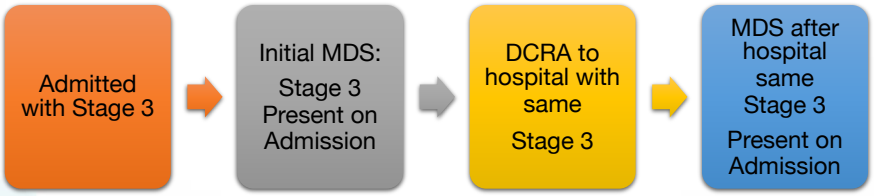
1. Review the medical record for the history of the ulcer/injury.
2. Review for location and stage at the time of admission/entry or reentry.
3. If pressure ulcer/injury was present on admission and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage should not be considered as “present on admission.”
4. If the pressure ulcer/injury was present on admission and becomes unstageable due to slough or eschar, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and should not be coded as “present on admission.”
5. If the pressure ulcer/injury was unstageable on admission, then becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should not be coded as “present on admission.”

6. If a resident who has a pressure ulcer/injury that was originally acquired in the facility is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury should not be coded as "present on admission" because it was present and acquired at the facility prior to the hospitalization.
7. If a resident who has a pressure ulcer/injury that was "present on admission" (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer is still coded as "present on admission" because it was originally acquired outside the facility and has not changed in stage.
8. If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable due to slough or eschar during the hospitalization, it should be coded as "present on admission" upon reentry.

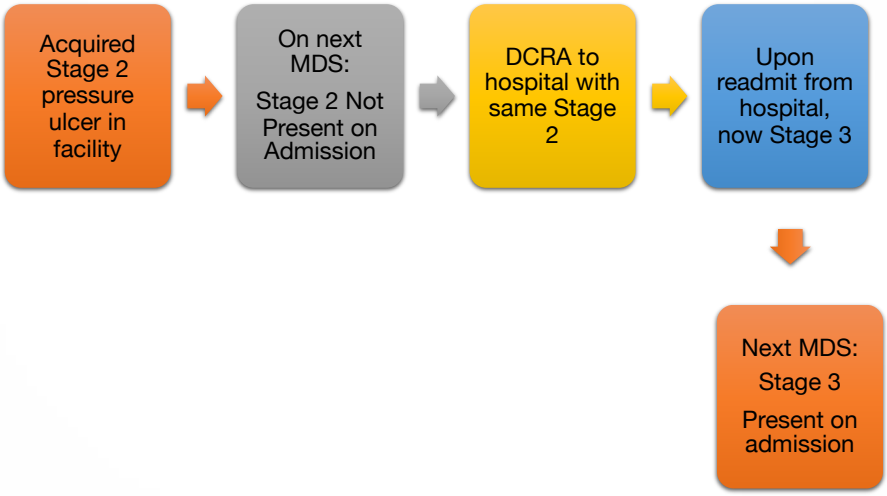
9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.**
10. If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."

Examples:

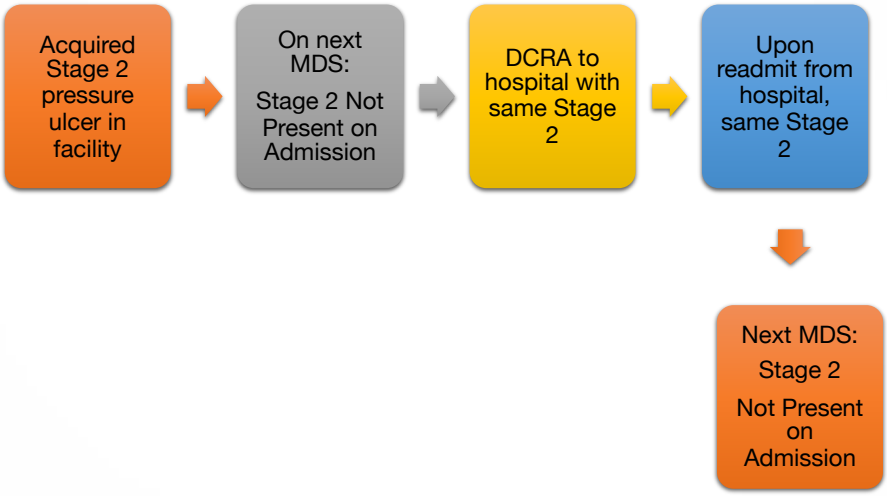




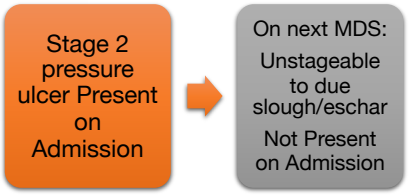
Examples:



Examples:



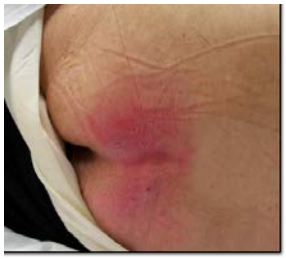
Examples:



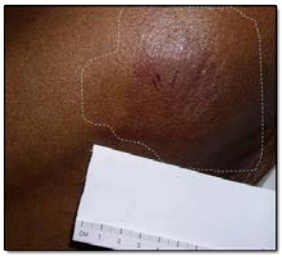
M-19

Stage 1 Pressure Ulcers:

Intact skin with non-blanchable redness of a localized area usually over a bony prominence.



Reddened areas of tissue that do not lose skin color when firmly pressed with a finger.

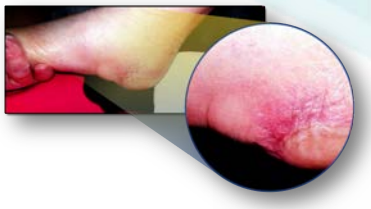


Darkly pigmented skin may not have a visible blanching; may appear with persistent blue or purple hues.

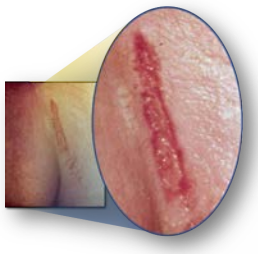
M-11

Stage 2 Pressure Ulcers:

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising.
May also present as an intact or open/ ruptured blister. May be covered by a scab.



Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.

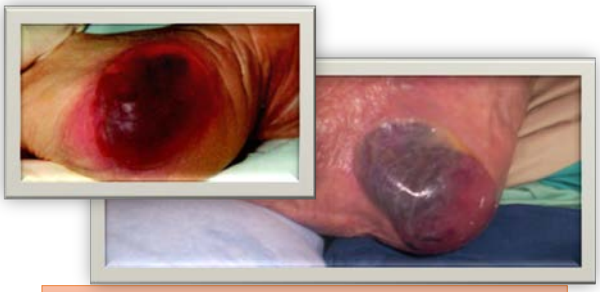


M-12

Blister caused by pressure: Stage 2 Pressure Ulcer or DTI

Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.

Color Change
Bogginess
Firmness
Tenderness
Warmth
Coolness

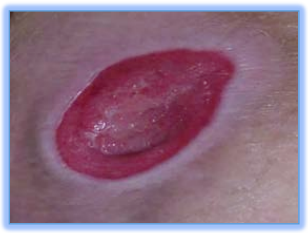


These are Deep Tissue Injuries, not St 2 PrU!

M-13

Stage 3 Pressure Ulcers

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 or tunneling



M-11

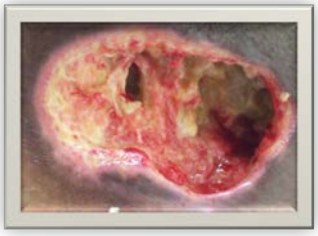
M-15

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

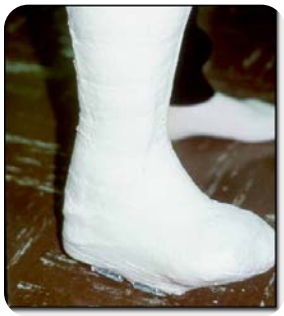
Stage 4 Pressure Ulcers

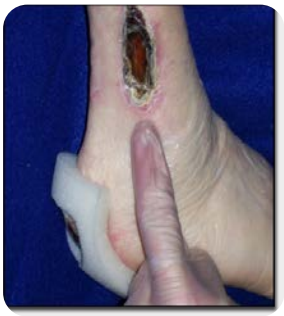
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4. M-19



Unstageable PrU: 3 Types:

1. Non-removable dressing/device is covering a known pressure ulcer.

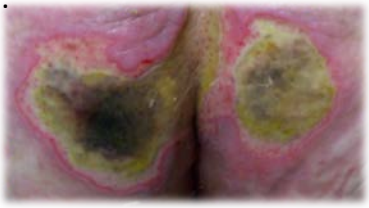




Unstageable PrU: Slough/Eschar

SLOUGH TISSUE
Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE
Dead or devitalized issue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.



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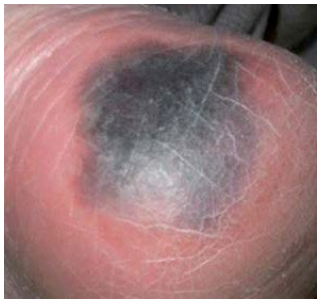
-

Unstageable PrU: 3 Types:

3. Deep Tissue Injury
   - Purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue damage. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.

In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.



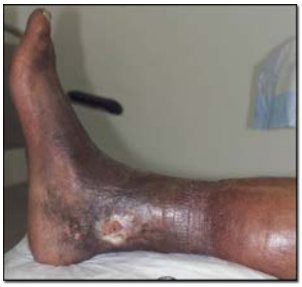
M-19

Coding Tips: DTI M-25

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

Venous Ulcers

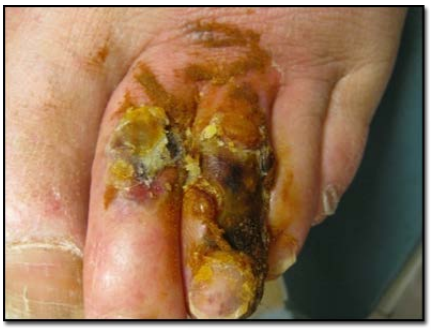
- Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- Wound may start due to minor trauma.
- Usual location is lower leg area or medial or lateral malleolus.
- Characterized by:
  - Irregular wound edges
- Hemosiderin staining (dark yellow-brown)
- Leg edema



M-31

ARTERIAL ULCERS

Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.



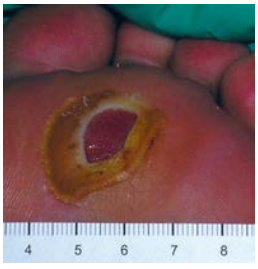
Other Skin Problems

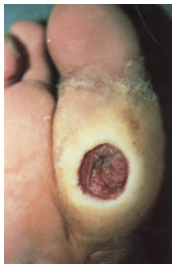
M1040G Skin Tear(s)
Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040F Burns (Second or Third Degree)
- Do **not** include first degree burns (changes in skin color only).

Diabetic Foot Ulcer

- Ulcers caused by the neuropathic and small blood vessel complications of diabetes.
  - Typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot.
  - Usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges.
  - Very regular in shape, wound edges are even with a punched-out appearance.
  - Typically not painful.





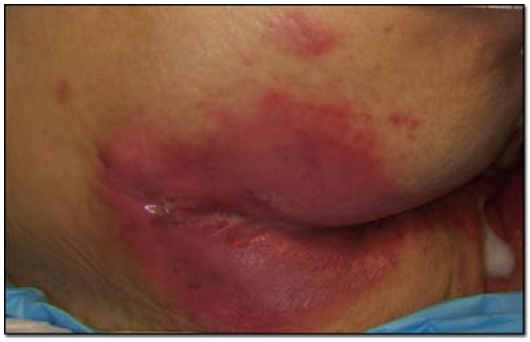
M1040E Surgical Wounds

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.

- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

Moisture Associated Skin Damage

- Caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. MASD is also referred to as incontinence dermatitis.



M1200: Skin and Ulcer Treatments

- M1200A/M1200B Pressure Reducing Devices
  - Do not include egg crate cushions of any type or doughnut/ring devices in this category.
- M1200C Turning/Repositioning Program
  - Must be specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
  - Progress notes, assessments, and other documentation should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

TURNING/REPOSITIONING PROGRAM
Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS
Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

- **M1200E Pressure Ulcer Care**
  - Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.

M1200F Surgical Wound Care

- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look- back period, the assessor should check that MDS item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND- AID® bandages).

M1200H Application of Ointments/Medications Other than to Feet

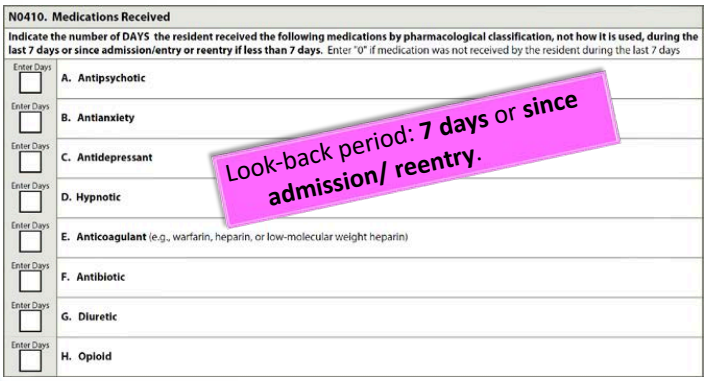
- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Section N: Medications

N0410A–G: Code medications according to the pharmacological classification, not how they are being used.



N0410. Medications Received

Indicate the number of DAYS the resident received the following 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. Enter "0" if medication was not received by the resident during the last 7 days

Enter Days ☐	**A. Antipsychotic**
Enter Days ☐	**B. Antianxiety**
Enter Days ☐	**C. Antidepressant**
Enter Days ☐	**D. Hypnotic**
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**
Enter Days ☐	**H. Opioid**

E. Anticoagulant: Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. N-7 Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant. N-9

N0400: Coding tips

- Code based on therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety.
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine [Compazine] is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- Include any route in any setting while a resident.
  - Even if given only once during lookback.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are given during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)

Coding tips

- A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the MDS, and only the days the staff attaches the patch to the skin are counted for the MDS. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0410H Opioid would be coded 3, because the application occurred on 3 days during the look-back period.
- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.

N-8

Coding Tips

- In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's website.
- Herbal and alternative medicine products are considered to be dietary supplements by the FDA. These products are not regulated by the FDA and their composition is not standardized. Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root).

N08

- Resources and Tools:
- GlobalRPh Drug Reference, http://globalrph.com/drug- A.htm
- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6.
  - *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"
- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html
- List not all-inclusive, not required for MDS completion. CMS is not responsible for the content or accessibility of the pages found at these sites.
- Providers responsible for coding each medication's pharmacological/therapeutic classification accurately. Caution should be exercised when using lists of medication categories, and providers should always refer to the details concerning each medication when determining its medication classification.

N0450: Antipsychotic Medication Review:

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Item sets: NC, NQ

Steps for Assessment

1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent.
2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted.
3. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated.

N0450A Did the resident receive antipsychotic medications since admission/entry or reentry or prior OBRA assessment, whichever is more recent?

- **Code 0, no:** if antipsychotics were not received. Skip to Section O.
- **Code 1, yes:** if antipsychotics received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 2, yes:** if antipsychotics received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 3, yes:** if antipsychotics received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted?

N0450B: Has a gradual dose reduction (GDR) been attempted?

Gradual Dose Reduction (GDR) Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued. N-8

- **Code 0, no:** if a GDR has not been attempted. Skip to N0450D, Physician documented GDR as clinically contraindicated.
- **Code 1, yes:** if a GDR has been attempted. Continue to N0450C, Date of last attempted GDR.

N0450C:

• Enter the date of the last attempted Gradual Dose Reduction.

N0450B&C Coding Tips

- Within 1st year
  - when admitted on antipsychotic medication or
  - after the facility has initiated an antipsychotic medication

  facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated. See F758 for more.
- In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted.

N-13

N0450B&C Coding Tips

- Do not include GDRs that occurred prior to **admission** to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).
- If resident admitted to facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C.
- If the resident received a dose or doses of an antipsychotic medication that was not part of a documented GDR attempt, such as if the resident received a dose or doses of the medication PRN or one or two doses were ordered for the resident for a specific day or procedure, these are **not coded as a GDR attempt** in N0450B and N0450C.

N-13

N0450B&C Coding Tips

- Discontinuation of antipsychotic, even without a GDR process, should be coded in N0450B and N0450C as GDR. When antipsychotic is discontinued without a GDR, the date of the GDR in N0450C is **the first day the resident did not receive the discontinued antipsychotic medication**. N-13
- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching from one antipsychotic to another.
- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the **first day the resident received the reduced dose** of the antipsychotic.
- **I**n cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C.
- If multiple dose reductions have been attempted since admission OR since initiation of the antipsychotic medication, record the date of the most recent reduction attempt in N0450C.

N-13 & N-14

N0450D: Physician Documented GDR clinically contraindicated

- **Code 0, no:** if a GDR has not been documented by a physician as clinically contraindicated.
- **Code 1, yes:** if a GDR has been documented by a physician as clinically contraindicated. Continue to N0450E, Date physician documented GDR as clinically contraindicated.

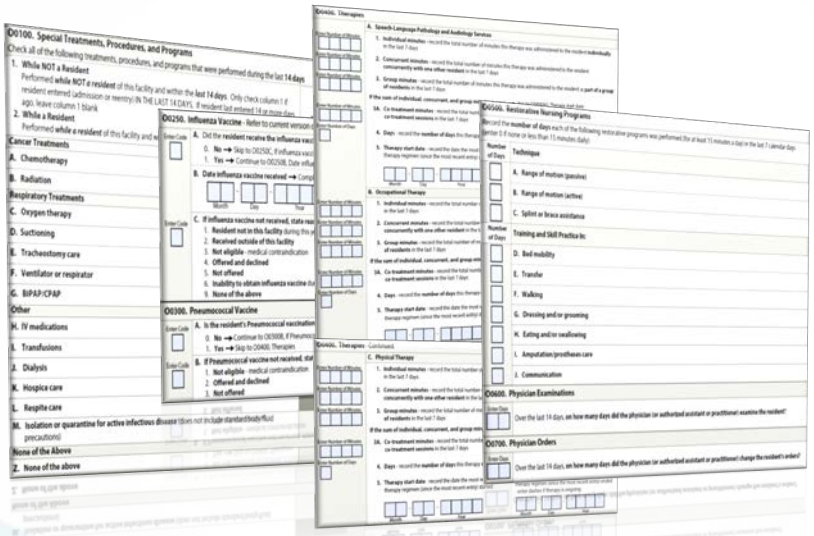
If "yes" enter date in N0450E

In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.

N0450E: Coding TIps

- In N0450D and N0450E, include physician documentation that GDR attempt is clinically contraindicated since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted to the facility.
- Physician documentation indicating dose reduction attempts are clinically contraindicated **must include the clinical rationale for why an attempted dose reduction is inadvisable**. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

Section O: Special Treatments, Procedures, and Programs



O0100:

O0100. Special Treatments and Programs Check all of the following treatments, programs and procedu 1. While NOT a Resident Procedure performed *while NOT a resident* of this facility column 1 if resident entered (admission or reentry) IN TH or more days ago, leave column 1 blank 2. While a Resident Procedure performed *while a resident* of this facility and		
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
G. BiPAP/CPAP	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
L. Respite care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

Do not code services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

- Chemotherapy: chemotherapy agents administered as an antineoplastic – to treat cancer.
  - Do not code chemotherapy agents that are NOT being used to treat cancer.
  - *Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should **not** be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS . Ex: Tamoxifin*
  - Do not code IV fluid, IV medication, and blood transfusions administered during dialysis or chemotherapy.
- Radiation: includes implants
- Oxygen Therapy: For lungs not hyperbaric oxygen for wound therapy.

- Suctioning: Nose or trach, not oral
- Trach Care: Code cleansing of trach and/or cannula
- *Invasive Mechanical Ventilator (*ventilator or respirator*)* Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become *(such as during weaning attempts)* **unable to support his or her own respiration** in this item.
  - Via ET tube or trach

- ***Non-invasive Mechanical Ventilator (*BiPAP/CPAP*): A***ny type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask *or other device* continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask*/device* enables the individual to **support his or her own *spontaneous* respiration** by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask*/device*.

- IV Medications: Code any drug or biological, (e.g. contrast material) given by intravenous push, epidural pump, or drip through a central or peripheral port.
  - May code epidural, intrathecal, and baclofen pumps.
  - Do not code:
    - Flushes to keep an IV access port patent
    - IV fluids without medication
    - Subcutaneous pumps
    - Medications administered during dialysis or chemotherapy
    - IV Dextrose 50% or Lactated Ringers
- Transfusions: Transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- Dialysis: Peritoneal or renal, Record treatments of hemofiltration, SCUF, CAVH, and CAPD.
  - Do not code IV fluid, IV medication, and blood transfusions administered during dialysis or chemotherapy.
- Hospice: Must be licensed by state or certified under the Medicare program as a hospice provider.
- Respite: Short-term stay for providing relief to a primary home-based caregiver(s)

O0100 M: Isolation O-4

- Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns.

O0100 M: Isolation O-4

- Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for single room isolation only when all of the following conditions are met:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's plan of care will likely need to be completed.

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?

0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O-7

Steps for Assessment

1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.

Coding Tips and Special Populations

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm.
- Facilities can also contact their local health department website for local influenza surveillance information.

O0300: Pneumococcal vaccine

Steps for Assessment

1. Review the resident's medical record to determine whether *any* pneumococcal vaccine*s* ha*ve* been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he *or* she received *any* pneumococcal vaccine*s outside of the facility*. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, ask the same question of *the* responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.

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O0300: Pneumococcal vaccine

4. If *pneumococcal* vaccination status cannot be determined, administer the *recommended* vaccine*(s)* to the resident, according to the standards of clinical practice.
   - *If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.*
   - *If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.*
   - *If the resident has a minor illness (e.g., a cold) check with the resident's physician before administering the vaccine.*

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Coding Tips

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf.
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at
  - https://www.cdc.gov/vaccines/schedules/hcp/index.html
  - http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
  - https://www.cdc.gov/pneumococcal/vaccination.html

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Coding Tips

- If a resident has received one *or more* pneumococcal vaccination*s and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed,* O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

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Pneumococcal Vaccine Timing for Adults

Make sure your patients are up to date with pneumococcal vaccination.

Two pneumococcal vaccines are recommended for adults:
- 13-valent pneumococcal conjugate vaccine (PCV13, Prevnar13®)
- 23-valent pneumococcal polysaccharide vaccine (PPSV23, Pneumovax®23)

PCV13 and PPSV23 should not be administered during the same office visit.

When both are indicated, PCV13 should be given before PPSV23 whenever possible.

If either vaccine is inadvertently given earlier than the recommended window, do not repeat the dose.

One dose of PCV13 is recommended for adults:
- 65 years or older who have not previously received PCV13.
- 19 years or older with certain medical conditions and who have not previously received PCV13. *See Table 1 for specific guidance.*

One dose of PPSV23 is recommended for adults:
- 65 years or older, regardless of previous history of vaccination with pneumococcal vaccines.
  - Once a dose of PPSV23 is given at age 65 years or older, no additional doses of PPSV23 should be administered.
- 19 through 64 years with certain medical conditions.
  - A second dose may be indicated depending on the medical condition. *See Table 1 for specific guidance.*

Pneumococcal vaccine timing for adults 65 years or older

For those who have not received any pneumococcal vaccines, or those with unknown vaccination history

PCV13 (at ≥ 65 years) → At least 1 year apart for most immunocompetent adults → PPSV23 (at ≥ 65 years)

PCV13 (at ≥ 65 years) → At least 8 weeks apart for adults with certain medical conditions → PPSV23 (at ≥ 65 years)

- Administer 1 dose of PCV13.
- Administer 1 dose of PPSV23 **at least 1 year** later for most immuno*competent* adults or **at least 8 weeks** later for adults with immuno*compromising* conditions, cerebrospinal fluid leaks, or cochlear implants. *See Table 1 for specific guidance.*

For those who have previously received 1 dose of PPSV23 at ≥ 65 years and no doses of PCV13

PPSV23 (at ≥ 65 years) → At least 1 year apart for all adults → PCV13 (at ≥ 65 years)

- Administer 1 dose of PCV13 **at least 1 year** after the dose of PPSV23 for all adults, regardless of medical conditions.

NCIRDig410 | 11.30.2015

www.cdc.gov/pneumococcal/vaccination.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Pneumococcal vaccine timing for adults with certain medical conditions

Indicated to receive 1 dose of PPSV23 at 19 through 64 years

PPSV23 (at 19–64 years) → At least 1 year apart → PCV13 (at ≥ 65 years) → At least 1 year apart → PPSV23 (at ≥ 65 years)

At least 5 years apart

Includes adults with:

- chronic heart or lung disease
- diabetes mellitus
- alcoholism
- chronic liver disease

Also includes adults who smoke cigarettes

For those who have **not** received any pneumococcal vaccines, or those with unknown vaccination history:

- Administer 1 dose of PPSV23 at 19 through 64 years.
- Administer 1 dose of PCV13 at 65 years or older. This dose should be given **at least 1 year** after PPSV23.
- Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 1 year** after PCV13 and at least 5 years after the most recent dose of PPSV23.

Indicated to receive 1 dose of PCV13 at ≥ 19 years and 1 or 2 doses of PPSV23 at 19 through 64 years

PCV13 (at 19–64 years) → At least 8 weeks apart → PPSV23 (at 19–64 years) → At least 5 years apart → PPSV23 (at 19–64 years) → At least 5 years apart → PPSV23 (at ≥ 65 years)

Includes adults with:

- cerebrospinal fluid (CSF) leaks*
- cochlear implants*
- sickle cell disease or other hemoglobinopathies
- congenital or acquired asplenia
- congenital or acquired immunodeficiencies
- HIV infection
- chronic renal failure
- nephrotic syndrome
- leukemia
- lymphoma
- Hodgkin disease
- generalized malignancy
- iatrogenic immunosuppression
- solid organ transplant
- multiple myeloma

For those who have **not** received any pneumococcal vaccines, or those with unknown vaccination history:

- Administer 1 dose of PCV13.
- Administer 1 dose of PPSV23 **at least 8 weeks** later.
- Administer a second dose of PPSV23 **at least 5 years** after the previous dose (**note: a second dose is not indicated for those with CSF leaks or cochlear implants*).
- Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 5 years** after the most recent dose of PPSV23.

Table 1. Medical conditions or other indications for administration of PCV13 and PPSV23 for adults

Medical indication	Underlying medical condition	PCV13 for ≥ 19 years	PPSV23* for 19 through 64 years		PCV13 at ≥ 65 years	PPSV23 at ≥ 65 years
		Recommended	Recommended	Revaccination	Recommended	Recommended
None	None of the below				✓	✓ ≥ 1 year after PCV13
Immunocompetent persons	Alcoholism		✓		✓	✓ ≥ 1 year after PCV13 ≥ 5 years after any PPSV23 at < 65 years
	Chronic heart disease†					
	Chronic liver disease					
	Chronic lung disease§					
	Cigarette smoking					
	Diabetes mellitus					
	Cochlear implants	✓	✓ ≥ 8 weeks after PCV13		✓ If no previous PCV13 vaccination	✓ ≥ 8 weeks after PCV13 ≥ 5 years after any PPSV23 at < 65 years
	CSF leaks					
Persons with functional or anatomic asplenia	Congenital or acquired asplenia	✓	✓ ≥ 8 weeks after PCV13	✓ ≥ 5 years after first dose PPSV23	✓ If no previous PCV13 vaccination	✓ ≥ 8 weeks after PCV13 ≥ 5 years after any PPSV23 at < 65 years
	Sickle cell disease/other hemoglobinopathies					
Immunocompromised persons	Chronic renal failure	✓	✓ ≥ 8 weeks after PCV13	✓ ≥ 5 years after first dose PPSV23	✓ If no previous PCV13 vaccination	✓ ≥ 8 weeks after PCV13 ≥ 5 years after any PPSV23 at < 65 years
	Congenital or acquired immunodeficiencies¶					
	Generalized malignancy					
	HIV infection					
	Hodgkin disease					
	Iatrogenic immunosuppression#					
	Leukemia					
	Lymphoma					
	Multiple myeloma					
	Nephrotic syndrome					
	Solid organ transplant					

*This PPSV23 column only refers to adults 19 through 64 years of age. All adults 65 years of age or older should receive one dose of PPSV23 regardless of any prior dose of PPSV23, regardless of previous history of vaccination with pneumococcal vaccine. No additional doses of PPSV23 should be administered following the dose administered at 65 years of age or older.

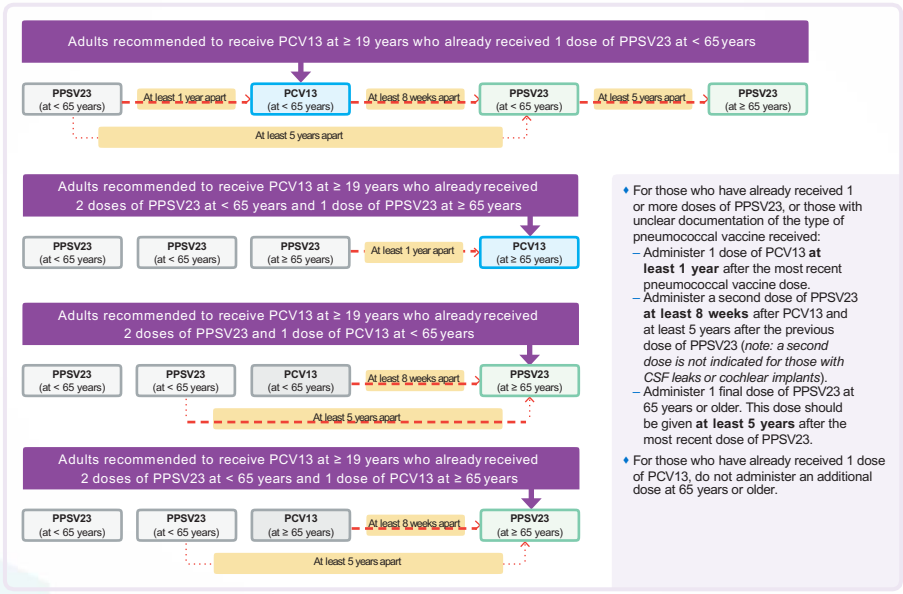
†Including congestive heart failure and cardiomyopathies.

§Including chronic obstructive pulmonary disease, emphysema, and asthma

¶Includes B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease)

#Diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and radiation therapy

Additional scenarios: completing the pneumococcal vaccination series for adults



- For those who have already received 1 or more doses of PPSV23, or those with unclear documentation of the type of pneumococcal vaccine received:
  - Administer 1 dose of PCV13 **at least 1 year** after the most recent pneumococcal vaccine dose.
  - Administer a second dose of PPSV23 **at least 8 weeks** after PCV13 and at least 5 years after the previous dose of PPSV23 (*note: a second dose is not indicated for those with CSF leaks or cochlear implants*).
  - Administer 1 final dose of PPSV23 at 65 years or older. This dose should be given **at least 5 years** after the most recent dose of PPSV23.
- For those who have already received 1 dose of PCV13, do not administer an additional dose at 65 years or older.

Examples

Mr. L., who is 72 years old, received the PCV13 pneumococcal vaccine at his physician's office last year. He had previously been vaccinated with PPSV23 at age 66.

Coding: O0300A would be **coded 1, yes;** skip to O0400, Therapies.

Rationale: Mr. L, who is over 65 years old has received the recommended PCV13 and PPSV23 vaccines.

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Example

Mrs. A, who has congestive heart failure, received PPSV23 vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 years old and was admitted to the nursing home one week ago for rehabilitation. She was offered and given PCV13 on admission.

Coding: O0300A would be **coded 1, yes;** skip to O0400, Therapies.

Rationale: Mrs. A received PPSV23 before age 65 years because she has a chronic heart disease and received PCV13 at the facility because she is age 65 years or older. She should receive another dose of PPSV23 at least 1 year after PCV13 **and** 5 years after the last PPSV23 dose (i.e., Mrs. A should receive 1 dose of PPSV23 at age 79 years, but is currently up to date because she must wait at least 1 year since she received PCV13).

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Example

Mr. T., who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 64 years old and is being admitted to the nursing home for chemotherapy and respite care. He has not been offered any additional pneumococcal vaccines.

Coding: O0300A would be **coded 0, no;** and O0300B would be **coded 3, Not offered**

Rationale: Mr. T received 1 dose of PPSV23 vaccine prior to 65 years of age because he is a smoker. Because Mr. T is now immunocompromised, he should receive PCV13 for this indication. He will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after his last dose of PPSV23 (i.e., Mr. T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).

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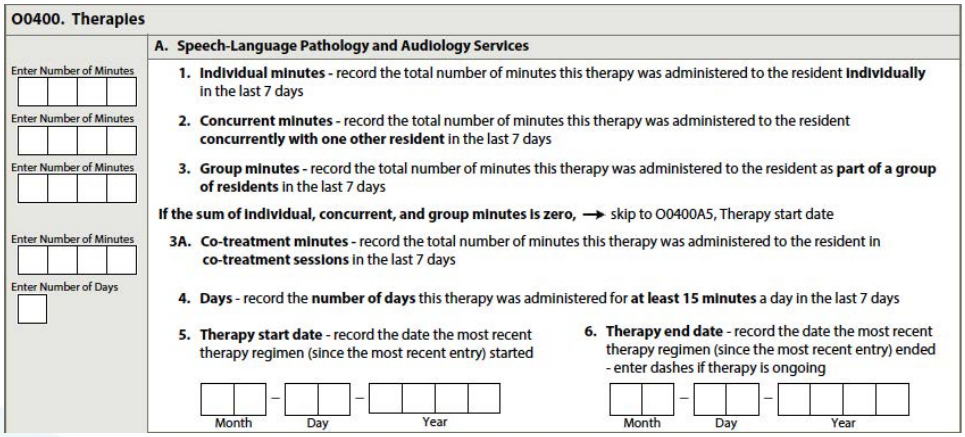
O0400. Therapies

A. Speech-Language Pathology and Audiology Services

B. Occupational Therapy

C. Physical Therapy



O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

Enter Number of Minutes

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month – Day – Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month – Day – Year

- Individual: One resident, one therapist, OR
  - Co-treatment: Two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
- Concurrent: Two residents, one therapist, not performing the same or similar activities
  - Not allowed under Part B
- Group: Exactly 4 residents, one therapist, performing the same or similar activities (or more than one at at time if Part B)

- Co-Treatment: Use should be limited and reason well documented
  - **For Part A:** When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full.
  - **For Part B:** Therapists, or therapy assistants, working together as a team to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

- Therapy Days: Count number of days in 7 day lookback or since most recent entry/reentry in which at least 15 minutes of specific therapy was delivered.
- Therapy Start Date: Date of ***initial evaluation*** of most recent regimen of therapy since the most recent entry for each discipline.
  - Eval only with no initiation of therapy treatment: Not a therapy start date, do not code on MDS
- Therapy End Date: Last date, since most recent entry, resident received treatment minutes for each discipline.
  - If discipline is on-going*, enter dashes

Therapy End Date O-26

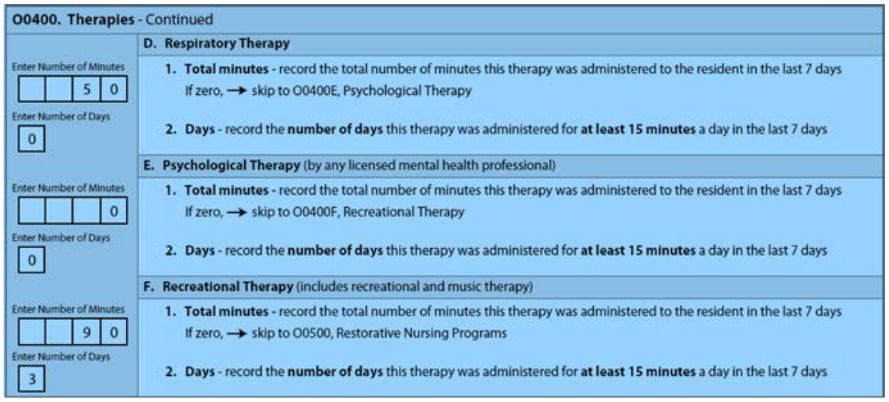
- Therapy is considered to be ongoing if:
  - The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
  - The resident's SNF benefit exhausted and therapy continued to be provided, or
  - The resident's payer source changed and therapy continued to be provided.

O0420. Distinct Calendar Days of Therapy

Enter Number of Days	Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.
☐	

Record the number of calendar days in the 7 day lookback, or since admit/reentry, in which the resident received at least 15 minutes of one discipline.

Respiratory, Psychological, Recreational Therapy



O0400. Therapies - Continued

D. Respiratory Therapy

Enter Number of Minutes: 5 0
Enter Number of Days: 0

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes: 0
Enter Number of Days: 0

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400F, Recreational Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes: 9 0
Enter Number of Days: 3

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0500, Restorative Nursing Programs
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

Total Minutes: Actual number of minutes therapy services were provided in the last 7 days.
Days: Number of days therapy was provided for at least 15 minutes.

Appendix A: Definitions

Respiratory therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

Appendix A: Glossary

Psychological Therapy: The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth. Psychological therapy may be provided by a psychiatrist, psychologist, clinical social worker, or clinical nurse specialist in mental health as allowable under applicable state laws.

Recreational Therapy: Services that are provided or directly supervised by a qualified recreational therapist who holds a national certification in recreational therapy, also referred to as a Certified Therapeutic Recreation Specialist. Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment

Respiratory, Psychological, Recreational Therapy Criteria for Coding on MDS:

- MD order must include frequency, duration, and scope of treatment.
- Must be directly and specifically related to an active written treatment plan based on an initial evaluation performed by qualified personnel.
- Required and provided by qualified personnel.
- Must be reasonable and necessary for treatment of the resident's condition.

Minutes of therapy: Respiratory Therapy: O-19

Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes. (O-19)

Minutes of Therapy: Psychological Therapy

- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

O-19

O0500: Restorative Nursing

O0500. Restorative Nursing Programs	
Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	J. Communication

O-36

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record.
2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative nursing programs must be met in order to code O0500:
   - Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.

O-37

Steps for Assessment continued

- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- This category does not include groups with more than four residents per supervising helper or caregiver.

O-37

Steps for Assessment continued

- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- Restorative nursing does not require a physician's order.
- Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, but must be coded as restorative therapy in O0500.
- Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

O-37

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of ST, OT or PT that quality as skilled therapy.
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more.
  - For example, to check **Technique—Range of Motion [Passive]** item O0500A, 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item O0500A, 5 minutes of **Technique—Range of Motion [Active]** item O0500B, and 5 minutes of **Splint or Brace Assistance** item O0500C, over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

Technique: All must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- O0500A, Range of Motion (Passive) - Provision of passive movements in order to maintain flexibility and useful motion in the joints of the body.
- O0500B, Range of Motion (Active) - Exercises performed by the resident, with cueing, supervision, or physical assist by staff. Include active ROM and active-assisted ROM.
- O0500C, Splint or Brace Assistance - Provision of
  - (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or
  - (2) a scheduled program of applying and removing a splint or brace.
- O0500D, Bed Mobility - Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.

Technique: All must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

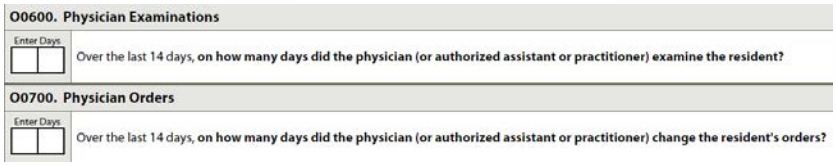
- O0500E, Transfer - Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.
- O0500F, Walking - Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
- O0500G, Dressing and/or Grooming - Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.
- O0500H, Eating and/or Swallowing - Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Technique: All must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- O0500I, Amputation/ Prosthesis Care - Activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.
- O0500J, Communication - Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

Coding Tips

- For PROM: caregiver moves the body part around a fixed point or joint through the resident's available range of motion. Resident provides no assistance.
- For AROM: any participation by the resident in the ROM activity should be coded here.
- For both AROM & PROM: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- Use of CPM devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by MD, (2) nursing staff have been trained in technique, and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff.



For Both:

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

Virginia Not required: Virginia may put dashes in both

O-43 & O-45

Virginia

http://www.dmas.virginia.gov/Content_atchs/pr/DMAS%20MDS%203.0%20Guidance%20October%2002_2017.pdf

MDS 3.0 Guidance Document
Department of Medical Assistance Services
Provider Reimbursement Division
Revised October 2017

Data Items O0600: Physician Examinations and O0700: Physician Orders Update

Effective October 1, 2017 data items O0600 and O0700 in the MDS are optional per CMS determination. DMAS will not require providers to enter data items O0600 or O0700 of the MDS. Providers shall use the standard "no information code" as directed by the RAI manual.

Data Items O0600: Physician Examinations and O0700: Physician Orders will not affect the RUG code or CMI sore calculated for RUG-IV Grouper 48 and will not impact reimbursement. However, RUG codes and CMI scores generated using RUG-III Grouper 34 on or after October 1, 2017 will be invalid if either data item O0600 or O0700 are not completed.

Section P: Restraints and Alarms

Section P	Restraints and Alarms
P0100. Physical Restraints	
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	Used in Bed
	☐ A. Bed rail
	☐ B. Trunk restraint
	☐ C. Limb restraint
	☐ D. Other
	Used in Chair or Out of Bed
	☐ E. Trunk restraint
	☐ F. Limb restraint
	☐ G. Chair prevents rising
	☐ H. Other
P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	☐ A. Bed alarm
	☐ B. Chair alarm
	☐ C. Floor mat alarm
	☐ D. Motion sensor alarm
	☐ E. Wander/elopement alarm
	☐ F. Other alarm

Intent: The intent of this section is 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.

Steps for Assessment

1. Review medical record to determine if physical restraints were used during the 7-day look-back period.
2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
3. Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use.
4. Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or equipment attached or adjacent to his or her body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether or not the manual method or physical or mechanical device, material or equipment restrict freedom of movement or restrict the resident's access to his or her own body.

P-3

Steps for Assessment

5. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident.
6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any manual method or physical or mechanical device, material, equipment as a restraint depends on the effect it has on the resident.

P-3

Steps for Assessment

7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have:
   - physician documentation of a medical symptom that supports the use of the restraint,
   - physician's order for the type of restraint and parameters of use, and
   - care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

P-3

PHYSICAL RESTRAINTS

Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP).

P-1

Clarifications

- **"Remove easily"** means that the manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).
- **"Freedom of movement"** means any change in place or position for the body or any part of the body that the person is physically able to control or access.

P-3

- **"Medical symptoms/diagnoses"** are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the resident's subjective symptoms and medical diagnoses should be considered when determining the presence of medical symptom(s) that might support restraint use. **The resident's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the resident's condition, circumstances, and environment, and not a way to justify restraint use.**

P-4

Selected Coding Tips

- In classifying a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use. It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining him or her.
- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section "Considerations Involving Secured/Locked Areas" of F603 in Appendix PP of the State Operations Manual.

- **Bed rails** any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
  - *Bed rails used as positioning devices.* If the use of bed rails meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A.
  - *Bed rails used with residents who are immobile.* If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.

Bed Rails Continued

- For residents who have no voluntary movement, the staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others.
- Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment.
- For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered.
- While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.

- **Trunk restraints** include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body.
- **Limb restraints** include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category.
  - **Trunk or limb restraints**, if used in both bed and chair, should be marked in both sections.

- **Chairs that prevent rising** include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers. For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.
  - For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising.

- Geriatric chairs used for residents who are immobile: For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
- Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising.

An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.

Code any type of alarm, ***audible or inaudible***, used during the look-back period in this section.

- ☐ **A. Bed alarm**
- ☐ **B. Chair alarm**
- ☐ **C. Floor mat alarm**
- ☐ **D. Motion sensor alarm**
- ☐ **E. Wander/elopement alarm**
- ☐ **F. Other alarm**

Coding:

0. **Not used**
1. **Used less than daily**
2. **Used daily**

P-8

Health-related Quality of Life

- An alarm is <u>any</u> physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

P-8

Planning for care

- Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being.
- When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident.
- When an alarm is used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident.

P-9

Steps for Assessment

1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
3. Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

Coding Tips

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.
- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
- **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.

Coding Tips

- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in this section. .

Coding Tips

- While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.
- Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.
- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section "Determination of the Use of Position Change Alarms as Restraints" of F604 in Appendix PP of the State Operations Manual.

F604: Restraints

- *Examples of* facility practices that meet the definition of a *physical* restraint include, but are not limited to:
- *Using a position change alarm to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm.*
- ***"Position change alarms"** are alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in a certain way.*
  - *Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors.*
  - *Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.*

Determination of the Use of Position Change Alarms as Restraints

- While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement.
- For example, a resident may be afraid to move to avoid setting off the alarm and creating noise that is a nuisance to the resident(s) and staff, or is embarrassing to the resident. For this resident, a position change alarm may have the potential effect of a physical restraint.

F603

- *Use the Physical Restraints Critical Element (CE) Pathway, along with the above Guidance: • When a resident's clinical record reflects the use of a physical restraint;*
  • If the survey team observes a position change alarm, or other device or practice that restricts or potentially restricts a resident's freedom of movement (physically or psychologically);
- *If the resident or other individuals report that a restraint is being used on the resident; or • If an allegation of inappropriate use of a physical restraint is received.*

Examples of negative potential or actual outcomes which may result from the use of position change alarms as a physical restraint, include:

- *Loss of dignity;*
- *Decreased mobility;*
- *Bowel and bladder incontinence;*
- *Sleep disturbances due to the sound of the alarm or because the resident is afraid to move in bed thereby setting off the alarm; and*
- *Confusion, fear, agitation, anxiety, or irritation in response to the sound of the alarm as residents may mistake the alarm as a warning or as something they need to get away from.*

Questions/Discussion

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