Centers for Medicare & Medicaid Services

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

Version 1.1*9*.1

October 202*4*

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Centers for Medicare & Medicaid Services'
Long-Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual
October 2024
For Use Effective October 1, 2024

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The *Long-Term Care Facility Resident Assessment Instrument User's Manual* for Version 3.0 is published by the Centers for Medicare & Medicaid Services (CMS) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities.

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CMS ACKNOWLEDGEMENTS

The collective hard work and dedication of so many people, over the years in the development, testing, writing, formatting, and ongoing review and maintenance of the MDS 3.0 RAI Manual, MDS 3.0 Data Item Set, and MDS 3.0 Data Specifications are too numerous to list, but their dedication has resulted in an RAI process that increases clinical relevancy, data accuracy, clarity, and notably adds more of the resident voice to the assessment process. CMS acknowledges and thanks the many people, organizations, and stakeholders that have contributed to making these updates and enhancements possible. Thank you for the work you do to promote the care and services to individuals in nursing homes.

Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

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CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT (RAI)

1.1 Overview

The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care. Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans. The RAI helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff with evaluating goal achievement and revising care plans accordingly by enabling the nursing home to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining their highest practical level of well-being.

The RAI helps nursing home staff look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. Nursing homes have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and activities/recreational therapy in the RAI process has fostered a more holistic approach to resident care and strengthened team communication. This interdisciplinary process also helps to support the spheres of influence on the resident's experience of care, including: workplace practices, the nursing home's cultural and physical environment, staff satisfaction, clinical and care practice delivery, shared leadership, family and community relationships, and Federal/State/local government regulations.[1]

Persons generally enter a nursing home because of problems with functional status caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. Sometimes, the individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment, and/or rehabilitation is needed for the resident to maintain and/or restore function or to live safely from day to day. While there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). This is true for both long-term residents and residents in a rehabilitative program anticipating return to their previous environment or another environment of their choice.

[1] Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf.

1.2 Content of the RAI for Nursing Homes

The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as "items") in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data elements for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, OBRA Discharge, Entry Tracking, PPS item sets) can be found *on CMS's website at https://www.cms.gov/Medicare/Quality/Nursing-Home-Improvement/Resident-Assessment-Instrument-Manual*.
- **Care Area Assessment (CAA) Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been identified or "triggered," nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include:
  - **Care Area Triggers (CATs)** are specific coding responses for one or a combination of MDS data elements. The triggers identify residents who have or are at risk for developing specific problems and require further assessment.
  - **Care Area Assessment** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The **CAA** resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources is not mandatory and the list of Web links is neither all-inclusive nor government endorsed.
  - **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning.
- **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. The Utilization Guidelines, also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, includes instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual).

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1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments are also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS has also been adapted for use by non-critical access hospitals (non-CAHs) with a swing bed (SB) agreement. Non-CAH SBs are required to complete the MDS for reimbursement under the SNF PPS.

- **Medicare and Medicaid Payment Systems.** The MDS contains data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection instrument to classify Medicare residents into PDPM components. The PDPM classification system is used in the SNF PPS for skilled nursing facilities and non-CAH SB programs. States may use PDPM, a Resource Utilization Group (RUG)-based system, or an alternate system to group residents into similar resource use categories for the purposes of Medicaid reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html for comprehensive information on SNF PPS, including, but not limited to, SNF coverage, SNF policies, and claims processing.
- **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs), which are derived from data collected on the MDS, were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the QMs for opportunities to improve their effectiveness, reliability, and validity.
- **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Medicare Care Compare tool (https://www.medicare.gov/care-compare/) provides public access to information about a variety of health care providers, including nursing homes. Information available regarding nursing homes includes their characteristics, staffing data, and quality of care measures for certified nursing homes.

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

(1) who should participate in the assessment process,

(2) how the assessment process is completed, and

(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483.35(e) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative).

b. **Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating their needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process.

c. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident's active participation in the process.

d. **Care Planning**—Establishing a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

e. **Implementation**—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident's care goals and approaches; carrying out the "how" and "when" of resident care.

f. **Evaluation**—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, goals, or improvement or decline.

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The following pathway illustrates a problem identification process flowing from MDS (and other assessments), to the CAA decision-making process, care plan development, care plan implementation, and finally to evaluation. This manual will refer to this process throughout several chapter discussions.



If you look at the RAI process as a solution oriented and dynamic process, it becomes a richly practical means of helping nursing home staff gather and analyze information in order to improve a resident's quality of care and quality of life. The RAI offers a clear path toward using all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to successfully using the RAI process is to understand that its structure is designed to enhance resident care, increase a resident's active participation in care, and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff (across all shifts), residents and families (and/or guardian or other legally authorized representative) and physicians (or other authorized healthcare professionals as allowable under state law) are all involved in its "hands on" approach. The result is a process that flows smoothly and allows for good communication and tracking of resident care. In short, it works.

Since the RAI has been implemented, nursing home staff who have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

- **Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and enhanced quality of life. Nursing home providers have found that when residents actively participate in their care, and care plans reflect appropriate resident-specific approaches to care based on careful consideration of individual problems and causes, linked with input from residents, residents' families (and/or guardian or other legally authorized representative), and the interdisciplinary team, residents have experienced goal achievement and either their level of functioning has improved or has deteriorated at a slower rate. Nursing home staff report that, as individualized attention increases, resident satisfaction with quality of life also increases.
- **Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from performing the CAAs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality is accommodated in the care plan.

- **Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident goals, needs, interests, strengths, problems, preferences, and lifestyle choices. When considering all of this information, staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.
- **Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

The purpose of this manual is to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help nursing home staff achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. This tool assesses a resident's ability to perform daily life functions, identifies significant impairments in a resident's functional capacity, and provides opportunities for direct resident interview. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

Furthermore, with the consistent application of item definitions, the RAI ensures standardized communication both within the nursing home and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.5 MDS 3.0

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008; available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/MDS30FinalReport.pdf).

Goals

The goals of the MDS 3.0 revision were to introduce advances in assessment measures, increase the clinical relevance of data elements, improve the accuracy and validity of the assessment instrument, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the instrument's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement (via Patient Driven Payment Model [PDPM] classification).

In addition to improving the content and structure of the MDS, the RAND/Harvard team also aimed to improve user satisfaction. User attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the MDS are often cited as a reason that nursing homes have not fully implemented the information from the MDS into targeted care planning.

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

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- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and residents in a Medicare Part A SNF PPS stay in non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

1.7 Layout of the RAI Manual

The layout of the RAI manual is as follows:

- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

Appendices

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Locations RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: Patient Health Questionnaire (PHQ)-Scoring Rules and Instruction for BIMS (When Administered in Writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Forms

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Section	Title	Intent
A	Identification Information	Obtain key demographic information to uniquely identify each resident, administrative information, nursing home in which they reside, reason for assessment, and potential care needs, including access to transportation.
B	Hearing, Speech, and Vision	Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and the resident's ability to see objects nearby in their environment.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information, and whether the resident has signs and symptoms of delirium.
D	Mood	Identify signs and symptoms of mood distress and social isolation.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for their daily routine and activities.
GG	Functional Abilities	Assess the need for assistance with self-care and mobility activities, prior function, admission performance, discharge performance, functional limitations in range of motion, and current and prior device use.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident. Also includes use and indication of high-risk drug classes, antipsychotic use and drug regimen review to identify potentially significant medication issues.
O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.
P	Restraints and Alarms	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.
Q	Participation in Assessment and Goal Setting	Record the participation and expectations of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	To identify an MDS record already present in iQIES system for modification or inactivation.

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Section	Title	Intent
Z	Assessment Administration	Provide billing information and signatures of persons completing and attesting to the accuracy of the assessment, as well as the signature and date by the RN Assessment Coordinator verifying the assessment is complete.

1.8 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.70(i) and 483.75(i)(4), release of information from the resident's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Internet Quality Improvement Evaluation System (iQIES). The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

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Contractual Agreements

Providers who are part of a multi-facility corporation may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in 42 CFR at 483.10(h)(3)(i)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

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PRIVACY ACT STATEMENT – HEALTH CARE RECORDS
Long Term Care-Minimum Data Set (MDS) System of Records revised 04/28/2007

(Issued: 9-6-12, Implementation/Effective Date: 6-17-13)

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

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3. **ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

   (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

   (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

   (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

   (4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;

   (5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

   (6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

   (7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

   (8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION.** The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of Resident or Sponsor Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

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CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Prospective Payment System (PPS) assessments in nursing homes and the mandated PPS assessments in non-critical access hospitals with a swing bed agreement.

2.1 Introduction to the Requirements for the RAI

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.

The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.

MDS assessments are also required to be completed and submitted to the iQIES system for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Other payors (e.g., Medicare Advantage Plans) may require Health Insurance Prospective Payment System (HIPPS) codes or other MDS data for billing purposes. However, facilities must not code assessments done for these purposes as PPS assessments in A0310B and A0310H or submit these assessments to iQIES.

It is important to note that, in most cases, when the OBRA and PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. (Refer to Sections 2.10 and 2.11 for combining OBRA and PPS assessments).

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2.2 CMS Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by CMS. The Federal requirement also mandates facilities to encode and electronically transmit MDS 3.0 data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items.

- CMS' specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.
- CMS' specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
- All comprehensive RAIs specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including Care Area Triggers (CATs) and the CAA Summary (Section V).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer-generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer-generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the RAI specified by CMS).

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c04.pdf. For more information about your State's assessment requirements, contact your State RAI Coordinator (see Appendix B).

2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice residents:** When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.
- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, an OBRA Discharge assessment is required:
  - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("**-**") (See Chapter 3 for more information).
  - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs and must initiate a plan of care to meet those needs upon admission.
  - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g., pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed facilities:** SNF-level services of non-critical access hospital (non-CAH) swing bed (SB) facilities were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed facilities must assess the clinical condition of Medicare beneficiaries by completing certain MDS assessments for each Medicare resident receiving Medicare Part A SNF level of care in order to be reimbursed under the SNF PPS Patient Driven Payment Model. CMS began collecting MDS data for quality monitoring purposes of non-CAH SB facilities effective October 1, 2010. Therefore, SB providers must complete these assessments: Swing Bed PPS (SP) and Swing Bed Discharge (SD) assessments, and Entry Tracking and Death in Facility records. Swing bed facilities may also choose to complete an Interim Payment Assessment (IPA) at any time during the resident's stay in the facility. Swing bed providers must adhere to the same assessment requirements including, but not limited to, completion date, encoding

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requirements, submission time frame, and RN signature. Swing bed facilities must use the instructions in this manual when completing MDS assessments.

Skilled Nursing Facility Quality Reporting Program: The IMPACT Act of 2014 established the SNF QRP. Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that SNFs are to collect and report on standardized resident assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year. Data collected for the SNF QRP is submitted through the Internet Quality Improvement Evaluation System (iQIES) as it currently is for other MDS assessments.

- Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.

The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.*
  - Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into iQIES. Therefore, these assessments cannot be submitted to iQIES.
  - Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to iQIES.
    - For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, OBRA Discharge, etc., the facility may

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receive a sequencing warning message, but should still submit the required assessment.

- **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments.

— *NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.

- **Adding Certified Beds:**
  - — If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - — Medicare and Medicaid residents should not be placed in one of these additional beds until the facility has been notified that the beds have been certified.
- **Change in Ownership:** There are two types of change in ownership transactions:
  - — 1) Assumption of Assets and Liabilities: This is the most common situation and requires the new owner to assume the assets and liabilities of the prior owner and retain the current CMS Certification Number (CCN). In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - Staff with iQIES user IDs continue to use the same iQIES user IDs.
    - **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 5-Day PPS assessment was combined with the OBRA Admission assessment, the next PPS assessment could be an Interim Payment Assessment (IPA), if the provider chooses to complete one, and would also be submitted under the existing provider number.
  - — 2) No Assumption of Assets or Liabilities: There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - The beds are no longer certified.
    - There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, CMS Certification Number (CCN), etc.
    - The previous owner would complete an OBRA Discharge assessment - return not anticipated, thus code A0310F = 10, A2000 = date of ownership change, and A2105 = 02 or 03 for those residents who will remain in the facility. Refer to Chapter 3, Section A for additional guidance regarding A1805.

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- The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F = 01, A1600 = date of ownership change, A1700 = 1 (admission), and A1805 = 02 or 03. Refer to Chapter 3, Section A for additional guidance regarding A1805.
- Staff who worked for the previous owner **must** update their iQIES role to submit data for the CCN associated with the new owner.
- Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.

- **Resident Transfers:**

— When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.

— When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within 14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-Day assessment.

— The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.

— When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their CMS Location (formerly known as Regional Office), State Agency, and Medicare Administrative Contractor (MAC) for guidance.

— When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their CMS Location, State Agency, and MAC for guidance.

— More information on emergency preparedness can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.

2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
  - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The15-month requirement for maintenance of the RAI data must be adhered to.
  - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
  - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the active clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State Agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated

CAA(s) completion (items V0200B-C), correction completion (items X1100A-E), and assessment completion (items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.

- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident.
- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a handwritten **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion date for all assessments and correction requests. This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility tracking records and MDS Correction Requests (including signed attestation).
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR
- when the resident has been in this facility previously and was discharged return not anticipated; OR

- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

Assessment Combination refers to the use of one assessment to satisfy both OBRA and PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. Sections 2.10 and 2.11 provide more detailed information on combining PPS and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and OBRA Discharge assessment.

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 PPS assessments.

Assessment Reference Date (ARD) refers to the specific endpoint for the observation (or "look-back") periods in the MDS assessment process. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7-day look-back period. If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding.

Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

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Assessment Submission refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

Assessment Timing refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the PPS assessment timing schedule is provided in Section 2.8.

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary Team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.
- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have an SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.

Assessment Transmission refers to the electronic transmission of submission files to iQIES. Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

Comprehensive MDS assessments include both the completion of the MDS as well as completion of the CAA process and care planning. Comprehensive MDSs include Admission, Annual, SCSA, and SCPA.

Death in Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required.

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Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Section 2.6 provides detailed instructions regarding return anticipated and return not anticipated types, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.
- Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed.
- Resident's Medicare Part A stay ends, but the resident remains in the facility.

Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information.

Entry is a term used for both an admission and a reentry and requires completion of an Entry tracking record.

Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.

Interdisciplinary Team (IDT[1]) is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident.

[1] 42 CFR 483.21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).

Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

Interruption Window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Examples of when there **is** an Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and no Part A PPS Discharge or OBRA Discharge is completed, nor is a 5-Day or Entry Tracking record required when Part A resumes.
- If a resident is discharged from Part A, **leaves the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required.

Examples of when there is **no** Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and does not resume Part A within the 3-day interruption window**, it is **not** an interrupted stay. Therefore, a Part A PPS Discharge and a 5-Day assessment are both required (as long as resumption of Part A occurs within the 30-day window allowed by Medicare).
- If a resident is discharged from Part A, **leaves the facility, and does not resume Part A within the 3-day interruption window**, it is not an interrupted stay and the Part A PPS Discharge and OBRA Discharge are both required and must be combined if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000) (see Part A PPS Discharge assessment in Section 2.5). Any return to the facility in this instance would be considered a new entry—that means that an Entry Tracking record, OBRA admission and/or 5-Day assessment would be required.

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Item Set refers to the MDS items that are active on a particular assessment type or tracking form. There are 9 different item subsets for nursing homes and 5 for swing bed providers as follows:

- Nursing Home
  - **Comprehensive (NC)[2] Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, SCSA, and SCPA). This item set is used whether the OBRA Comprehensive assessment is standalone or combined with any other assessment (PPS assessment and/or Discharge assessment).
  - **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly assessment [SCQA]). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.
  - **PPS (NP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
  - **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
  - **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in iQIES.
- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Discharge (SD) Item Set.** This is the set of items active on a standalone Swing Bed Discharge assessment (either return anticipated or not anticipated).
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

[2] The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

— **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in iQIES.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the Type of Provider, item A0200 (indicating nursing home or swing bed), and the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2.14 of this chapter provides manual lookup tables for determining the item set when automated software is unavailable.

Item Set Codes are those values that correspond to the OBRA-required and PPS assessments represented in items A0310A, A0310B, A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the resident.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return of the resident to the facility, providers should make appropriate documentation in the medical record regarding any changes in the resident's status. If significant changes in status are noted after an LOA, a Significant Change in Status Assessment (SCSA) may be necessary (see Section 2.6).

Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly assessments and SCQAs.

Observation (Look-Back, Assessment) Period is the time period over which the 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.

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OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

Tracking records

- Entry
- Death in facility

Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

PPS Assessments provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. These assessments are coded on the MDS 3.0 in items A0310B (PPS Assessment) and A0310H (Is this a Part A PPS Discharge Assessment?). They include:

- 5-Day assessment
- Interim Payment Assessment (IPA)
- Part A PPS Discharge Assessment

Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and an OBRA Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

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2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in items A0310A and A0310F (Entry/discharge reporting). PPS reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

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RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)

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RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

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Comprehensive Assessments

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:

- Admission Assessment
- Annual Assessment
- Significant Change in Status Assessment
- Significant Correction to Prior Comprehensive Assessment

Each of these assessment types will be discussed in detail in this section. They are **not** required for residents in swing bed facilities.

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD (item A2300) is the last day of the observation/look-back period, and day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[3] In closing the record, the nursing home should note why the RAI was not completed.

[3] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[4] In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- The nursing home may combine a comprehensive assessment with a Discharge assessment.
- In the process of completing any OBRA comprehensive assessment except an Admission and an SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into iQIES, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a 5-Day assessment or SNF Part A PPS Discharge assessment (see Sections 2.10 and 2.11 for details) or any Discharge assessment type.

OBRA-required comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (item A0310A).

01. Admission Assessment (A0310A = 01)

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:

[4] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day "1" of admission.
- The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than day 14.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry tracking record **each time** the resident returns to the facility and an OBRA Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

02. Annual Assessment (A0310A = 03)

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

Assessment Management Requirements and Tips for Annual Assessments:

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

03. Significant Change in Status Assessment (SCSA) (A0310A = 04)

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

A **"significant change"** is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.

A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

Assessment Management Requirements and Tips for Significant Change in Status Assessments:

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.
- An SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
  - The resident's condition is not expected to return to baseline within two weeks.
  - For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from an SCSA during the intervening period, the staff must complete an SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- An SCSA may **not** be completed prior to an OBRA Admission assessment.
- An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0110K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
- An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice

election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0110K1. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.
- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

Guidelines for Determining a Significant Change in a Resident's Status: Note: this is not an exhaustive list

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.

Some Guidelines to Assist in Deciding If a Change Is Significant or Not:

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA. This time frame may vary depending on clinical judgment and resident needs. For

example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.
- **If there is only one change**, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT must make the decision as to whether or not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion.
- An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- An SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.
- **Decline in two or more of the following:**
  - Resident's decision-making ability has changed;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
  - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;
  - Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
  - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- — Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- — Resident begins to use a restraint of any type when it was not used before; and/or
- — Emergence of a condition/disease in which a resident is judged to be unstable.

- **Improvement in two or more of the following:**
  - — Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, setup or clean-up assistance, or supervision or touching assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - — Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - — Resident's decision making improves;
  - — Resident's incontinence pattern improves.

Examples (SCSA):

1. Resident T no longer responds to verbal requests to alter their screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. They are also starting to resist their daily care, pushing staff away from themself as the staff members attempt to assist with their ADLs. This is a significant change, and an SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Resident T's behavioral symptoms could have many causes, and an SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Resident T's disruptive behavior.

2. Resident T required supervision with ADLs. They fractured their hip and upon return to the facility require maximal assistance with all ADLs. Rehab has started and staff is hopeful they will return to their prior level of function in 4–6 weeks.

3. Resident G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission they were very frail, had trouble thinking, were confused, and had many behavioral complications. The course of treatment led to steady improvement and they are now stable. They are no longer confused or exhibiting inappropriate behaviors. The resident, their family, and staff agree that they have made remarkable progress. An SCSA is required at this time. The resident is not the person they were at admission - their initial problems have resolved and they will be remaining in the facility. An SCSA will permit the interdisciplinary team to review their needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status Is Not Significant:
Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a

psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require an SCSA).

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate an SCSA).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

Guidelines for Determining the Need for an SCSA for Residents with Terminal Conditions:
Note: this is not an exhaustive list

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

Examples (SCSA):

1. Resident M has been in this nursing home for two and one-half years. They have been a favorite of staff and other residents, and their child has been an active volunteer on the unit. Resident M is now in the end stage of their course of chronic dementia, diagnosed as probable Alzheimer's. They experience recurrent pneumonias and swallowing difficulties, their prognosis is guarded, and family members are fully aware of their status. They are on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of their child in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Resident M's care is of a high quality, and as their physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.

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2. Resident K came into the nursing home with identifiable problems and has steadily responded to treatment. Their condition has improved over time and has recently hit a plateau. They will be discharged within 5 days. The initial RAI helped to set goals and start their care. The course of care provided to Resident K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if Resident K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if they are not discharged, an SCSA is required by the end of the allotted 14-day period.

3. Resident P, too, has responded to care. Unlike Resident K, however, they continue to improve. Their discharge date has not been specified. They are benefiting from their care and full restoration of their functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an SCSA at this time. However, if their condition were to stabilize and their discharge was not imminent, an SCSA would be in order.

Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:

- If an SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.[5]
- PASRR is not a requirement of the resident assessment process but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at http://www.cms.gov/.
- The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

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5 The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident's plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with an SCSA.)

Example (PASRR & SCSA):

1. Resident L has a diagnosis of serious mental illness, but their primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and they become ambulatory, even if other conditions exist for which Resident L receives medical care, they should be referred for a PASRR evaluation to determine whether a change in their placement or services is needed.

Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

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04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A = 05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCPA is appropriate when:
  - the erroneous comprehensive assessment has been completed and transmitted/submitted into iQIES; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

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Non-Comprehensive Assessments and Entry and Discharge Reporting

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:

- Quarterly Assessment
- Significant Correction to Prior Quarterly Assessment
- Discharge Assessment – Return not Anticipated
- Discharge Assessment – Return Anticipated

The Quarterly assessments, OBRA Discharge assessments and SCQAs are not required for Swing Bed residents. However, Swing Bed providers are required to complete the Swing Bed Discharge item set (SD).

Tracking records include a select number of MDS items and are required for **all** residents in the nursing home and swing bed facility. They include:

- Entry Tracking Record
- Death in Facility Tracking Record

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

- The ARD is considered the last day of the observation/look-back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look-back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA.

  For example:

  — Resident A has a Quarterly assessment with an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3rd (which is day 14 after the ARD).

  — Resident B also has a Quarterly assessment with an ARD of March 20th. They go to the hospital on March 20th and returns March 30th. While there is no significant

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change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[6] In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[6] When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and an SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into iQIES and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan.
- The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a 5-Day assessment or SNF Part A PPS Discharge Assessment (see Sections 2.10 and 2.11 for details).

[6] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

05. Quarterly Assessment (A0310A = 02)

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

Assessment Management Requirements and Tips:

- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period. Assuming the resident does not have an SCSA or SCPA completed and was not discharged from the nursing home, a typical 12-month OBRA schedule would look like this:



- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions.
- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, SCQA, or Annual assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).

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06. Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A = 06)

The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (item A2300) and completion dates (item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment.

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCQA is appropriate when:
  - the erroneous Quarterly assessment has been completed (MDS completion date, item Z0500B) and transmitted/submitted into iQIES; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be less than or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

Tracking Records and Discharge Assessments (A0310F)

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry and discharge reporting is required for residents in Swing Beds or those in respite care.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit OBRA Discharge assessments and Entry tracking records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

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OBRA-required Tracking Records and Discharge Assessments include the following types (item A0310F):

07. Entry Tracking Record (Item A0310F = 01)

There are two types of entries – admission and reentry.

Admission (Item A1700 = 1)

- Entry tracking record is coded an Admission every time a resident:
  - is admitted for the first time to this facility; or
  - is readmitted after a discharge return not anticipated; or
  - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

Example (Admission):

1. Resident S. was admitted to the nursing home on February 5, 2011 following a stroke. They regained most of their function and returned to their home on March 29, 2011. They were discharged return not anticipated. Five months later, Resident S. underwent surgery for a total knee replacement. They returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

   A0310F = 01
   A1600 = 08-27-2011
   A1700 = 1

Reentry (Item A1700 = 2)

- Entry tracking record is coded Reentry every time a person:
  - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

Example (Reentry):

1. Resident W. was admitted to the nursing home on April 11, 2011. Four weeks later they became very short of breath during lunch. The nurse assessed them and noted their lung sounds were not clear. Their breathing became very labored. They were discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, Resident W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

   A0310F = 01
   A1600 = 05-18-2011
   A1700 = 2

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Assessment Management Requirements and Tips for Entry Tracking Records:

- The Entry tracking record is the first item set completed for all residents.
- Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility), including upon return if a resident in a Medicare Part A stay is discharged from the facility and does not resume Part A within the same facility within the 3-day interruption window (see Interrupted Stay in Section 2.5, Assessment Types and Definitions above).
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a standalone tracking record.
- May **not** be combined with an assessment.

08. Death in Facility Tracking Record (A0310F = 12)

- Must be completed when the resident dies in the facility or when on LOA.
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any type of assessment.

Example (Death in Facility):

1. Resident W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. They passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

   A0310F = 12
   A2000 = 11-13-2011
   A2105 = 13

OBRA Discharge Assessments (A0310F)

OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.

09. Discharge Assessment–Return Not Anticipated (A0310F = 10)

- Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
- Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident returns, the Entry tracking record will be coded A1700 = 1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the provider must determine whether the interrupted stay policy applies. Refer to Section 2.9 for instructions on the PPS assessments.

Examples (Discharge-return not anticipated):

1. Resident S. was admitted to the nursing home on February 5, 2011 following a stroke. They regained most of their function and were discharged return not anticipated to their home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:

   A0310F = 10
   A2000 = 03-29-2011
   A2105 = 01

2. Resident K. was transferred from a Medicare-certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

   A0310F = 10
   A2000 = 12-12-2013
   A2105 = 02

10. OBRA Discharge Assessment–Return Anticipated (A0310F = 11)

- Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
- For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that they will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
- Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days).

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- Must be submitted within 14 days after the MDS completion date (item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns to the nursing home, the IDT must determine if criteria are met for an SCSA (only when the OBRA Admission assessment was completed prior to discharge).
  - If criteria are met, complete an SCSA.
  - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If an interrupted stay occurs, an SCSA should be completed if clinically indicated.
- If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

Example (Discharge-return anticipated):

1. Resident C. was admitted to the nursing home on May 22, 2011. They tripped while at a restaurant with their child. They were discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows:

   A0310F = 11
   A2000 = 05-31-2011
   A2105 = 04

Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge in Section 2.5, Assessment Types and Definitions).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed if a resident in a Medicare Part A stay is discharged from the facility regardless of whether the resident resumes Part A within the 3-day interruption window (see Interrupted Stay, Section 2.5, Assessment Types and Definitions above).
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.

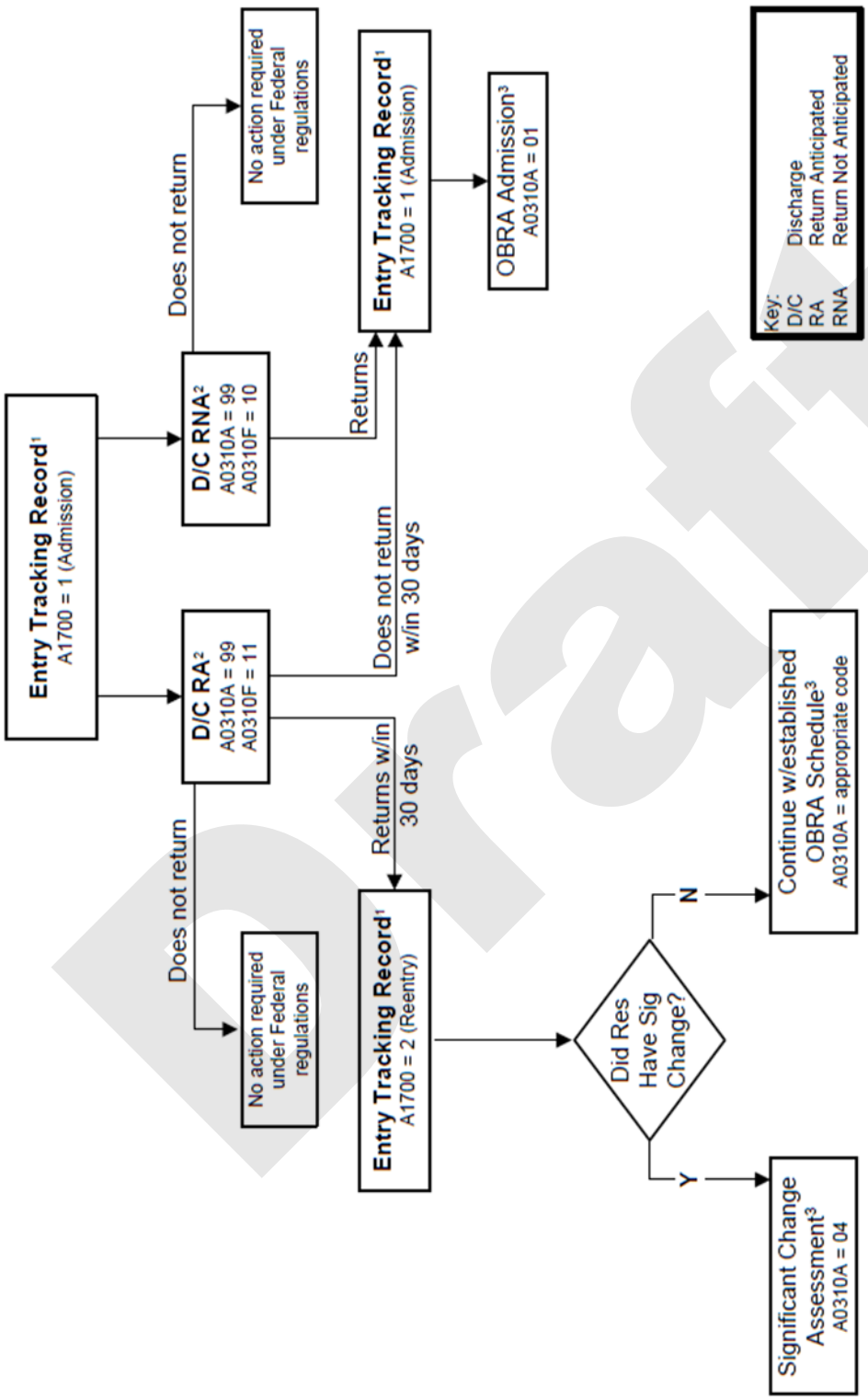
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- May be combined with any OBRA or 5-Day and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000).
- For an OBRA Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met.
- For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
  - An unplanned discharge includes, for example:
    - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
    - Resident unexpectedly leaving the facility against medical advice; or
    - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

The following chart details the sequencing and coding of Tracking records and OBRA Discharge assessments.

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Entry, OBRA Discharge, and Reentry Algorithms



[1]A0310A = 99 A0310B = 99 A0310E = 0 A0310F = 01

[2]A0310B – E = appropriate code [3]A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

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2.7 The Care Area Assessment (CAA) Process and Care Plan Completion

Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.

CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (item V0200B2) must be either later than or the same date as the MDS completion date (item Z0500B). In no event should either date be later than the established time frames as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

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Care Plan Completion

- Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (item V0200C2) must be either later than or the same date as the CAA completion date (item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (item Z0500B) must be earlier than or the same date as the care plan completion date. In no event should either date be later than the established time frames as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 Skilled Nursing Facility Prospective Payment System Assessment Schedule

SNFs must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF PPS. In addition to the PPS assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the PPS assessments, such as completion and submission time frames.

Assessment Window

The PPS 5-Day assessment has defined days within which the Assessment Reference Date (ARD) must be set. The ARD must be a day within the prescribed window of Days 1 through 8

of the Part A stay and must be set on the MDS form itself or in the facility software before this window has passed.

The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes and for purposes of the variable per diem adjustment, as discussed in Chapter 6, Section 6.7. In most cases, the first day of Medicare Part A coverage is the date of admission. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date. See Chapter 6, Section 6.7, for more detailed information.

Scheduled PPS Assessment

The PPS-required standard assessment is the 5-Day assessment, which has a predetermined time period for setting the ARD. The SNF provider must set the ARD on days 1–8 to assure compliance with the SNF PPS PDPM requirements.

Unscheduled PPS Assessments

There are situations when a SNF provider may complete an assessment after the 5-Day assessment. This assessment is an unscheduled assessment called the Interim Payment Assessment (IPA). When deemed appropriate by the provider, this assessment may be completed to capture changes in the resident's status and condition.

Tracking Records and Discharge Assessments Reporting

Tracking records and Discharge assessments reporting are required on **all** residents in the SNF and swing bed facilities. Tracking records and standalone Discharge assessments do not impact payment.

Part A PPS Discharge Assessment (A0310H)

The Part A PPS Discharge assessment contains data elements used to calculate current and future SNF QRP quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which Post-Acute Care (PAC) providers (which includes SNFs) are required to submit standardized resident assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that resident assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting.

- Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay)**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment must also be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required. In

situations in which the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) equals the day of discharge as listed in A2000.

Part A PPS Discharge Assessment (A0310H = 1):

- For the Part A PPS Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- If the End Date of the Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) **must** be equal to the Discharge Date (A2000). The Part A PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met (please see Section 2.10 Combining PPS Assessments and OBRA Assessments).
- If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.
- The Part A PPS Discharge assessment must be completed (item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- The Part A PPS Discharge assessment must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits do not resume within 3 days, the PPS schedule starts again with a 5-Day assessment. If the Medicare Part A stay does resume within the 3-day interruption window, then this is an interrupted stay (see below).
- If the resident leaves the facility for an interrupted stay, no Part A PPS Discharge Assessment is required when the resident leaves the building at the outset of the interrupted stay; however, an OBRA Discharge record is required if the discharge criteria are met (see Section 2.5). If the resident returns to the facility within the interruption window, as defined above, an Entry tracking form is required; however, no new 5-Day assessment is required.

The following chart summarizes the PPS assessments, tracking records, and discharge assessments:

PPS Assessments, Tracking Records, and Discharge
Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or is combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

2.9 MDS PPS Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in items A0310A and A0310B respectively. If the assessment is being used for reimbursement under the SNF PPS, the PPS Reason for Assessment must be coded in item A0310B. The OBRA Reason for Assessment is described earlier in this section while the PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and PPS requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and PPS assessments is discussed below and in more detail in Sections 2.10 and 2.11.

PPS Assessments for a Medicare Part A Stay

01. 5-Day Assessment

- ARD (item A2300) must be set for Days 1 through 8 of the Part A SNF covered stay.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for entire PPS stay (except in cases when an IPA is completed).
- Must be submitted electronically and accepted into iQIES within 14 days after completion (item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).

- Is the first PPS-required assessment to be completed when the resident is first admitted for a SNF Part A stay.
- Is the first PPS-required assessment to be completed when the resident is re-admitted to the facility for a Part A stay following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- A 5-Day assessment is not required at the time when a resident returns to a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption (facility discharge, resident no longer skilled, payer change, etc.).
- If a resident changes payers from Medicare Advantage to Medicare Part A, the SNF must complete a 5-Day assessment with the ARD set for one of days 1 through 8 of the Medicare Part A stay, with the resident's first day covered by Medicare Part A serving as Day 1, unless it is a case of an interrupted stay.

02. Interim Payment Assessment

- Optional assessment.
- ARD (item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day assessment.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for remainder of the PPS stay, beginning on the ARD.
- Must be submitted electronically and accepted into iQIES within 14 days after completion (item Z0500B) (completion + 14 days).
- The ARD for an IPA may not precede that of the 5-Day assessment.
- May not be combined with any other assessments (PPS or OBRA).

03. Part A PPS Discharge Assessment

- See definition provided in Section 2.8, Part A PPS Discharge Assessment (A0310H = 1).

2.10 Combining PPS Assessments and OBRA Assessments[7]

SNF providers are required to meet two assessment standards in a Medicare certified nursing facility:

- The OBRA standards are designated by the reason selected in item A0310A, **Federal OBRA Reason for Assessment**, and item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The PPS standards are designated by the reason selected in item A0310B, **PPS Assessment** and item A0310H, **Is this a SNF Part A PPS Discharge Assessment?**
- When the OBRA and PPS assessment time frames coincide (except the IPA), one assessment may be used to satisfy both requirements. PPS and OBRA assessments (except

[7] OBRA assessments do not apply to Swing Bed providers; however, Swing Bed providers are required to complete the Entry Tracking record, Swing Bed PPS (SP), Swing Bed Discharge (SD) assessment, and Death in Facility Tracking record.

the IPA) may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and PPS assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 5-Day assessment. For the OBRA Admission, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For the 5-Day, the ARD must be set for days 1 through 8. However, when combining a 5-Day assessment with the OBRA Admission assessment, the use of the latter end of the OBRA Admission ARD window would cause the 5-Day assessment to be considered late. To assure the assessment meets both standards, an ARD of a day between Day 1 and 8 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/ 5-Day assessment, completion by day 14 would be required. Finally, when combining a PPS assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed.

Some states require providers to complete additional state-specific items (Section S) for selected assessments. States may also add comprehensive items to the Quarterly and/or PPS item sets. Providers must ensure that they follow their state requirements in addition to any OBRA and/or PPS requirements.

The following tables provide the item set for each type of assessment or tracking record. When two or more assessments are combined, then the appropriate item set contains all items that would be necessary if each of the combined assessments were being completed individually.

Item Sets by Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Sets	Quarterly and PPS* Item Sets	Other Assessments and Tracking Records/Item Sets
Standalone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • 5-Day	• Entry Tracking Record • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Interim Payment Assessment (IPA)
Combined Assessment Types	• OBRA Admission and 5-Day • Annual and 5-Day • SCSA and 5-Day • SCPA and 5-Day • Any OBRA comprehensive and any Discharge	• Quarterly and 5-Day • Significant Correction to Prior Quarterly and 5-Day • 5-Day and any Discharge • Significant Correction to Prior Quarterly and any Discharge	• OBRA Discharge assessment and Part A PPS Discharge Assessment

*Nursing home-based SNFs must check with their State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

Item Sets by Assessment Type for Swing Bed Providers

	Swing Bed PPS/Item Set	Other Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	• (SP) Swing Bed PPS assessment	• Entry Tracking record • Death in Facility Tracking record • (SD) Swing Bed Discharge • Interim Payment Assessment (IPA)
Assessment Type Combinations	• (SP) Swing Bed PPS assessment and (SD) Swing Bed Discharge	• N/A

Tracking records (Entry and Death in Facility) and the Interim Payment Assessment can never be combined with other assessments.

2.11 PPS and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. A provider may choose to combine more than two assessment types when all requirements are met. The coding of items in A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in item A0310 (see Section 2.14).

5-Day Assessment and OBRA Admission Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

5-Day Assessment and Annual Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

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5-Day Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and Significant Correction to Prior Quarterly Assessment

- See 5-Day assessment and OBRA Quarterly Assessment.

5-Day Assessment and OBRA Discharge Assessment

- PPS item set.
- ARD (item A2300) must be set for the day of discharge (item A2000) **and** the date of discharge must fall within the allowed window of the 5-Day as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

5-Day Assessment and Part A PPS Discharge Assessment

- PPS item set.
- ARD (item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the 5-Day assessment as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

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2.12 Factors Impacting SNF PPS Assessment Scheduling[8]

Resident Expires Before or On the Eighth Day of SNF Stay

If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in iQIES, the provider must bill the default rate for any Medicare days. The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (e.g., transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in iQIES, the provider must bill the default rate for any Medicare days.

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required.

When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments must be combined. (See Sections 2.10 and 2.11 for details on combining a PPS assessment with a Discharge assessment.)

Resident Is Admitted to an Acute Care Facility and Returns

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF to resume Part A coverage, the resident requires a new 5-Day assessment, unless it is an instance of an interrupted stay. If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form. An IPA may be completed, if deemed appropriate.

Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, a new 5-Day PPS assessment is not required, though an IPA may be completed, if deemed appropriate. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the "midnight rule." For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of their Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of their return to the SNF, Thursday,

[8] These requirements/policies also apply to swing bed providers.

becomes day 22 of their Part A stay. This means that this day is skipped for purposes of the variable per diem adjustment, described in Chapter 6.

Resident Takes a Leave of Absence from the SNF

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-13 in this chapter, there may be payment implications. For example, if a resident leaves a SNF at 6:00 p.m. on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3).

Resident Discharged from Part A Skilled Services and from the Facility and Returns to SNF Part A Skilled Level Services

In the situation when a beneficiary is discharged from Medicare Part A and is physically discharged from the facility, but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and can be combined (see Part A PPS Discharge in Section 2.5).

On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new 5-Day and Entry Tracking record must be completed. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

However, in the case of an interrupted stay, that is, if a resident **leaves the facility and resumes Part A within the 3-day interruption window**, only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.

The beneficiary should be assessed to determine if there was a significant change in status.

Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility

In the situation when a resident's Medicare Part A stay ends, but the resident is not physically discharged from the facility, remaining in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item A1900) and must also complete a Part A PPS Discharge assessment.

If Part A benefits resume, there is no reason to change the OBRA schedule; the PPS schedule would start again with a 5-Day assessment, MDS item A0310B = 01, **unless** it is a case of an

interrupted stay—that is, if the resident is discharged from Part A, remains in the facility, and resumes Part A **within the 3-day interruption window**, no Part A PPS Discharge is completed, nor is a 5-Day required when Part A resumes.

Delay in Requiring and Receiving Skilled Services

There are instances when the beneficiary does not require SNF level of care services when initially admitted to the SNF. See Chapter 6, Section 6.7.

Non-Compliance with the PPS Assessment Schedule

According to Part 42 Code of Federal Regulation (CFR) Section 413.343, an assessment that does not have its ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missed assessments may result in additional review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the Health Insurance Prospective Payment System (HIPPS) code reflecting the lowest acuity level for each PDPM component and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a 5-Day assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 of the Part A stay and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed.

Missed PPS Assessment

If the SNF fails to set the ARD of a 5-Day assessment prior to the end of the last day of the ARD window, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A.

Errors on a PPS Assessment

To correct an error on an MDS that has been submitted to iQIES, the SNF must follow the normal MDS correction procedures (see Chapter 5).

2.13 Expected Order of MDS Records

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (item A1700) indicating admission, and the next record is expected to be an Admission assessment, a

5-Day assessment, a Discharge assessment, or Death in Facility tracking record. iQIES will issue a warning when an unexpected record is submitted. Examples include an assessment record after a discharge (an entry is expected) or any record after a Death in Facility tracking record.

The target date, rather than the submission date, is used to determine the order of records. The target date is the Assessment Reference Date (item A2300) for assessment records, the Entry Date (item A1600) for entry records, and the Discharge Date (item A2000) for discharge or Death in facility records. In the following table, the prior record is represented in the columns and the next (subsequent) record is represented in the rows. A "no" has been placed in a cell when the next record is not expected to follow the prior record; iQIES will issue a record order warning for record combinations that contain a "no." A "yes" indicates that the next record is expected to follow the prior record; a record order warning will ***not*** be issued for these combinations. Note that there are not any iQIES record order warnings produced for Swing Bed MDS records.

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Expected Order of MDS Records

	Prior Record									
Next Record	**Entry**	**OBRA Admission**	**OBRA Annual**	**OBRA Quarterly**	**5-Day**	**IPA**	**OBRA Discharge**	**Part A PPS Discharge**	**Death in facility**	**No prior record**
Entry	no	no	no	no	no	no	yes	no	no	yes
OBRA Admission	yes	no	no	no	yes	yes	no	yes	no	no
OBRA Annual	yes	no	no	yes	yes	yes	no	yes	no	no
OBRA Quarterly, sign. change, sign correction	yes	yes	yes	yes	yes	yes	no	yes	no	no
5-Day	yes	yes	yes	yes	no	no	no	yes	no	no
IPA	yes	yes	yes	yes	yes	yes	no	no	no	no
OBRA Discharge	yes	yes	yes	yes	yes	yes	no	yes	no	no
Part A PPS Discharge	yes	yes	yes	yes	yes	yes	no	no	no	no
Death in facility	yes	yes	yes	yes	yes	yes	no	yes	no	no

Note: "No" indicates that the record sequence is not expected; record order warnings will be issued for these combinations.
"Yes" indicates expected record sequences; no record order warning will be issued for these combinations.

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2.14 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the item set code (ISC) and Description columns for that row. If the combination of items A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by iQIES.

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01, 03, 04, 05	01, 99	10, 11, 99	0, 1	NC	Comprehensive
02, 06	01, 99	10, 11, 99	0, 1	NQ	Quarterly
99	01	10, 11, 99	0, 1	NP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	ND	OBRA Discharge
99	99	01, 12	0	NT	Tracking
99	99	99	1	NPE	Part A PPS Discharge

Consider examples of the use of this table. If items A0310A = 01, A0310B = 99, item A0310F = 99, and A0310H = 0 (a standalone OBRA Admission assessment), then these values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if item A0310F is changed to 10 (Admission assessment combined with a return not anticipated Discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If items A0310A = 99, A0310B = 99, item A0310F = 12, and A0310H = 0 (a Death in Facility tracking record), then these values are matched in the second to last row and the item set is a tracking record (NT). Finally, if items A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.

There is one additional item set not listed in the above table used for inactivation request records. This is the set of items active on a request to inactivate a record in iQIES. An inactivation request is indicated by A0050 = 3. The item set for this type of record is "Inactivation" with an ISC code of XX.

The next lookup table is for swing bed records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and

A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by iQIES.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	Entry/ Discharge (A0310F)	Part A Discharge (A0310H)	ISC	Description
99	01	10, 11, 99	0, 1	SP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	SD	Discharge
99	99	01, 12	0	ST	Tracking

The "Inactivation" (XX) item set is also used for swing beds when item A0050 = 3.

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CHAPTER 3: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE MDS 3.0

This chapter provides item-by-item coding instructions for all required sections and items in the MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes.

3.1 Using this Chapter

Throughout this chapter, MDS assessment sections are presented using a standard format for ease of review and instruction. In addition, screenshots of each section are available for illustration purposes. Note: There are images imbedded in this manual and if you are using a screen reader to access the content contained in the manual you should refer to the MDS 3.0 item set to review the referenced information. The order of the sections is as follows:

- **Intent.** The reason(s) for including this set of assessment items in the MDS.
- **Item Display.** To facilitate accurate resident assessment using the MDS, each assessment section is accompanied by screenshots, which display the item from the MDS 3.0 item set.
- **Item Rationale.** The purpose of assessing this aspect of a resident's clinical or functional status.
- **Health-related Quality of Life.** How the condition, impairment, improvement, or decline being assessed can affect a resident's quality of life, along with the importance of staff understanding the relationship of the clinical or functional issue related to quality of life.
- **Planning for Care.** How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning.
- **Steps for Assessment.** Sources of information and methods for determining the correct response for coding each MDS item.
- **Coding Instructions.** The proper method of recording each response, with explanations of individual response categories.
- **Coding Tips and Special Populations.** Clarifications, issues of note, and conditions to be considered when coding individual MDS items.
- **Examples.** Case examples of appropriate coding for most, if not all, MDS sections/items.

Additional layout issues to note include: (1) the  symbol is displayed in all MDS 3.0 sections/items that require a resident interview, and (2) important definitions are highlighted in text boxes, and may be found, along with other definitions of interest, in Appendix A: Glossary and Common Acronyms.

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3.2 Becoming Familiar with the MDS-recommended Approach

1. **First, reading the Manual is essential.**
   - The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the primary source of information for completing an MDS assessment.
   - Notice how the manual is organized.
   - Using it correctly will increase the accuracy of your assessments.
   - While it is important to understand and apply the information in Chapter 3, facilities should also become familiar with Chapters 1, 2, 4, 5 and 6. These Chapters provide the framework and supporting information for data collected on the item set as well as the process for further assessment and care planning, submitting and modifying assessments, and information on the SNF PPS payment system.
   - It is important to understand the entire process of the RAI in conjunction with the intent and rationale for coding items on the MDS 3.0 item set.
   - Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
   - If you require further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Locations RAI/MDS Contacts available in the Downloads section on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
2. **Second, review the MDS item sets.**
   - Notice how sections are organized and where information should be recorded.
   - Work through one section at a time.
   - Examine item definitions and response categories as provided on the item sets, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.
   - There are several item sets, and depending on which item set you are completing, the skip patterns and items active for each item set may be different.
3. **Complete a thorough review of Chapter 3.**
   - Review procedural instructions, time frames, and general coding conventions.
   - Become familiar with the intent of each item, rationale and steps for assessment.
   - Become familiar with the item itself with its coding choices and response options, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
   - Do the definitions and instructions differ from current practice at your facility?
   - Do your facility processes require updating to comply with MDS requirements?

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- Complete a test MDS assessment for a resident at your facility. Enter the appropriate codes on the MDS.
- Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.
- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.
- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Functional Abilities?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete your initial case differently?
- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B**: State Agency and CMS Locations RAI/MDS Contacts available in the Downloads section on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

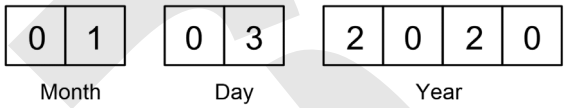
4. **Use of information in this chapter:**
   - Keep this chapter with you during the assessment process.
   - Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

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 J, 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.
- When determining the response to items that have a look-back period relating back to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to iQIES. PPS assessments that are completed for private insurance and Medicare Advantage Plans must **not** be submitted to iQIES and therefore should not be considered when determining the "prior assessment."

- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, if B0100 is answered **code 1, yes**, the assessor is instructed to skip to item GG0110, **Activities of Daily Living (ADL) Assistance**. The intervening items from B0200–F0800 would not be coded (i.e., left blank). If B0100 was answered **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200, **Hearing**).
- Use a check mark for boxes where the instructions state to "check all that apply," if the specified condition is met; otherwise, these boxes should remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., M1030, **Number of Venous and Arterial Ulcers**).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly to ensure accurate encoding of data.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2020 is recorded as:



- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to iQIES.
  - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
  - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
  - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
  - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.
- When the term "physician" is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.

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- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident's family, significant other, and guardian or legally authorized representative should be consulted.
- Several times throughout the manual the word "significant" is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0, the term "significant" when discussing clinical, medical, or laboratory findings refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term "significant" is used in discussing relationships between people, as in "significant other," it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.
- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g., for item K0200B, if the weight was 1010 lbs., you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.

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SECTION A: IDENTIFICATION INFORMATION

Intent: The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident, potential care needs including access to transportation, and the home in which they reside.

A0050: Type of Record

A0050. Type of Record

Enter Code ☐

1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

Coding Instructions for A0050, Type of Record

- **Code 1, Add new record:** if this is a **new record** that has not been previously submitted and accepted in iQIES. If this item is **coded as 1**, continue to A0100 Facility Provider Numbers.

  If there is an existing database record for the same resident, the same facility, the same reasons for assessment/tracking, and the same date (assessment reference date, entry date, or discharge date), then the current record is a duplicate and not a new record. In this case, the submitted record will be rejected and not accepted in iQIES and a "fatal" error will be reported to the facility on the Final Validation Report.

- **Code 2, Modify existing record:** if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the Internet Quality Improvement and Evaluation System (iQIES).

  If this item is **coded as 2**, continue to A0100, Facility Provider Numbers.

  When a modification request is submitted, iQIES will take the following steps:

  1. The system will attempt to locate the existing record in iQIES for this facility with the resident, reasons for assessment/tracking, and date (Assessment Reference Date (ARD), entry date, or discharge date) indicated in subsequent Section X items.

  2. If the existing record is not found, the submitted modification record will be rejected and not accepted in iQIES. A "fatal" error will be reported to the facility on the Final Validation Report.

  3. If the existing record is found, then the items in all sections of the submitted modification record will be edited. If there are any fatal errors, the modification record will be rejected and not accepted in iQIES. The "fatal" error(s) will be reported to the facility on the Final Validation Report.

  4. If the modification record passes all the edits, it will replace the prior record being modified in iQIES. The prior record will be moved to a history file in iQIES.

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A0050: Type of Record (cont.)

- **Code 3, Inactivate existing record:** if this is a **request to inactivate** a record that already has been submitted and accepted in iQIES.

  If this item is **coded as 3**, skip to X0150, Type of Provider.

  When an inactivation request is submitted, iQIES will take the following steps:

  1. The system will attempt to locate the existing record in iQIES for this facility with the resident, reasons for assessment/tracking, and date (ARD, entry date, or discharge date) indicated in subsequent Section X items.

  2. If the existing record is not found in iQIES, the submitted inactivation request will be rejected and a "fatal" error will be reported to the facility on the Final Validation Report.

  3. All items in Section X of the submitted record will be edited. If there are any fatal errors, the current inactivation request will be rejected and no record will be inactivated in iQIES.

  4. If the existing record is found, it will be removed from the active records in iQIES and moved to a history file.

Identification of Record to be Modified/Inactivated

The Section X items from X0200 through X0700 identify the existing iQIES assessment or tracking record that is in error. In this section, reproduce the information **EXACTLY** as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the database.

> **Example:** A MDS assessment for Joan L. Smith is submitted and accepted by iQIES. A data entry error is then identified on the previously submitted and accepted record: The encoder mistakenly entered "John" instead of "Joan" when entering a prior assessment for Joan L. Smith. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under Identification of Record to be Modified/Inactivated. When completing X0200A, the Resident First Name, "John" will be entered in this item. This will permit the MDS system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" were entered, iQIES would not locate the prior assessment.

The correction to the name from "John" to "Joan" will be made by recording "Joan" in the "normal" A0500A, Resident First Name in the modification record. The modification record must include all items appropriate for that assessment, not just the corrected name. This modification record will then be submitted and accepted into iQIES, which causes the desired correction to be made.

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A0100: Facility Provider Numbers

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

Item Rationale

- Allows the identification of the facility submitting the assessment.

Coding Instructions

- Enter the facility provider numbers:
  - A. National Provider Identifier (NPI).
  - B. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank.
  - C. State Provider Number (optional). This number is assigned by the State survey agency and provided to the intermediary. When known, enter the State Provider Number in A0100C. Completion of this is not required; however, your State may require the completion of this item.

DEFINITIONS

NATIONAL PROVIDER IDENTIFIER (NPI)
A unique Federal number that identifies providers of health care services. The NPI applies to the nursing home for all of its residents.

CMS CERTIFICATION NUMBER (CCN)
Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE PROVIDER NUMBER
Medicaid Provider Number established by a state.

A0200: Type of Provider

A0200. Type of Provider

Enter Code

Type of provider
1. Nursing home (SNF/NF)
2. Swing Bed

Item Rationale

- Allows designation of type of provider.

Coding Instructions

- **Code 1, nursing home (SNF/NF):** if a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF).
- **Code 2, swing bed:** if a non-critical access hospital with swing bed approval.

DEFINITION

SWING BED
A rural non-critical access hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

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A0310: Type of Assessment

For all Federally required assessments and records as well as all PPS assessments.

A0310. Type of Assessment

Enter Code ☐☐ **A. Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐ **B. PPS Assessment**
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code ☐ **E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Enter Code ☐☐ **F. Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code ☐ **G. Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

Enter Code ☐ **G1. Is this a SNF Part A Interrupted Stay?**
0. **No**
1. **Yes**

Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

Item Rationale

- Allows identification of needed assessment content.

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A0310: Type of Assessment (cont.)

Coding Instructions for A0310, Type of Assessment

Enter the code corresponding to the reason or reasons for completing this assessment.

If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B), all requirements for both types of assessments must be met. See Chapter 2, Section 2.10, Combining PPS Assessments and OBRA Assessments, for details of these requirements. Assessments completed for other reasons (e.g., to facilitate billing for Medicare Advantage Plans) are not coded in A0310 and are not submitted to iQIES.

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code "99".

01. Admission assessment (required by day 14)
02. Quarterly review assessment
03. Annual assessment
04. Significant change in status assessment
05. Significant correction to prior comprehensive assessment
06. Significant correction to prior quarterly assessment
99. None of the above

Coding Tips and Special Populations

- If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). The nursing home is required to complete an SCSA when the resident comes off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
- It is a CMS requirement to have an SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.

Draft

A0310: Type of Assessment (cont.)

Coding Instructions for A0310B, PPS Assessment

- Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01 and 08, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded as 01 or 08, enter code "99."
- See Chapter 2 on assessment schedules for detailed information on the timing of the assessments.

DEFINITION

PROSPECTIVE PAYMENT SYSTEM (PPS)
Method of reimbursement in which Medicare payment is made based on the classification system of that service.

PPS Scheduled Assessment for Medicare Part A Stay

01. 5-day scheduled assessment

PPS Unscheduled Assessment for Medicare Part A Stay

08. IPA-Interim Payment Assessment

Not PPS Assessment

99. None of the above

Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, Scheduled PPS, or OBRA Discharge) since the Most Recent Admission/Entry or Reentry?

- **Code 0, no:** if this assessment is not the first of these assessments since the most recent admission/entry or reentry.
- **Code 1, yes:** if this assessment is the first of these assessments since the most recent admission/entry or reentry.

Coding Tips and Special Populations

- A0310E = 0 for:
  - Entry or Death in Facility tracking records (A0310F = 01 or 12);
  - A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or
  - An Interim Payment Assessment (A0310A = 99, A0310B = 08, A0310F = 99, and A0310H=0).
- A0310E = 1 on the first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: the first submitted assessment may not be an OBRA Admission assessment.

Draft

A0310: Type of Assessment (cont.)

Coding Instructions for A0310F, Federal OBRA & PPS Entry/Discharge Reporting

- Enter the number corresponding to the reason for completing this assessment or tracking record. This item contains 2 digits. For code 01, enter "0" in the first box and place "1" in the second box. If the assessment is not coded as "01" or "10 or "11" or "12," enter "99":

  01. Entry tracking record
  10. Discharge assessment-return not anticipated
  11. Discharge assessment-return anticipated
  12. Death in facility tracking record
  99. None of the above

Coding Instructions for A0310G, Type of Discharge (complete only if A0310F = 10 or 11)

- Enter the number corresponding to the type of discharge.
- **Code 1:** if type of discharge is a planned discharge.
- **Code 2:** if type of discharge is an unplanned discharge.

DEFINITION

Part A PPS Discharge Assessment
A discharge assessment developed to inform current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; and must be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Draft

A0310: Type of Assessment (cont.)

Enter Code ☐ G1. Is this a SNF Part A Interrupted Stay?
0. No
1. Yes

Coding Instructions for A0310G1, Is this a SNF Part A Interrupted Stay?

- **Code 0, no:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but **did not** resume SNF care in the same SNF within the interruption window.
- **Code 1, yes:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did resume SNF care in the same SNF within the interruption window.

Coding Tips

- Item A0310G1 indicates whether or not an interrupted stay occurred.
- The interrupted stay policy applies to residents who either leave the SNF, then return to the same SNF within the interruption window, or to residents who are discharged from Part A-covered services and remain in the SNF, but then resume a Part A-covered stay within the interruption window.

DEFINITIONS

Interrupted Stay
Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

Interruption Window
Is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Draft

A0310: Type of Assessment (cont.)

- The following is a list of examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services within the interruption window. Examples include, but are not limited to, the following:
    - Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window.
    - Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window.
    - Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window.
    - Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window.
    - Resident leaves against medical advice and returns to the same SNF within the interruption window.
- The following is a list of examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following:
    - Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window.
    - Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes.
    - Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.
- If a resident is discharged from SNF care, remains in the facility, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption.
- If a resident leaves the SNF and returns to resume Part A-covered services in the **same** SNF within the interruption window, this is an interrupted stay. Although this situation does not end the resident's Part A PPS stay, the resident left the SNF, and therefore an OBRA Discharge assessment is required. On return to the SNF, no 5-Day would be required. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.

DRAFT

A0310: Type of Assessment (cont.)

- When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay.
- If a resident is discharged from SNF care, remains in the SNF and **does not** resume Part A-covered services within the interruption window, an interrupted stay did **not** occur. In this situation, a Part A PPS Discharge is required. If the resident qualifies and there is a resumption of Part A services within the 30-day window allowed by Medicare, a 5-Day would be required as this would be considered a **new** Part A stay. The OBRA schedule would continue from the resident's original date of admission (item A1900).
- If a resident leaves the SNF and **does not** return to resume Part A-covered services in the **same** SNF within the interruption window, an interrupted stay did **not** occur. In this situation, both the Part A PPS and OBRA Discharge assessments are required (and must be combined if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)). If the resident returns to the same SNF, this would be considered a **new** Part A stay. An Entry Tracking record and 5-Day would be required on return. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.
- The OBRA assessment schedule is unaffected by the interrupted stay policy. Please refer to Chapter 2 for guidance on OBRA assessment scheduling requirements.

Coding Instructions for A0310H, Is this a Part A PPS Discharge Assessment?

- **Code 0, no:** if this is not a Part A PPS Discharge assessment.
- **Code 1, yes:** if this is a Part A PPS Discharge assessment.
- A Part A PPS Discharge assessment (NPE Item Set) is required under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility.
- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

DRAFT

A0410: Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation

Enter Code ☐

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified

Item Rationale

- In coding this item, the facility must consider its Medicare and/or Medicaid status as well as the state's authority to collect MDS records. State regulations may require submission of MDS data to iQIES or directly to the state for residents residing in licensed-only beds.
- Nursing homes must be certain they are submitting MDS assessments to iQIES for those residents who are on a Medicare and/or Medicaid certified unit. Swing bed facilities must be certain that they are submitting MDS assessments only for those residents whose stay is covered by Medicare Part A benefits. For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to iQIES or directly to the state in accordance with state requirements.
- Payer source is not the determinant by which this item is coded. This item is coded solely according to the authority CMS has to collect MDS data for residents who are on a Medicare and/or Medicaid certified unit and the authority that the state may have to collect MDS data under licensure. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to iQIES.

Steps for Assessment

1. Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, Medicaid certified or dually certified (Medicare/Medicaid).

2. If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative if there are units that are state licensed and if the state requires MDS submission for residents on that unit.

3. Identify all units in the nursing home that are not certified or licensed by the state, if any.

Draft

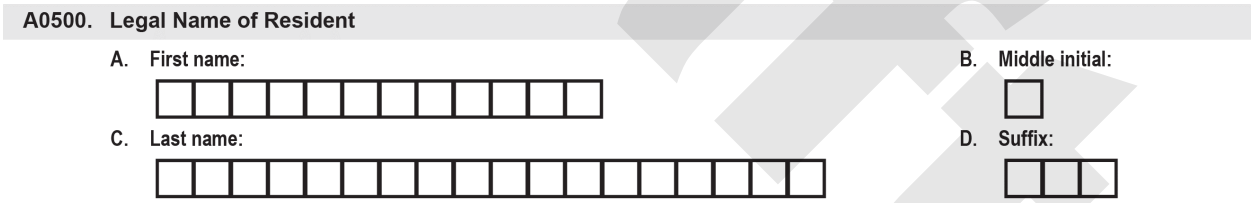
A0410: Unit Certification or Licensure Designation (cont.)

Coding Instructions

- **Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State:** if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and neither CMS nor the state has authority to collect MDS information for residents on this unit, the facility may not submit MDS records to iQIES. If any records are submitted under this certification designation, they will be rejected by iQIES.
- **Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State:** if the nursing home resident is on a unit that is neither Medicare nor Medicaid certified, but the state has authority under state licensure to collect MDS information for residents on such units, the facility should submit the resident's MDS records per the state's requirement to iQIES or directly to the state.

  Note that this certification designation does not apply to swing-bed facilities. Assessments for swing-bed residents on which A0410 is coded "2" will be rejected by iQIES.
- **Code 3, Unit is Medicare and/or Medicaid certified:** if the resident is on a Medicare and/or Medicaid certified unit, regardless of payer source (i.e., even if the resident is private pay or has their stay covered under Medicare Advantage, Medicare HMO, private insurance, etc.), the facility is required to submit MDS records (OBRA and SNF PPS only) to iQIES for these residents. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to iQIES.

A0500: Legal Name of Resident



Item Rationale

- Allows identification of resident.
- Also used for matching each of the resident's records.

Steps for Assessment

1. Ask resident, family, significant other, and/or guardian/legally authorized representative.

DEFINITION

LEGAL NAME
Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document.

Draft

A0500: Legal Name of Resident (cont.)

2. Check the resident's name on their Medicare card, or if not in the program, check a Medicaid card or other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

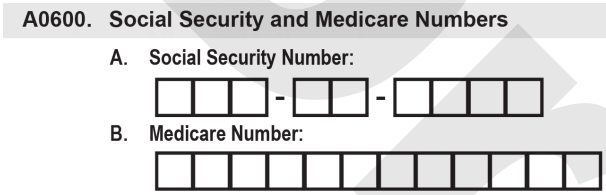
A. First Name

B. Middle Initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name)

C. Last Name

D. Suffix (e.g., Jr./Sr.)

A0600: Social Security and Medicare Numbers



Item Rationale

- Allows identification of the resident.
- Allows records for resident to be matched in system.

Coding Instructions

- Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no SSN is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank. Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.
- Enter Medicare number in A0600B exactly as it appears on the resident's documents.
- For PPS assessments (A0310B = 01 or 08), the Medicare number (A0600B) must be present (i.e., may not be left blank).
- A0600B must be a Medicare number.

DEFINITIONS

SOCIAL SECURITY NUMBER
A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER
An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier is different from the resident's Social Security Number (SSN) and may contain both letters and numbers.

Draft

A0700: Medicaid Number

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



Item Rationale

- Assists in correct resident identification.

Coding Instructions

- Record this number if the resident is a Medicaid recipient.
- Enter one number or letter per box beginning in the leftmost box.
- Recheck the number to make sure you have entered the digits correctly.
- Enter a "+" in the leftmost box if the number is pending. If you are notified later that the resident does have a Medicaid number, just include it on the next assessment.
- If not applicable because the resident is not a Medicaid recipient, enter "N" in the leftmost box.

Coding Tips and Special Populations

- To obtain the Medicaid number, check the resident's Medicaid card, admission or transfer records, or medical record.
- Confirm that the resident's name on the MDS matches the resident's name on the Medicaid card.
- It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. However, a correction may be a State-specific requirement.

A0800: Gender

A0800. Gender

Enter Code

1. **Male**
2. **Female**

Item Rationale

- Assists in correct identification.
- Provides demographic gender specific health trend information.

Coding Instructions

- **Code 1:** if resident is male.
- **Code 2:** if resident is female.

Coding Tips and Special Populations

- Resident gender on the MDS must match what is in the Social Security system.

Draft

A0900: Birth Date

A0900. Birth Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Item Rationale

- Assists in correct identification.
- Allows determination of age.

Coding Instructions

- Fill in the boxes with the appropriate birth date. If the complete birth date is known, do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example: January 2, 1918, should be entered as 01-02-1918.
- Sometimes, only the birth year or the birth year and birth month will be known. These situations are handled as follows:
  - If only the birth year is known (e.g., 1918), then enter the year in the "year" portion of A0900, and leave the "month" and "day" portions blank. If the birth year and birth month are known, but the day of the month is not known, then enter the year in the "year" portion of A0900, enter the month in the "month" portion of A0900, and leave the "day" portion blank.

A1005: Ethnicity



A1005. Ethnicity
Are you of Hispanic, Latino/a, or Spanish origin?

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

Draft

A1005: Ethnicity (cont.)

Item Rationale

- The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.
- The ethnicity data element uses a one-question multi-response format based on whether or not the resident is of Hispanic, Latino/a, or Spanish origin. Collection of ethnic data provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.

DEFINITION

ETHNICITY

HISPANIC OR LATINO/A

A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race. The term "Spanish Origin" can be used in addition to Hispanic or Latino/a.

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report ethnic categories. Response choices A1005B through A1005E roll up to the Hispanic or Latino/a category of the OMB standard (see Definition Ethnicity). The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute-care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.
- For the source of these categories and definitions, see "Racial and Ethnic Categories and Definitions for NIH Diversity Programs and for Other Reporting Purposes, Notice Number: NOT-OD-15-089" available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-089.html. Additional information on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status is available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53.

Draft

A1005: Ethnicity (cont.)

Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A1005.

    - Individuals may be more comfortable if this question is introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their ethnic background. We would like you to tell us your ethnic background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005).

2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.

3. Ethnic category definitions are provided only if requested in order to answer the item.

4. Respondents should be offered the option of selecting one or more ethnic designations.

5. Only use medical record documentation to code A1005, Ethnicity if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.

6. If the resident declines to respond, do not code based on other resources (family, significant other, or guardian/legally authorized representative or medical records).

Coding Instructions

Check all that apply.

- If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.
- **Code X, Resident unable to respond:** if the resident is unable to respond.
    - — In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, including X. Resident unable to respond.
    - — If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

Draft

A1005: Ethnicity (cont.)



- **Code Y, Resident declines to respond:** if the resident declines to respond.
  - — When the resident declines to respond, code only Y. Resident declines to respond.
  - — When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Examples

1. Resident R is admitted following an acute cerebral vascular accident (CVA) with mental status changes and is unable to respond to questions regarding their ethnicity. Their spouse informs the nurse that Resident R is Cuban.

   Coding: A1005 would be coded as D. Yes, Cuban and X. Resident unable to respond.

   Rationale: If Resident R is unable to respond but their family, significant other, or legally authorized representative provided the response, code both that response and X. Resident unable to respond.

2. Resident K is admitted following a total hip arthroplasty and declines to respond when asked their ethnicity.

   Coding: A1005, Ethnicity would be coded as Y. Resident declines to respond.

   Rationale: If a resident declines to respond to this item, code only Y. Resident declines to respond. Do not use other resources (family, significant other, or legally authorized representative or medical record documentation) to complete A1005, Ethnicity when a resident declines to respond.

Draft

A1010. Race

A1010. Race
What is your race?

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

Draft

A1010. Race (cont.)

Item Rationale

- The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to social determinants of health, including race.
- Collection of A1010. Race provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.
- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial categories (see Definitions: Race). Response choices A1010D through A1010J roll up to the Asian category of the OMB standard. Response choices A1010K through A1010N roll up to the Native Hawaiian or Other Pacific Islander category of the OMB standard. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Collection of race data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute-care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to the resident's race from the list in A1010, Race.
   - Individuals may be more comfortable if this question is introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their racial background. We would like you to tell us your racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005).

DEFINITION

RACE

AMERICAN INDIAN OR ALASKAN NATIVE

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

ASIAN

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam.

BLACK OR AFRICAN AMERICAN

A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American."

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

WHITE

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

DRAFT

A1010. Race (cont.)

2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
3. Racial category definitions are provided only if requested in order to answer the item.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only use medical record documentation to code A1010, Race if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Coding Instructions

Check all that apply.

- If the resident provides a response, check the box(es) indicating the race category or categories identified by the resident.
- **Code X, Resident unable to respond:** if the resident is unable to respond.
  - In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, check all boxes that apply, including X. Resident unable to respond.
  - If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code as X. Resident unable to respond.
- **Code Y, Resident declines to respond:** if the resident declines to respond.
  - When the resident declines to respond, code only Y. Resident declines to respond.
  - When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).
- **Code Z, None of the above:** if the resident reports or it is determined from other resources (family, significant other, or legally authorized representative or medical records) that none of the listed races apply.

DRAFT

A1010. Race (cont.)

Examples

1. Resident W has severe dementia with agitation. During the Admission assessment, they are unable to provide their race. Their child informs the nurse that Resident W is Korean and African American.

   Coding: A1010, Race would be coded as B. Black or African American, H. Korean, and X. Resident unable to respond.

   Rationale: If Resident W is unable to respond but their family, significant other, or legally authorized representative provided the response, code those responses and X. Resident unable to respond.

2. Resident Q declines to provide their race during the admission assessment stating "I'd rather not answer."

   Coding: A1010, Race would be coded as Y. Resident declines to respond.

   Rationale: If a resident declines to respond to this item, then code only Y. Resident declines to respond. Do not make attempts to code A1010, Race when a resident declines to respond based on other resources (family, significant other, or legally authorized representative or medical records).

3. Resident V, who is admitted to the SNF following a recent CVA resulting in confusion, is unable to answer when asked their race. Their family member reports that none of the listed races apply.

   Coding: A1010, Race would be coded as X. Resident unable to respond and Z. None of the above.

   Rationale: If a resident is unable to respond, family, significant other, or legally authorized representative input may be used to code A1010, Race and the assessor should code both the information determined via family, significant other, or legally authorized representative input or medical records (in this case, Z. None of the above) and X. Resident unable to respond.

Draft

A1110: Language

A1110. Language

A. What is your preferred language?

Enter Code ☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

Item Rationale

Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can lead to social isolation, depression, resident safety issues, and unmet needs.
- Language barriers can interfere with accurate assessment.

Planning for Care

- When a resident needs or wants interpreter services, the nursing home must ensure that an interpreter is available.
- An alternate method of communication also should be made available to help ensure that basic needs can be expressed at all times (e.g., communication board with pictures on it for the resident to point to, if able).
- Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

Steps for Assessment

1. Ask for the resident's preferred language.
2. Ask the resident if they need or want an interpreter to communicate with a doctor or health care staff.
3. If the resident—even with the assistance of an interpreter—is unable to respond, a family member, significant other, and/or guardian/legally authorized representative should be asked.
4. If neither the resident nor a family member, significant other, nor guardian/legally authorized representative source is able to provide a response for this item, medical documentation may be used.
5. It is acceptable for a family member, significant other, and/or legally authorized representative to be the interpreter if the resident is comfortable with it and if the family member, significant other, and/or guardian/legally authorized representative will translate exactly what the resident says without providing their interpretation.

Draft

A1110: Language (cont.)



Coding Instructions for A1110A

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other and/or guardian/legally authorized representative and/or reviewing the medical record.
- If the resident, family member, significant other, guardian/legally authorized representative and/or medical record documentation cannot or does not identify preferred language, enter a dash (—) in the first box. A dash indicates "no information." CMS expects dash use to be a rare occurrence.

Coding Instructions for A1110B

- **Code 0, No:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates there is no need or want of an interpreter to communicate with a doctor or health care staff.
- **Code 1, Yes:** if the resident (family, significant other, guardian/legally authorized representative or medical record) indicates the need or want of an interpreter to communicate with a doctor or health care staff. Ensure that preferred language is indicated.
- **Code 9, Unable to determine:** if the resident is unable or declines to respond or any available source (family, significant other, guardian/legally authorized representative or medical records) cannot or does not identify the need or want of an interpreter.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

Draft

A1200: Marital Status

A1200. Marital Status

Enter Code ☐

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

Item Rationale

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.
- Demographic information.

Steps for Assessment

1. Ask the resident about their marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither the family member nor significant other can report, review the medical record for information.

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:
  - **1.** Never Married
  - **2.** Married
  - **3.** Widowed
  - **4.** Separated
  - **5.** Divorced

Draft

A1250. Transportation

A1250. Transportation (from NACHC©)
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

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

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Item Rationale

Health-related Quality of Life

- Access to transportation for ongoing health care and medication access needs is essential for effective care management.
- Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.

Planning for Care

- Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

Steps for Assessment: Interview Instructions

1. Ask the resident:
   - "In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"
   - "In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"
2. Respondents should be offered the option of selecting more than one "yes" designation, if applicable.
3. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
4. Only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative may provide a response for this item, use medical record documentation.
5. If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Draft

A1250. Transportation (cont.)

Coding Instructions

- **Code A, Yes, it has kept me from medical appointments or from getting my medications:** if the resident indicates that lack of transportation has kept the resident from medical appointments or from getting medications.
- **Code B, Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need:** if the resident indicates that lack of transportation has kept the resident from non-medical meetings, appointments, work, or from getting things that the resident needs.
- **Code C, No:** if the resident indicates that a lack of transportation has not kept the resident from medical appointments, getting medications, non-medical meetings, appointments, work, or getting things that the resident needs.
- **Code X, Resident unable to respond:** if the resident is unable to respond.
  - In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical records, check all boxes that apply, including X. Resident unable to respond.
  - If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1250 as only X. Resident unable to respond.
- **Code Y, Resident declines to respond:** if the resident declines to respond.
  - When the resident declines to respond, code only Y. Resident declines to respond.
  - When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

Draft

A1250. Transportation (cont.)

Example

1. Resident E is admitted with Multiple Sclerosis. They are confused and unable to understand when asked if they have had a lack of transportation that has kept them from medical appointments, meetings, work, or from getting things needed for daily living. No family, significant other, or legally authorized representative with related information is available, but their medical record indicates that their spouse uses their car to transport Resident E wherever they need to go.

   Coding: A1250 would be coded as C. No and X. Resident unable to respond.

   Rationale: If neither Resident E nor their family, significant other, or legally authorized representative was able to provide a response but the medical record documentation can provide the necessary information, code both the information in the medical record and X. Resident unable to respond.

A1300: Optional Resident Items

A1300. Optional Resident Items

A. **Medical record number:**

B. **Room number:**

C. **Name by which resident prefers to be addressed:**

D. **Lifetime occupation(s)** - put "/" between two occupations:

Item Rationale

- Some facilities prefer to include the nursing home medical record number on the MDS to facilitate tracking.
- Some facilities conduct unit reviews of MDS items in addition to resident and nursing home level reviews. The unit may be indicated by the room number.
- Preferred name and lifetime occupation help nursing home staff members personalize their interactions with the resident.
- Many people are called by a nickname or middle name throughout their life. It is important to call residents by the name they prefer in order to establish comfort and respect between staff and resident. Also, some cognitively impaired or hearing impaired residents might have difficulty responding when called by their legal name, if it is not the name most familiar to them.
- Others may prefer a more formal and less familiar address. For example, a physician might appreciate being referred to as "Doctor."

Draft

A1300: Optional Resident Items (cont.)

- Knowing a person's lifetime occupation is also helpful for care planning and conversation purposes. For example, a carpenter might enjoy pursuing hobby shop activities.
- These are optional items because they are not needed for CMS program function.

Coding Instructions for A1300A, Medical Record Number

- Enter the resident's medical record number (from the nursing home medical record, admission office or Health Information Management Department) if the nursing home chooses to exercise this option.

Coding Instructions for A1300B, Room Number

- Enter the resident's room number if the nursing home chooses to exercise this option.

Coding Instructions for A1300C, Name by Which Resident Prefers to Be Addressed

- Enter the resident's preferred name. This field captures a preferred nickname, middle name, or title that the resident prefers staff use.
- Obtained from resident self-report or family or significant other if resident is unable to respond.

Coding Instructions for A1300D, Lifetime Occupation(s)

- Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the nursing home. When two occupations are identified, place a slash (/) between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker." For a resident who is a child or an intellectually disabled/developmentally disabled adult resident who has never had an occupation, record as "none."

Draft

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01, 03, 04, or 05

Enter Code ☐

Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when an SCSA is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.[1]
- Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html for CMS information on PASRR.

[1] The statute may also be referenced as 42 USC 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

Planning for Care

- The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.
- The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to Resident Review upon change in condition.

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, SCSA, Significant Correction to Prior Comprehensive Assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

- **Code 0, no:** and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:
  - PASRR Level I screening did not result in a referral for Level II screening, or
  - Level II screening determined that the resident does not have a serious MI and/or ID/DD or related conditions, or
  - PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which they received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

Draft

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- **Code 1, yes:** if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.
- **Code 9, not a Medicaid-certified unit:** if bed is not in a Medicaid-certified nursing home. Skip to A1550, Conditions Related to ID/DD Status. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.
  - Note that the requirement is based on the certification of the part of the nursing home the resident will occupy. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building.

A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions
Complete only if A0310A = 01, 03, 04, or 05

↓	Check all that apply
☐	A. Serious mental illness
☐	B. Intellectual Disability
☐	C. Other related conditions

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, SCSA, Significant Correction to Prior Comprehensive Assessment).
2. Check all that apply.

Coding Instructions

- **Code A, Serious mental illness:** if resident has been diagnosed with a serious mental illness.
- **Code B, Intellectual Disability:** if resident has been diagnosed with intellectual disability/developmental disability.
- **Code C, Other related conditions:** if resident has been diagnosed with other related conditions.

Draft

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status

A1550. Conditions Related to ID/DD Status
If the resident is 22 years of age or older, complete only if A0310A = 01
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

☐ A. Down syndrome
☐ B. Autism
☐ C. Epilepsy
☐ D. Other organic condition related to ID/DD

ID/DD Without Organic Condition

☐ E. ID/DD with no organic condition

No ID/DD

☐ Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

1. If resident is 22 years of age or older on the ARD, complete only if A0310A = 01 (Admission assessment).
2. If resident is 21 years of age or younger on the ARD, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, SCSA, Significant Correction to Prior Comprehensive Assessment).

Coding Instructions

- Check all conditions related to ID/DD status that were present before age 22.
- When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- **Code A:** if Down syndrome is present.
- **Code B:** if autism is present.
- **Code C:** if epilepsy is present.
- **Code D:** if other organic condition related to ID/DD is present.

DEFINITIONS

DOWN SYNDROME
A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.

AUTISM
A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.

EPILEPSY
A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.

Draft

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status (cont.)

- **Code E:** if an ID/DD condition is present but the resident does not have any of the specific conditions listed.
- **Code Z:** if ID/DD condition is not present.

DEFINITION

OTHER ORGANIC CONDITION RELATED TO ID/DD

Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

A1600–A1805: Most Recent Admission/Entry or Reentry into this Facility

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**

A1805. Entered From

Enter Code ☐☐

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

Draft

A1600: Entry Date

Most Recent Admission/Entry or Reentry into this Facility
A1600. Entry Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Item Rationale

- To document the date of admission/entry or reentry into the facility.

DEFINITION

ENTRY DATE
The initial date of admission to the facility, or the date the resident most recently returned to your facility after being discharged.

Coding Instructions

- Enter the most recent date of admission/entry or reentry to this facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
- In the case of an interrupted stay, the return date (i.e., date of continuation of Medicare Part A stay in the same SNF) is entered in A1600 using the format above.

A1700: Type of Entry

A1700. Type of Entry

Enter Code ☐
1. Admission
2. Reentry

Item Rationale

- Captures whether date in A1600 is an admission/entry or reentry date.

Coding Instructions

- **Code 1, admission:** when one of the following occurs:
  1. resident has never been admitted to this facility before; OR
  2. resident has been in this facility previously and was discharged return not anticipated; OR
  3. resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- **Code 2, reentry:** when all three of the following occurred prior to this entry; the resident was:
  1. admitted to this facility, AND
  2. discharged return anticipated, AND
  3. returned to facility within 30 days of discharge.

Draft

A1805: Entered From

A1805. Entered From

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

Item Rationale

- Knowing the setting the individual was in immediately prior to facility admission/entry or reentry informs the delivery of services and care planning that the resident receives during their stay and may also inform discharge planning. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.
- Demographic information.

Steps for Assessment

1. Review transfer and admission records.
2. Ask the resident and/or family member, significant other, and/or guardian/legally authorized representative.

Coding Instructions

Enter the two-digit code that best describes the setting the resident was in immediately preceding this admission/entry or reentry.

- **Code 01, Home/Community:** if the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly.
- **Code 02, Nursing Home (long-term care facility):** if the resident was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.

DEFINITIONS

PRIVATE HOME OR APARTMENT
Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.

BOARD AND CARE/ ASSISTED LIVING/ GROUP HOME
A non-institutional community residential setting that includes services of the following types: home health services, homemaker/ personal care services, or meal services.

Draft

A1805: Entered From (cont.)

- **Code 03, Skilled Nursing Facility (SNF, swing bed):** if the resident was admitted from a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes residents admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.
- **Code 04, Short-Term General Hospital (acute hospital/IPPS):** if the resident was admitted from a hospital that is contracted with Medicare to provide acute inpatient care and accepts a predetermined rate as payment in full.
- **Code 05, Long-Term Care Hospital (LTCH):** if the resident was admitted from a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit.
- **Code 06, Inpatient Rehabilitation Facility (IRF, free standing facility or unit):** if the resident was admitted from a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents admitted from a rehabilitation unit of a critical access hospital.
- **Code 07, Inpatient Psychiatric Facility (psychiatric hospital or unit):** if the resident was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. This category also includes residents admitted from a psychiatric unit of a critical access hospital.
- **Code 08, Intermediate Care Facility (ID/DD):** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).
- **Code 09, Hospice (home/non-institutional):** if the resident was admitted from a community-based program for terminally ill persons.
- **Code 10, Hospice (institutional facility):** if the resident was admitted from an inpatient program for terminally ill persons where an array of services is necessary 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.
- **Code 11, Critical Access Hospital (CAH):** if the resident was admitted from a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge.
- **Code 12, Home under care of organized home health service organization:** if the resident was admitted from home under care of an organized home health service organization. This includes only skilled services provided by a home health agency.

A1805: Entered From (cont.)

- **Code 99, Not listed:** if the resident was admitted from none of the above.

Coding Tips and Special Populations

- If an individual was enrolled in a home-based hospice program enter **09, Hospice**, instead of **01, Home/Community**.

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

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



Item Rationale

- To document the date this episode of care in this facility began.

Coding Instructions

- Enter the date this episode of care in this facility began. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
- The Admission Date may be the same as the Entry Date (A1600) for the entire stay (i.e., if the resident is never discharged).

Examples

1. Resident H was admitted to the facility from an acute care hospital on 09/14/2020 for rehabilitation after a hip replacement. In completing their Admission assessment, the facility entered 09/14/2020 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 04, Short-Term General Hospital (acute hospital, IPPS) in item A1805, Entered From; and entered 09/14/2020 in item A1900, Admission Date.
2. The facility received communication from an acute care hospital discharge planner stating that Resident H, a former resident of the facility who was discharged home return not anticipated on 11/02/2020 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/2021 and wished to return to the facility for rehabilitation after hospital discharge. Resident H returned to the facility on 2/15/2021. Although Resident H was a resident of the facility in September of 2020, they were discharged home return not anticipated; therefore, the facility rightly considered Resident H as a new admission. In completing their Admission assessment, the facility entered 02/15/2021 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 04, Short-Term General Hospital (acute hospital, IPPS) in item A1805, Entered From; and entered 02/15/2021 in item A1900, Admission Date.

Draft

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

3. Resident K was admitted to the facility on 10/05/2020 and was discharged to the hospital, return anticipated, on 10/20/2020. They returned to the facility on 10/26/2020. Since Resident K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Resident K was considered as continuing in their current stay. Therefore, when the facility completed Resident K's Entry Tracking Record on return from the hospital, they entered 10/26/2020 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 04, Short-Term General Hospital (acute hospital, IPPS) in item A1805; and entered 10/05/2020 in item A1900, Admission Date.

   Approximately a month after their return, Resident K was again sent to the hospital, return anticipated on 11/05/2020. They returned to the facility on 11/22/2020. Again, since Resident K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Resident K was considered as continuing in their current stay. Therefore, when the facility completed Resident K's Entry Tracking Record, they entered 11/22/2020 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 04, Short-Term General Hospital (acute hospital, IPPS) in item A1805; and entered 10/05/2020 in item A1900, Admission Date.

4. Resident S was admitted to the facility on 8/26/2021 for rehabilitation after a total knee replacement. Three days after admission, Resident S spiked a fever and their surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent Resident S to the emergency room and completed their OBRA Discharge assessment as return anticipated. The hospital called the facility to inform them Resident S was admitted. A week into their hospitalization, Resident S developed a blood clot in their affected leg, further complicating their recovery. The facility was contacted to readmit Resident S for rehabilitative services following discharge from the hospital on 10/10/2021. Even though Resident S was a former patient in the facility's rehabilitation unit and was discharged return anticipated, they did not return within 30 days of discharge to the hospital. Therefore, Resident S is considered a new admission to the facility. On their return, when the facility completed Resident S's Admission assessment, they entered 10/10/2021 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 04, Short-Term General Hospital (acute hospital, IPPS) in item A1805, Entered From; and entered 10/10/2021 in item A1900, Admission Date.

Coding Tips and Special Populations

- Both swing bed facilities and nursing homes must apply the above instructions for coding items A1600 through A1900 to determine whether a patient or resident is an admission/entry or reentry.
- In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

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

- If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same.
- If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900.
- Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1805 (Entered From). It is also tied to the concepts of a "stay" and an "episode." A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident's time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.
- A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.
- When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1805 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1805 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began their first stay in the episode).

DRAFT

A2000: Discharge Date

A2000. Discharge Date
Complete only if A0310F = 10, 11, or 12



Item Rationale

- Closes the episode in iQIES.

Coding Instructions

- Enter the date the resident was discharged (whether or not return is anticipated). This is the date the resident leaves the facility.
- For OBRA Discharge assessments, the Discharge Date (A2000) and ARD (A2300) must be the same date.
- Do not include leave of absence or hospital observational stays less than 24 hours unless admitted to the hospital.
- Obtain data from the medical, admissions or transfer records.

Coding Tips and Special Populations

- A Part A PPS Discharge assessment (NPE Item Set) is required under the SNF QRP when the resident's Medicare Part A stay ends, but the resident does not leave the facility.
- The PPS Discharge assessment is completed whenever a Medicare Part A stay ends. The PPS Discharge assessment must be combined with the OBRA Discharge assessment when the Medicare Part A stay ends on or one day prior to the day of discharge from the facility. When the OBRA and Part A discharge assessments are combined, the ARD (A2300) must be equal to the day of discharge from the facility (A2000).
- The PPS Discharge assessment is also completed when the resident's Medicare Part A stay ends, but the resident remains in the facility. When this occurs, the ARD (A2300) of the PPS Discharge assessment must be the last Medicare Part A covered day. The PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met (please see Section 2.10 Combining PPS Assessments and OBRA Assessments).

Draft

A2105: Discharge Status

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

Item Rationale

- This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. See the Glossary and Common Acronyms in Appendix A for additional descriptions of these settings.
- Demographic and outcome information.

Steps for Assessment

1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location.

Coding Instructions

Select the two-digit code that corresponds to the resident's discharge status.

- **Code 01, Home/Community:** if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly.
- **Code 02, Nursing Home (long-term care facility):** if the resident was discharged to an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.

Draft

A2105: Discharge Status (cont.)

- **Code 03, Skilled Nursing Facility (SNF, swing beds):** if the resident was discharged to a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes patients admitted from a SNF swing bed in a swing bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.
- **Code 04, Short-Term General Hospital (acute hospital/IPPS):** if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full.
- **Code 05, Long-Term Care Hospital (LTCH):** if the resident was discharged to a Medicare certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit.
- **Code 06, Inpatient Rehabilitation Facility (IRF, free standing facility or unit):** if the resident was discharged to a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents discharged to a rehabilitation unit of a critical access hospital.
- **Code 07, Inpatient Psychiatric Facility (psychiatric hospital or unit):** if the resident was discharged to an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents. This category also includes residents discharged to a psychiatric unit of a critical access hospital.
- **Code 08, Intermediate Care Facility (ID/DD):** if the resident was discharged to an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual disabilities (ID) or developmental disabilities (DD).
- **Code 09, Hospice (home/non-institutional):** if the resident was discharged to a community-based program for terminally ill persons.
- **Code 10, Hospice (institutional facility):** if the resident was discharged to an inpatient program for terminally ill persons where an array of services is necessary 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.
- **Code 11, Critical Access Hospital (CAH):** if the resident was discharged to a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria to be designated by CMS as a CAH and was receiving acute care services from the CAH at the time of discharge.

DRAFT

A2105: Discharge Status (cont.)

- **Code 12, Home under care of organized home health service organization:** if the resident was discharged home under care of an organized home health service organization. This includes only skilled services provided by a home health agency.
- **Code 13, deceased:** if resident is deceased.
- **Code 99, Not listed:** if the resident was discharged to none of the above.

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

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

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1 and A2105 = 02-12

Enter Code ☐

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

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

Item Rationale

- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care and help subsequent providers reconcile medications, and it may mitigate adverse outcomes related to medications. Communication of medication information at discharge is critical to ensure safe and effective transitions from one health care setting to another.

Steps for Assessment

1. Determine whether the resident was discharged to one of the subsequent providers defined below under Coding Tips, based on discharge location item A2105.
2. If yes, determine whether, at the time of discharge, your facility provided a current reconciled medication list to the resident's subsequent provider.

Coding Instructions

- **Code 0, No:** if at discharge to a subsequent provider, your facility did not provide the resident's current reconciled medication list to the subsequent provider, or the resident was not discharged to a subsequent provider.
- **Code 1, Yes:** if at discharge to a subsequent provider, your facility did provide the resident's current reconciled medication list to the subsequent provider.

Draft

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

Coding Tips

- **Subsequent provider**—For the purposes of coding this item, a subsequent provider is based on the discharge locations in A2105 and defined as any of the following:

  02. Nursing home (long-term care facility)
  03. Skilled nursing facility (SNF, swing beds)
  04. Short-term general hospital (acute hospital, IPPS)
  05. Long-term care hospital (LTCH)
  06. Inpatient rehabilitation facility (IRF, free standing facility or unit)
  07. Inpatient psychiatric facility (psychiatric hospital or unit)
  08. Intermediate care facility (ID/DD facility)
  09. Hospice (home/non-institutional)
  10. Hospice (institutional facility)
  11. Critical access hospital (CAH)
  12. Home under care of organized home health service organization

- While the resident may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be a subsequent provider for the purpose of coding this item.

  Current Reconciled Medication list—This refers to a list of the resident's current medications at the time of discharge that was reconciled by the facility prior to the resident's discharge.

DEFINITION

MEANS OF PROVIDING A CURRENT RECONCILED MEDICATION LIST

Providing the current reconciled medication list at the time of transfer or discharge can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record [EHR]), giving providers access to a portal).[2]

- Your facility should be guided by current standards of care and any applicable regulations and guidelines (e.g., Requirements of Participation) in determining what information should be included in a current reconciled medication list.
- In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes.

[2] A portal is a secure online website that gives providers, patients, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, providers and patients can view health information such as current medications, recent doctor visits and discharge summaries. Retrieved from https://www.healthit.gov/faq/what-patient-portal April 2, 2019.

Draft

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

- In the case of a standalone Medicare Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1) and the resident is moving to a different unit and/or interdisciplinary team (IDT), code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

Additional Considerations for Important Medication List Content

- The following information on the important content that may be included in a reconciled medication list is provided as guidance. This guidance does not dictate what information should be included in your facility's current reconciled medication list in order to code 1, Yes, that a current reconciled medication list was provided to the subsequent provider. The completeness of this reconciled medication list is left to the discretion of the providers who are coordinating this care with the resident. Examples of information that could be part of a reconciled medication list can be, but are not limited to:
  - **Types of medications**—Current prescribed and over-the-counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route at the time of discharge. Medications may also include total parenteral nutrition (TPN) and oxygen.
  - The list of reconciled medications could include those that are:
    - active, including those that are scheduled to be discontinued after discharge;
    - held during the stay and planned to be continued/resumed after discharge; and
    - discontinued during the stay, if potentially relevant to the resident's subsequent care.
  - **Information included**—A reconciled medication list often includes important information about (1) the resident—including their name, date of birth, active diagnoses, known medication and other allergies, and known drug sensitivities and reactions; and (2) each medication, including the name, strength, dose, route of medication administration, frequency or timing, purpose/indication, and any special instructions (e.g., crush medications). For any held medications, it may include the reason for holding the medication and when medication should resume. This information can improve medication safety. Additional information may be applicable and important to include in the medication list, such as the resident's weight and date taken, preferred language, and ability to self-administer medication; when the last dose of the medication was administered by the discharging provider; and when the final dose should be administered (e.g., end of treatment).

DRAFT

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

Examples

1. Resident B is being discharged from the SNF to an acute care hospital in the same health care system that uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see Definitions: EHR/EMR and definition in the glossary). Resident B's current reconciled medication list at the time of discharge from the SNF is accessible to the subsequent acute care hospital staff admitting Resident B, and this is how the medication list is shared.

   Coding: A2121 would be coded 1, Yes.

   Rationale: Having access to Resident B's medication list through the same EHR system is one way to transfer a medication list. This code of 1, Yes, is used for this passive means of transferring the medication list when the sending and receiving provider can access the same EHR system.

2. Resident D is not taking any prescribed or over-the-counter medications at the time of discharge.

   Coding: If the lack of any medications for a resident is clearly documented and communicated to the subsequent provider when the resident is discharged, code 1, Yes, that the medication list was transferred. If this information is not communicated to the subsequent provider, code 0, No.

   Rationale: Information confirming that the resident is not taking any medications at discharge is important for the subsequent provider.

3. Resident F was transferred to an acute care hospital with a reconciled medication list that included a list of their current medications, but with less additional information than is usually provided by the SNF at discharge because of the urgency of the situation. Some of the contraindications for the medications, as well as resident weight and height and dates taken, were omitted from the medication list.

   Coding: A2121 would be coded 1, Yes.

   Rationale: As long as a current reconciled list of medications is provided to the admitting provider, this item should be coded 1, Yes.

4. Resident J's Medicare Part A stay ended, and they were transferred to a long-term care unit in the same nursing home. The IDT from the subacute unit staff provided and reviewed with the long-term care unit staff a reconciled medication list at the time of transfer.

   Coding: A2121 would be coded 1, Yes.

   Rationale: If a current reconciled list of medications is provided to the subsequent provider (in this case, a different unit staff in the same nursing home), this item should be coded 1, Yes.

DRAFT

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

5. Resident P's Medicare Part A stay ended, and they remained in the same dually certified bed in the nursing home with care provided by the same IDT.

   Coding: A2121 would be coded 1, Yes

   Rationale: As the same IDT continued to care for Resident P and have access to the current list of reconciled medications, this item should be coded 1, Yes.

6. Resident G's reconciled medication list was electronically faxed to the subsequent provider, and this action is documented in their clinical record. However, the subsequent provider's records do not show documentation that the fax was successfully received.

   Coding: A2121, would be coded 1, Yes.

   Rationale: Documentation of the subsequent provider's successful receipt of the reconciled medication list is not a required component for this item.

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

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

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

The guidance below addresses coding A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider. Assessors should apply this same guidance to A2124. Route of Current Reconciled Medication List Transmission to Resident.

Item Rationale

This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

1. Identify all routes of transmission that were used to provide the resident's current reconciled medication list to the subsequent provider.

Draft

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

Coding Instructions

Select the codes that correspond to the routes of transmission used to provide the medication list to the subsequent provider.

- **Check A2122A, Electronic Health Record:** if your facility has an EHR, sometimes referred to as an electronic medical record (EMR), and used it to transmit or provide access to the reconciled medication list to the subsequent provider. This would include situations in which both the discharging and receiving provider have direct access to a common EHR system. Checking this route does not require confirmation that the subsequent provider has accessed the common EHR system for the medication list.
- **Check A2122B, Health Information Exchange:** if your facility participates in a Health Information Exchange (HIE) and used the HIE to electronically exchange the current reconciled medication list with the subsequent provider.
- **Check A2122C, Verbal:** if the current reconciled medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider.
- **Check A2122D, Paper-Based:** if the current reconciled medication list was transmitted to the subsequent provider using a paper-based method such as a printout, fax, or eFax.
- **Check A2122E, Other Methods:** if the current reconciled medication list was transmitted to the subsequent provider using another method not listed above (e.g., texting, email, CDs).

DEFINITIONS

EHR/EMR

An electronic health record (EHR), sometimes referred to as an electronic medical record (EMR), is an electronic version of a resident's medical history that is maintained by the provider over time.[3]

PORTAL

A portal is a secure online website that gives providers, residents, and others convenient, 24-hour access to personal health information from anywhere with an Internet connection.[4]

DRAFT

[3] https://www.healthit.gov/faq/what-electronic-health-record-ehr.

[4] Office of the National Coordinator, What is a patient portal? Available from https://www.healthit.gov/faq/what-patient-portal, Accessed June 10, 2019.

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

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

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1 and A2105 = 01, 99

Enter Code ☐

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

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

Item Rationale

- Communication of medication information to the resident at discharge is critical to ensuring safe and effective discharges. The item, collected at the time of discharge, can improve care coordination and quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- It is recommended that a reconciled medication list that is provided to the resident, family member, guardian/legally authorized representative, or caregiver use consumer-friendly terminology and plain language to ensure that the information provided is clear and understandable.[5]

Steps for Assessment

1. Determine whether the resident was discharged to a home setting, 01, defined below under Coding Tips, or 99, Not Listed based on discharge location item A2105.
2. If yes, determine whether, at discharge, your facility provided the resident's medication list to the resident, family member, guardian/legally authorized representative, and/or caregiver.

Coding Instructions

- **Code 0, No:** if at discharge to a home setting (A2105 = 01) or a not listed location (A2105 = 99), your facility did not provide the resident's current reconciled medication list to the resident, family, guardian/legally authorized representative, and/or caregiver.
- **Code 1, Yes:** if at discharge to a home setting (A2105 = 01) or a not listed location (A2105 = 99), your facility did provide the resident's current reconciled medication list to the resident, family, guardian/legally authorized representative, and/or caregiver.

[5] For examples of plain language resources for healthcare information see: https://www.plainlanguage.gov/resources/content-types/healthcare/

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

Coding Tips

- **Resident, family, significant other, guardian/legally authorized representative and/or caregiver**—The recipient of the current reconciled medication list can be the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

Examples

1. Resident D does not take any prescribed or over-the-counter medications at the time of discharge.

   Coding: If it is clearly documented that the resident is taking no medications and this is then clearly communicated to the resident, family member, significant other, and/or caregiver when the resident is discharged, A2123 would be coded 1, Yes, that the medication list was transferred. If this information is not communicated to the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver, code 0, No.

   Rationale: Information confirming that the resident is not taking any medications at discharge is important for the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver.

2. Resident F is cognitively impaired and unable to manage their medications after discharge. Their medication list is provided to their sibling, who will be their primary caregiver.

   Coding: A2123 would be coded 1, Yes.

   Rationale: The medication list must be provided to the resident, family member, significant other, guardian/legally authorized representative, and/or a caregiver in order to code 1, Yes. In this example, Resident F's sibling is a family member and a caregiver, so code 1, Yes.

3. Resident P chooses to leave the facility before their treatment is completed. They tell the charge nurse on their way out the door that their ride is waiting for them and they are going home. The charge nurse explains that they have not completed their course of treatment and are not ready to be discharged, but they insist that they are leaving now and proceed out of the facility.

   Coding: A2123 would be coded 0, No.

   Rationale: No medication list review was completed, and no medication list was provided to Resident P as they left against medical advice and did not want to keep their ride waiting.

Draft

A2124. Route of Current Reconciled Medication List Transmission to Resident

A2124. Route of Current Reconciled Medication List Transmission to Resident
Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

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

Item Rationale

This item collects important data to monitor how medication lists are transmitted at discharge.

Steps for Assessment

1. Identify all routes of transmission that were used to provide the resident's current reconciled medication list to the resident, family member, significant other, guardian/legally authorized representative, and/or caregiver.

Coding Instructions

Please refer to the coding instructions for A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider.

Coding Tips for A2122 and A2124

- The route of transmission usually is established with each subsequent provider, depending on how it is able to receive information from your facility. The route(s) may not always be documented in the resident's record. It will be helpful to understand and document how your facility typically transmits information to each subsequent provider at discharge to prepare for coding this item.
- More than one route of transmission may apply. Check all that apply.

Draft

A2124. Route of Current Reconciled Medication List Transmission to Resident (cont.)

Examples

1. A SNF is discharging and sending a resident to a hospital by ambulance. The driver obtains a printout and brings the resident's medication list to the hospital. The facility follows up with a call to the subsequent provider and discusses the resident's medications.

   Coding: Check paper-based (D) and verbal (C) for A2122.

   Rationale: Two routes for transmitting the medication list information were used—a paper copy of the list (D) and follow up verbal discussion (C). Both of these occurred at the time of discharge.

2. One of a SNF's referral HHAs is preparing to admit a resident who will discharge soon. The HHA intake nurse has secure access to the SNF's EHR to obtain important care planning information from the resident's records, including the medication list.

   Coding: Check Electronic Health Record (A) for A2122.

   Rationale: The SNF provided access to the resident's medication list through its EHR. Even if there is no confirmation that the intake nurse accessed the medication list from the SNF's EHR system, code EHR (A) because it was made available by the SNF.

3. Resident P receives a paper copy of their medication list, receives education about their medications from the SNF nurse at discharge, and is notified that the SNF's patient portal is another means by which they can obtain their discharge medication list.

   Coding: Check Electronic Health Record (A), verbal (C), and paper-based (D) for A2124.

   Rationale: The copy of the medication list is paper-based (D). The information about Resident P's medication list was also communicated verbally by the nurse at the time of discharge (C). The resident portal uses the SNF's EHR to provide access to the medication list (A). It is not necessary to confirm that Resident P is a registered user of and accessed the patient portal in order to code EHR (A) as a route.

Draft

A2124. Route of Current Reconciled Medication List Transmission to Resident (cont.)

4. A SNF participates in a regional HIE as does a local acute care hospital. When residents are discharged to this acute care hospital, the SNF's discharge medication list is included in the medications section of a transfer summary document from its EHR, which is electronically exchanged through the HIE. The acute care hospital is then able to obtain and integrate the medication information into its EHR.

   Coding: Check Electronic Health Record (A) and Health Information Exchange (B) for A2122.

   Rationale: The medication information is exchanged by the regional HIE through health IT standards. Sending the medication information in transfer summary allows the acute care hospital to integrate the medication information into its EHR. Code as EHR (A), since it was used to generate and exchange the information, and as HIE (B), since it is the means through which information exchange is possible with external providers.

5. A SNF has developed an interface that allows documents from its EHR to be electronically faxed to the subsequent provider. The SNF's EHR connects via a phone line to a designated receiver's secure email at the subsequent provider.

   Coding: Check paper-based (D) for A2122.

   Rationale: Faxing information is considered paper-based as faxed documents are comparable to hard-copy documents and not computable.

6. A SNF generates the current reconciled medication list electronically from the medication administration record (MAR) and treatment administration record (TAR) and electronically sends via secure email to the subsequent provider.

   Coding: Check Other Method (E) for A2122.

   Rationale: Providing the medication list through secure email is considered "Other Method" for coding this item. The source of the medication list is not the EHR, and the list is not transmitted directly to the subsequent provider's EHR, so do NOT check EHR (A).

Draft

A2200: Previous Assessment Reference Date for Significant Correction

A2200. Previous Assessment Reference Date for Significant Correction
Complete only if A0310A = 05 or 06

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Item Rationale

- To identify the ARD of a previous comprehensive (A0310 = 01, 03, or 04) or Quarterly assessment (A0310A = 02) in which a significant error is discovered.

Coding Instructions

- Complete only if A0310A = 05 (Significant Correction to Prior Comprehensive Assessment) or A0310A = 06 (Significant Correction to Prior Quarterly Assessment).
- Enter the ARD of the prior comprehensive or Quarterly assessment in which a significant error has been identified and a correction is required.

A2300: Assessment Reference Date

A2300. Assessment Reference Date

Observation end date:
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Item Rationale

- Designates the end of the observation period so that all assessment items refer to the resident's status during the same period of time.

  As the last day of the observation period, the ARD serves as the reference point for determining the care and services captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for an MDS item with a 7-day observation period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this observation period. For an item with a 14-day observation period, the information is collected for a 14-day period ending on and including the ARD. The observation period includes observations and events through the end of the day (midnight) of the ARD.

Draft

A2300: Assessment Reference Date (cont.)

Steps for Assessment

1. Interdisciplinary team members should select the ARD based on the reason for the assessment and compliance with all timing and scheduling requirements outlined in Chapter 2.

Coding Instructions

- Enter the appropriate date on the lines provided. Do not leave any spaces blank. If the month or day contains only a single digit, enter a "0" in the first space. Use four digits for the year. For example, October 2, 2010, should be entered as: 10-02-2010.
- For detailed information on the timing of the assessments, see Chapter 2 on assessment schedules.
- For discharge assessments, the discharge date item (A2000) and the ARD item (A2300) must contain the same date.

Coding Tips and Special Populations

- When the resident dies or is discharged prior to the end of the observation period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The observation period may not be extended simply because a resident was out of the nursing home during part of the observation period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the observation period, the 2 leave days are still considered part of the observation period.
- When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to their home for a holiday and the resident falls, the assessor will capture the fall in J1900: **Number of Falls Since Admission/Entry or Reentry or Prior Assessment** (OBRA or Scheduled PPS), whichever is more recent. This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

DEFINITION

ASSESSMENT REFERENCE DATE (ARD)

The specific end-point for the observation periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, this observation period, also called the look-back or assessment period, is a 7-day period ending on the ARD. Observation periods may cover the 7 days ending on this date, 14 days ending on this date, etc.

DRAFT

A2400: Medicare Stay

A2400. Medicare Stay

Complete only if A0310G1 = 0

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

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Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Item Rationale

- Identifies when a resident is receiving services under the scheduled PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.

Coding Instructions for A2400A, Has the Resident Had a Medicare-covered Stay since the Most Recent Entry?

- **Code 0, no:** if the resident has not had a Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.
- **Code 1, yes:** if the resident has had a Medicare Part A covered stay since the most recent admission/entry or reentry. Continue to A2400B.

Coding Instructions for A2400B, Start of Most Recent Medicare Stay

- **Code the date of day 1** of this Medicare stay if A2400A is **coded 1, yes**.

Coding Instructions for A2400C, End Date of Most Recent Medicare Stay

- **Code the date of last day** of this Medicare stay if A2400A is **coded 1, yes**.

DEFINITIONS

MOST RECENT MEDICARE STAY
This is a Medicare Part A covered stay that has started on or after the most recent admission/entry or reentry to the nursing facility.

MEDICARE-COVERED STAY
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

CURRENT MEDICARE STAY
NEW ADMISSION: Day 1 of Medicare Part A stay.
READMISSION: Day 1 of Medicare Part A coverage after readmission following a discharge.

Draft

A2400: Medicare Stay (cont.)

- If the Medicare Part A stay is ongoing, there will be no end date to report. Enter dashes to indicate that the stay is ongoing.
- The end of Medicare date is coded as follows, whichever occurs first:
  - Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
  - Date of last day covered as recorded on the effective date from the Notice of Medicare Non-Coverage (NOMNC); or
  - The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
  - Date the resident was discharged from the facility (see Item A2000, Discharge Date).

Coding Tips and Special Populations

- When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- The End Date of the Most Recent Medicare Stay (A2400C) may be **earlier** than the actual Discharge Date (A2000) from the facility. If this occurs, the Part A PPS Discharge assessment is required. If the resident subsequently physically leaves the facility, the OBRA Discharge assessment would be required.
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the same day** that the resident dies, a Death in Facility Tracking Record is completed, with the Discharge Date (A2000) equal to the date the resident died. In this case, a Part A PPS Discharge assessment is **not** required.
- For a **standalone** Part A PPS Discharge assessment, the End Date of the Most Recent Medicare Stay (A2400C) must be equal to the ARD (Item A2300).

DRAFT

A2400: Medicare Stay (cont.)

Examples

1. Resident G. began receiving services under Medicare Part A on October 14, 2021. Due to their stable condition and ability to manage their medications and dressing changes, the facility determined that they no longer qualified for Part A SNF coverage and began planning their discharge. An Advanced Beneficiary Notice (ABN) and an NOMNC with the last day of coverage as November 23, 2021 were issued. Resident G. was discharged home from the facility on November 24, 2021. Code the following on their combined OBRA and Part A PPS Discharge assessment:

   - A0310F = 10
   - A0310G = 1
   - A0310H = 1
   - A2000 = 11-24-2021
   - A2105 = 01
   - A2300 = 11-24-2021
   - A2400A = 1
   - A2400B = 10-14-2021
   - A2400C = 11-23-2021

   Rationale: Because Resident G's last day covered under Medicare was one day before their physical discharge from the facility, a combined OBRA and Part A PPS Discharge was completed.

2. Resident N began receiving services under Medicare Part A on December 11, 2021. They were unexpectedly sent to the emergency department on December 19, 2021 at 8:30 p.m. and were not admitted to the hospital. They returned to the facility on December 20, 2021, at 11:00 a.m. Upon Resident N's return, their physician's orders included significant changes in their treatment regime. The facility staff determined that an Interim Payment Assessment (IPA) was indicated as the PDPM nursing component was impacted. They completed the IPA with an ARD of December 24, 2021. Code the following on the IPA:

   - A2400A = 1
   - A2400B = 12-11-2021
   - A2400C = ----------

   Rationale: Resident N was out of the facility at midnight but returned in less than 24 hours and was not admitted to the hospital, so was considered LOA. Therefore, no Discharge assessment was required. Their Medicare Part A Stay is considered ongoing; therefore, the date in A2400C is dashed.

Draft

A2400: Medicare Stay (cont.)

3. Resident R. began receiving services under Medicare Part A on October 15, 2021. Due to complications from their recent surgery, they were unexpectedly discharged to the hospital for emergency surgery on October 20, 2021, but are expected to return within 30 days. Code the following on their OBRA Discharge assessment:

   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 10-20-2021
   - A2105 = 03
   - A2300 = 10-20-2021
   - A2400A = 1
   - A2400B = 10-15-2021
   - A2400C = 10-20-2021

   Rationale: Resident R's physical discharge to the hospital was unplanned, yet it is anticipated that they will return to the facility within 30 days. Therefore, only an OBRA Discharge was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

4. Resident K began receiving services under Medicare Part A on October 4, 2021. They were discharged from Medicare Part A services on December 17, 2021. They and their family had already decided that Resident K would remain in the facility for long-term care services, and they were moved into a private room (which was dually certified) on December 18, 2021. Code the following on their Part A PPS Discharge assessment:

   - A0310F = 99
   - A0310G = ^
   - A0310H = 1
   - A2000 = ^
   - A2105 = ^
   - A2300 = 12-17-2021
   - A2400A = 1
   - A2400B = 10-04-2021
   - A2400C = 12-17-2021

   Rationale: Because Resident K's Medicare Part A stay ended, and they remained in the facility for long-term care services, a **standalone** Part A PPS Discharge was required.

Draft

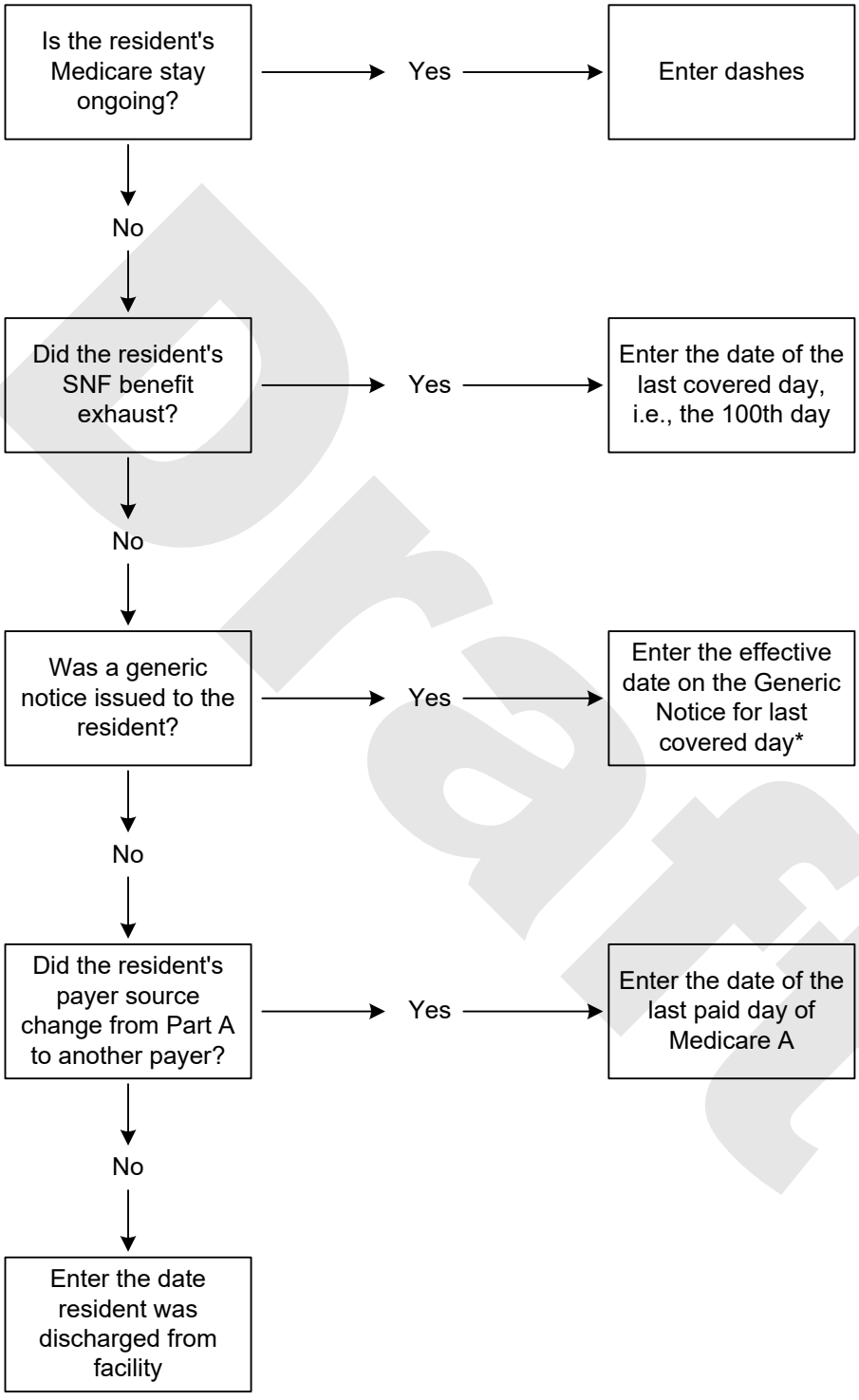
A2400: Medicare Stay (cont.)

5. Resident W began receiving services under Medicare Part A on November 15, 2021. Their Medicare Part A stay ended on November 25, 2021, and they were unexpectedly discharged to the hospital on November 26, 2021. However, they are expected to return to the facility within 30 days. Code the following on their OBRA Discharge assessment:
   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 11-26-2021
   - A2105 = 03
   - A2300 = 11-26-2021
   - A2400A = 1
   - A2400B = 11-15-2021
   - A2400C = 11-25-2021

   Rationale: Resident W's Medicare stay ended the day before discharge and they are expected to return to the facility within 30 days. Because their discharge to the hospital was unplanned, only an OBRA Discharge assessment was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

Draft

Medicare Stay End Date Algorithm
A2400C



*if resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

Draft

SECTION B: HEARING, SPEECH, AND VISION

Intent: The intent of items in this section is to document whether the resident is comatose, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, and the resident's ability to see objects nearby in their environment.

B0100: Comatose

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness

0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to GG0100, Prior Functioning: Everyday Activities

Item Rationale

Health-related Quality of Life

- Residents who are in a coma or persistent vegetative state are at risk for the complications of immobility, including skin breakdown and joint contractures.

Planning for Care

- Care planning should center on eliminating or minimizing complications and providing care consistent with the resident's health care goals.

DEFINITION

COMATOSE (coma)
A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; they do not open their eyes, do not speak and do not move their extremities on command or in response to noxious stimuli (e.g., pain).

Steps for Assessment

1. Review the medical record to determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

Coding Instructions

- **Code 0, no:** if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. Continue to B0200 **Hearing**.
- **Code 1, yes:** if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section GG, **Functional Abilities**.

DRAFT

B0100: Comatose (cont.)

Coding Tips

- Only code if a diagnosis of coma or persistent vegetative state has been assigned. For example, some residents in advanced stages of progressive neurologic disorders such as Alzheimer's disease may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here.

DEFINITION

PERSISTENT VEGETATIVE STATE

Sometimes residents who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.

B0200: Hearing

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)

0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders.
- Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment.

Planning for Care

- Address reversible causes of hearing difficulty (such as cerumen impaction).
- Evaluate potential benefit from hearing assistance devices.
- Offer assistance to residents with hearing difficulties to avoid social isolation.

Draft

B0200: Hearing (cont.)

- Consider other communication strategies for persons with hearing loss that is not reversible or is not completely corrected with hearing devices.
- Adjust environment by reducing background noise by lowering the sound volume on televisions or radios, because a noisy environment can inhibit opportunities for effective communication.

Steps for Assessment

1. Ensure that the resident is using their normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational.
2. Interview the resident and ask about hearing function in different situations (e.g. hearing staff members, talking to visitors, using the telephone, watching TV, attending activities).
3. Observe the resident during your verbal interactions and when they interact with others throughout the day.
4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone, speak more slowly or use gestures. The resident may need to see your face to understand what you are saying, or you may need to take the resident to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record.
6. Consult the resident's family, caregivers, direct care staff, activities personnel, and speech or hearing specialists.

Coding Instructions

- **Code 0, adequate:** No difficulty in normal conversation, social interaction, or listening to TV. The resident hears all normal conversational speech and telephone or group conversation.
- **Code 1, minimal difficulty:** Difficulty in some environments (e.g., when a person speaks softly or the setting is noisy). The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The resident's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- **Code 2, moderate difficulty:** Speaker has to increase volume and speak distinctly. Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

Draft

B0200: Hearing (cont.)

- **Code 3, highly impaired:** Absence of useful hearing. The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Coding Tips for Special Populations

- Residents who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The resident can be observed in their normal environment. Do they respond (e.g., turn their head) when a noise is made at a normal level? Does the resident seem to respond only to specific noise in a quiet environment? Assess whether the resident responds only to loud noise or do they not respond at all.

Examples

1. "When I'm at home, I usually keep the TV on a low volume and hear it just fine. When I have visitors, I can hear people from across the room."

   Coding: B0200 would be coded **0, Adequate.**

   Rationale: The resident hears normal conversational speech.

2. "Sitting at the dinner table, I can hear people who are sitting close by me within five feet, but not much if they are sitting down one end of the table speaking at a normal volume, and I'm at the other end of the table about eight feet away."

   Coding: B0200 would be coded **1. Minimal Difficulty.**

   Rationale: The resident has difficulty in some situations (when someone is sitting farther away) but can hear clearly when someone is sitting close.

3. The resident failed to respond during an interview with the assessor despite the interviewer increasing the volume of their voice and speaking distinctly. The resident's family shared that the resident cannot hear the spoken word, even when they are directly facing the resident and speak loudly and distinctly, and they noted that they often use a picture board to point to things to communicate with the resident.

   Coding: B0200 would be coded **3, Highly Impaired.**

   Rationale: The resident has no comprehension of conversational speech, even when the speaker makes maximum adjustments.

DRAFT

B0200: Hearing (cont.)

4. "I have trouble following normal conversations, especially when a lot of different people are talking at the same time. I can usually make out what someone is saying if they talk a little louder and make sure they speak clearly and I can see their face when they are talking to me."

Coding: B0200 would be coded **2. Moderate Difficulty.**

Rationale: The resident has difficulty hearing people in conversation, but comprehension is improved when the speaker makes adjustments like speaking at high volume, speaking clearly, and sitting close by so that the speaker's face is visible.

B0300: Hearing Aid

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to social isolation and mood and behavior disorders.
- Many residents with impaired hearing could benefit from hearing aids or other hearing appliances.
- Many residents who own hearing aids do not have the hearing aids with them or have nonfunctioning hearing aids upon arrival.

Planning for Care

- Knowing if a hearing aid was used when determining hearing ability allows better identification of evaluation and management needs.
- For residents with hearing aids, use and maintenance should be included in care planning.
- Residents who do not have adequate hearing without a hearing aid should be asked about history of hearing aid use.
- Residents who do not have adequate hearing despite wearing a hearing aid might benefit from a re-evaluation of the device or assessment for new causes of hearing impairment.

Steps for Assessment

1. Prior to beginning the hearing assessment, ask the resident if they own a hearing aid or other hearing appliance and, if so, whether it is at the nursing home.
2. If the resident cannot respond, write the question down and allow the resident to read it.

Draft

B0300: Hearing Aid (cont.)

3. If the resident is still unable, check with family and care staff about hearing aid or other hearing appliances.
4. Check the medical record for evidence that the resident had a hearing appliance in place when hearing ability was recorded.
5. Ask staff and significant others whether the resident was using a hearing appliance when they observed hearing ability (above).

Coding Instructions

- **Code 0, no:** if the resident did not use a hearing aid (or other hearing appliance) for the 7-day hearing assessment coded in **B0200, Hearing.**
- **Code 1, yes:** if the resident did use a hearing aid (or other hearing appliance) for the hearing assessment coded in **B0200, Hearing.**

B0600: Speech Clarity

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern

0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

Item Rationale

Health-related Quality of Life

- Unclear speech or absent speech can hinder communication and be very frustrating to an individual.
- Unclear **speech or absent speech can result in physical and psychosocial needs not being met and can contribute to depression and social isolation.**

DEFINITION

SPEECH
The verbal expression of articulate words.

Planning for Care

- If speech is absent or is not clear enough for the resident to make needs known, other methods of communication should be explored.
- Lack of speech clarity or ability to speak should not be mistaken for cognitive impairment.

Steps for Assessment

1. Listen to the resident.
2. Ask primary assigned caregivers about the resident's speech pattern.
3. Review the medical record.

Draft

B0600: Speech Clarity (cont.)

4. Determine the quality of the resident's speech, not the content or appropriateness—just words spoken.

Coding Instructions

- **Code 0, clear speech:** if the resident usually utters distinct, intelligible words.
- **Code 1, unclear speech:** if the resident usually utters slurred or mumbled words.
- **Code 2, no speech:** if there is an absence of spoken words.

B0700: Makes Self Understood

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**

Item Rationale

Health-related Quality of Life

- Problems making self understood can be very frustrating for the resident and can contribute to social isolation and mood and behavior disorders.
- Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.

Planning for Care

- Ability to make self understood can be optimized by not rushing the resident, breaking longer questions into parts and waiting for reply, and maintaining eye contact (if appropriate).
- If a resident has difficulty making self understood:
  - — Identify the underlying cause or causes.
  - — Identify the best methods to facilitate communication for that resident.

DEFINITION

MAKES SELF UNDERSTOOD

Able to express or communicate requests, needs, opinions, and to conduct social conversation in their 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.

B0700: Makes Self Understood (cont.)

Steps for Assessment

1. Assess using the resident's preferred language or method of communication.
2. Interact with the resident. Be sure they can hear you or have access to their preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.
3. Observe their interactions with others in different settings and circumstances.
4. Consult with the primary nurse assistants (over all shifts) and the resident's family and speech-language pathologist.

Coding Instructions

- **Code 0, understood:** if the resident expresses requests and ideas clearly.
- **Code 1, usually understood:** if the resident has difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. They may have delayed responses or may require some prompting to make self understood.
- **Code 2, sometimes understood:** if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
- **Code 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).

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.

B0800: Ability to Understand Others

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)

0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understood**

Draft

B0800: Ability to Understand Others (cont.)

Item Rationale

Health-related Quality of Life

- Inability to understand direct person-to-person communication
  - — Can severely limit association with others.
  - — Can inhibit the individual's ability to follow instructions that can affect health and safety.

Planning for Care

- Thorough assessment to determine underlying cause or causes is critical in order to develop a care plan to address the individual's specific deficits and needs.
- Every effort should be made by the facility to provide information to the resident in a consistent manner that they understand based on an individualized assessment.

DEFINITION

ABILITY TO UNDERSTAND OTHERS
Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written) or recognition of facial expressions.

Steps for Assessment

1. Assess in the resident's preferred language or preferred method of communication.
2. If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident's understanding of person-to-person communication.
3. Interact with the resident and observe their understanding of other's communication.
4. Consult with direct care staff over all shifts, if possible, the resident's family, and speech-language pathologist (if involved in care).
5. Review the medical record for indications of how well the resident understands others.

Coding Instructions

- **Code 0, understands:** if the resident clearly **comprehends** the message(s) and demonstrates comprehension by words or actions/behaviors.
- **Code 1, usually understands:** if the resident misses some part or intent of the message **but** comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2, sometimes understands:** if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or

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B0800: Ability to Understand Others (cont.)

instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.

- **Code 3, rarely/never understands:** if the resident demonstrates very limited ability to understand communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

B1000: Vision

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

Item Rationale

Health-related Quality of Life

DEFINITION

ADEQUATE LIGHT
Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

- A person's reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

Planning for Care

- Reversible causes of vision impairment should be sought.
- Consider whether simple environmental changes such as better lighting or magnifiers would improve ability to see.
- Consider large print reading materials for persons with impaired vision.
- For residents with moderate, high, or severe impairment, consider alternative ways of providing access to content of desired reading materials or hobbies.

Draft

B1000: Vision (cont.)

Steps for Assessment

1. Ask family, caregivers, and/or direct care staff over all shifts, if possible, about the resident's usual vision patterns during the 7-day look-back period (e.g., is the resident able to see newsprint, menus, greeting cards?).
2. Then ask the resident about their visual abilities.
3. Test the accuracy of your findings:
   - Ensure that the resident's customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
   - Ensure adequate lighting.
   - Ask the resident to look at regular-size print in a book or newspaper. Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.
   - When the resident is unable to read out loud (e.g. due to aphasia, illiteracy), you should test this by another means such as, but not limited to:
     — Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).

Coding Instructions

- **Code 0, adequate:** if the resident sees fine detail, including regular print in newspapers/books.
- **Code 1, impaired:** if the resident sees large print, but not regular print in newspapers/books.
- **Code 2, moderately impaired:** if the resident has limited vision and is not able to see newspaper headlines but can identify objects nearby in their environment.
- **Code 3, highly impaired:** if the resident's ability to identify objects nearby in their environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).
- **Code 4, severely impaired:** if the resident has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes.

Coding Tips and Special Populations

- Some residents have never learned to read or are unable to read English. In such cases, ask the resident to read numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).

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B1000: Vision (cont.)

- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if their eyes seem to follow movement of objects or people. Though these are gross measures of visual acuity, they may assist you in assessing whether or not the resident has any visual ability. For residents who appear to do this, **code 3, highly impaired.**

Examples

1. When asked about whether they can see fine detail, including regular print in newspaper/books, the resident responds, "When I wear my glasses, I can read the paper fine. If I forget to wear glasses, it is harder to see unless I hold the paper a little closer."

   Coding: B1000 would be coded **0, Adequate.**

   Rationale: The resident can read regular print when wearing glasses.

2. The assessor asks the resident to read aloud from a newspaper, starting with larger headlines and then the smaller print. The resident is able to read the headlines but not the regular newspaper print.

   Coding: B1000 would be coded **1. Impaired.**

   Rationale: The resident is able to read large, but not regular, print.

3. "I cannot read the newspaper headlines, even with glasses." When the assessor presents the resident with newspaper text, while wearing glasses, the resident is not able to correctly read the headlines. The resident is able to identify the objects on the table a few feet away.

   Coding: B1000 would be coded **2, Moderately Impaired.**

   Rationale: The resident is not able to read large print (i.e., newspaper headlines) but is able to identify objects in their environment.

4. During the assessment, the resident states, "I cannot see much of anything at this point, I can see blurry shapes and I can tell what large objects are, but I cannot read books anymore—even the ones with giant print. I do okay recognizing my caregivers by their voices, but I couldn't tell you what they look like. Everyone's just a blob of color, even with my glasses on." The resident's eyes appear to follow the assessor when they move about the room. When the assessor presents the resident with newspaper text, while wearing glasses, the resident is able to appropriately reach for and successfully hold the paper but is not able to correctly read the headlines.

   Coding: B1000 would be coded **3, Highly Impaired.**

   Rationale: The resident is able to follow objects and track movement in the environment (e.g., people moving throughout the room) but is unable to see people or objects in detail.

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B1200: Corrective Lenses

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Item Rationale

Health-related Quality of Life

- Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.
- Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.
- Many persons who benefit from and own visual aids do not have them on arrival at the nursing home.

Planning for Care

- Knowing if corrective lenses were used when determining ability to see allows better identification of evaluation and management needs.
- Residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning.
- Residents who do not have adequate vision without eyeglasses or other visual appliances should be asked about history of corrective lens use.
- Residents who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment.

Steps for Assessment

1. Prior to beginning the assessment, ask the resident whether they use eyeglasses or other vision aids and whether the eyeglasses or vision aids are at the nursing home. Visual aids do not include surgical lens implants.
2. If the resident cannot respond, check with family and care staff about the resident's use of vision aids during the 7-day look-back period.
3. Observe whether the resident used eyeglasses or other vision aids during reading vision test (B1000).
4. Check the medical record for evidence that the resident used corrective lenses when ability to see was recorded.
5. Ask staff and significant others whether the resident was using corrective lenses when they observed the resident's ability to see.

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B1200: Corrective Lenses (cont.)

Coding Instructions

- **Code 0, no:** if the resident did not use eyeglasses or other vision aid during the **B1000, Vision** assessment.
- **Code 1, yes:** if corrective lenses or other visual aids were used when visual ability was assessed in completing **B1000, Vision.**

B1300. Health Literacy



Complete only if A0310B = 01 ***or*** *A0310H = 1.*

B1300. Health Literacy
Complete only if A0310B = 01 **or** A0310H = 1

Enter Code ☐

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

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

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

Item Rationale

Health-related Quality of Life

- Similar to language barriers, low health literacy interferes with communication between provider and resident. Health literacy can also affect residents' ability to understand and follow treatment plans, including medication management.
- Poor health literacy is linked to lower levels of knowledge of health, worse outcomes, the receipt of fewer preventive services, and higher medical costs and rates of emergency department use.

DEFINITION
HEALTH LITERACY

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Planning for Care

- Assessing for health literacy will facilitate better care coordination and discharge planning.

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B1300. Health Literacy (cont.)



Steps for Assessment

This item is intended to be a resident self-report item. No other source should be used to identify the response.

1. Ask the resident, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

Coding Instructions

- **Code 0, Never:** if the resident indicates never needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 1, Rarely:** if the resident indicates rarely needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 2, Sometimes:** if the resident indicates sometimes needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 3, Often:** if the resident indicates often needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 4, Always:** if the resident indicates always needing help reading instructions, pamphlets, or other written materials from doctors or pharmacies.
- **Code 7, Resident declines to respond:** if the resident declines to respond.
- **Code 8, Resident unable to respond:** if the resident is unable to respond.

Example

1. When asked how often they need help when reading the instructions provided by their doctor, the resident reports that they never need help. The resident's adult child is present and shares that a family member must always accompany the resident to doctors' visits and that the resident often needs someone to explain the written materials to them multiple times before they understand, providing examples of needing to frequently explain to the resident why they are on a special diet and why and how to take some of their medications.

   Coding: B1300, Health Literacy is coded as **Code 0, Never.**

   Rationale: The resident indicates they never need help reading instructions from their doctor or pharmacist. B1300, Health Literacy is intended to be a resident self-report item and no other sources, including family members/caregivers, should be used to identify the response to this item.

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SECTION C: COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information and whether the resident has signs and symptoms of delirium. These items are crucial factors in many care-planning decisions.

C0100: Should Brief Interview for Mental Status Be Conducted?

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Item Rationale

Health-related Quality of Life

- Most residents are able to attempt the Brief Interview for Mental Status (BIMS), a structured cognitive interview.
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - — Without an attempted structured cognitive interview, a resident might be mislabeled based on their appearance or assumed diagnosis.
  - — Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care.

Planning for Care

- Structured cognitive interviews assist in identifying needed supports.
- The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).

Steps for Assessment

1. Interact with the resident using their preferred language (See A1110). Be sure they can hear you and/or have access to their preferred method for communication. If the resident needs or requires an interpreter, complete the interview with an interpreter. 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 C0600, Should the Staff Assessment for Mental Status be Conducted?, unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to C1310. Signs and Symptoms of Delirium.

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C0100: Should Brief Interview for Mental Status Be Conducted? (cont.)

Coding Instructions

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.
- **Code 1, yes:** if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

Coding Tips

- 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, including a resident who uses American Sign Language (ASL), every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0600-C1000, **Staff Assessment for Mental Status.**
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 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 for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done.
- Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, **only** in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

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C0200-C0500: Brief Interview for Mental Status (BIMS)



Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code ☐

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code ☐

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code ☐

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code ☐

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code ☐

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

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C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact residents may appear to be cognitively impaired because of extreme frailty, hearing impairment or lack of interaction.
- Some residents may appear to be more cognitively intact than they actually are.
- If cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.
- The BIMS is an opportunity to observe residents for signs and symptoms of delirium.

Planning for Care

- Assessment of a resident's mental state provides a direct understanding of resident function that may:
  - enhance future communication and assistance and
  - direct nursing interventions to facilitate greater independence such as posting or providing reminders for self-care activities.
- A resident's performance on cognitive tests can be compared over time.
  - An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life-threatening illness.
  - If performance worsens, then an assessment for delirium and/or depression should be considered, as a decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning.

Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)

1. Refer to Appendix D for a review of basic approaches to effective interviewing techniques.
2. Interview any resident not screened out by **Should Brief Interview for Mental Status Be Conducted?** (Item C0100).
3. Conduct the interview in a private setting, if possible.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.

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C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
6. Give an introduction before starting the interview.

   Suggested language: "I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult."

7. If the resident expresses concern that you are testing their memory, they may be more comfortable if you reply: "We ask these questions of everyone so we can make sure that our care will meet your needs."
8. Directly ask the resident each item in C0200 through C0400 at one sitting and in the order provided.
9. If the resident chooses not to answer a particular item, accept their refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect/no answer or could not recall.

Coding Instructions

See coding instructions for individual items.

Coding Tips

- If the interviewer is unable to articulate or pronounce any cognitive interview items clearly, for any reason (e.g., accent or speech impairment), have a different staff member conduct the BIMS.
- Rules for stopping the BIMS before it is complete:
  - Stop the interview after completing (C0300C) "Day of the Week" if:
    1. all responses up to this point have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR
    2. there has been no verbal or written response to any of the questions up to this point, OR
    3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.

DEFINITION

COMPLETE INTERVIEW
The BIMS is considered complete if the resident attempted and provided relevant answers to at least four of the questions included in C0200-C0400C. Relevant answers do not have to be correct but do need to be related to the question that was asked.

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C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

- If the interview is stopped, do the following:
  1. Code **(—), dash** in C0400A, C0400B, and C0400C.
  2. Code **99** in the BIMS Summary Score *(*C0500), and if the assessment being completed is a stand-alone Part A PPS Discharge, continue to C1310. Signs and Symptoms of Delirium. Otherwise, proceed to step 3.
  3. Code **1, yes** in **C0600, Should the Staff Assessment for Mental Status be Conducted?**
  4. Complete the **Staff Assessment for Mental Status**.
- If all responses to C0200, C0300A, C0300B, and C0300C are coded 0 because answers are incorrect, continue interview.
- When staff identify that the resident's primary method of communication is in written format, the BIMS can be administered in writing. **The administration of the BIMS in writing should be limited to only this circumstance.**
- See Appendix E for details regarding how to administer the BIMS in writing.
- Code 0 is used to represent three types of responses: incorrect answers (unless the item itself provides an alternative response code), nonsensical responses, and questions the resident chooses not to answer (or "refusals"). Since 0s resulting from these three situations are treated differently when coding the BIMS Summary Score in C0500, the interviewer may find it valuable to track the reason for each 0 response to aid in accurately calculating the summary score.

DEFINITION

NONSENSICAL RESPONSE
Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated.

Examples of Incorrect and Nonsensical Responses

1. Interviewer asks resident to state the year. The resident replies that it is 1935. This answer is incorrect but related to the question.

   Coding: This answer is **coded 0, incorrect** but would NOT be considered a nonsensical response.

   Rationale: The answer is wrong, but it is logical and relates to the question.

2. Interviewer asks resident to state the year. The resident says, "Oh what difference does the year make when you're as old as I am?" The interviewer asks the resident to try to name the year, and the resident shrugs.

   Coding: This answer is **coded 0, incorrect** but would NOT be considered a nonsensical response.

   Rationale: The answer is wrong because refusal is considered a wrong answer, but the resident's comment is logical and clearly relates to the question.

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C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)



3. Interviewer asks the resident to name the day of the week. Resident answers, "Sylvia, she's my daughter." The interviewer asks the resident the question again to confirm the resident is not hearing the question incorrectly, and the resident answers with the same response.

   Coding: The answer is **coded 0, incorrect**; the response is illogical and nonsensical.

   Rationale: The answer is wrong, and the resident's comment clearly does not relate to the question; it is nonsensical.

C0200: Repetition of Three Words



C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code ☐

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

Item Rationale

Health-related Quality of Life

- Inability to repeat three words on first attempt may indicate:
  - — a memory impairment,
  - — a hearing impairment,
  - — a language barrier, or
  - — inattention that may be a sign of delirium or another health issue.

Planning for Care

- A cue can assist learning.
- Cues may help residents with memory impairment who can store new information in their memory but who have trouble retrieving something that was stored (e.g., not able to remember someone's name but can recall if given part of the first name).
- Staff can use cues when assisting residents with learning and recall in therapy, and in daily and restorative activities.

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C0200: Repetition of Three Words (cont.)

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-4 and C-5. In addition, for repetition of three words:

1. Say to the resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed." Interviewers need to use the words and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.
2. Immediately after presenting the three words, say to the resident: "Now please tell me the three words."
3. After the resident's first attempt to repeat the items:

DEFINITION

CATEGORY CUE

Phrase that puts a word in context to help with learning and to serve as a hint that helps prompt the resident. The category cue for sock is "something to wear." The category cue for blue is "a color." For bed, the category cue is "a piece of furniture."

- If the resident correctly stated all three words, say, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture" [category cues].
- Category cues serve as a hint that helps prompt residents' recall ability. Putting words in context stimulates learning and fosters memory of the words that residents will be asked to recall in item C0400, even among residents able to repeat the words immediately.
- If the resident recalled two or fewer words, say to the resident: "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." If the resident still does not recall all three words correctly, you may repeat the words and category cues one more time.
- If the resident does not repeat all three words after three attempts, re-assess ability to hear. If the resident can hear, move on to the next question. If they are unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding.

Coding Instructions

*Record the maximum number of words that the resident correctly repeated on the **first** attempt. This will be any number between 0 and 3.*

- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item, but only the number correct on the first attempt go into the total score. Do not record the number of attempts that the resident needed to complete.
- **Code 0, none:** if the resident did not repeat any of the 3 words on the first attempt.
- **Code 1, one:** if the resident repeated only 1 of the 3 words on the first attempt.
- **Code 2, two:** if the resident repeated only 2 of the 3 words on the first attempt.
- **Code 3, three:** if the resident repeated all 3 words on the first attempt.

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C0200: Repetition of Three Words (cont.)

Examples

1. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." The resident replies, "Bed, sock, and blue." The interviewer repeats the three words with category cues, by saying, "That's right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture."

   Coding: C0200 would be **coded 3, three** words correct.

   Rationale: The resident repeated all three items on the first attempt. The order of repetition does not affect the score.

2. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." The resident replies, "Sock, bed, black." The interviewer repeats the three words plus the category cues, saying, "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." The resident says, "Oh yes, that's right, sock, blue, bed."

   Coding: C0200 would be **coded 2, two** of three words correct.

   Rationale: The resident repeated two of the three items on the first attempt. Residents are scored based on the first attempt.

3. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." The resident says, "Blue socks belong in the dresser." The interviewer codes according to the resident's response. Then the interviewer repeats the three words plus the category cues, saying, "Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words." The resident says, "Oh yes, that's right, sock, blue, bed."

   Coding: C0200 would be **coded 2, two** of the three words correct.

   Rationale: The resident repeated two of the three items—blue and sock on the first attempt. The resident put the words into a sentence, resulting in the resident repeating two of the three words.

4. The interviewer says, "The words are sock, blue, and bed. Now please tell me the three words." The resident replies, "What were those three words?" The resident's response is coded, and then the interviewer repeats the three words plus the category cues.

   Coding: C0200 would be **coded 0, none** of the words correct.

   Rationale: The resident did not repeat any of the three words after the first time the interviewer said them.

Draft

C0300: Temporal Orientation (Orientation to Year, Month, and Day)

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code ☐

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code ☐

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code ☐

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

Item Rationale

Health-related Quality of Life

- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.

Planning for Care

- If staff know that a resident has a problem with orientation, they can provide reorientation aids and verbal reminders that may reduce anxiety and encourage resident participation in activities.
- Reorienting those who are disoriented or at risk of disorientation may be useful in treating symptoms of delirium and cognitive problems associated with other medical conditions.
- Residents who are not oriented may need further assessment for delirium, especially if this fluctuates or is recent in onset.

DEFINITION

TEMPORAL ORIENTATION
In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-4 and C-5.

1. Ask the resident each of the three questions in Item C0300 separately.
2. Allow the resident up to 30 seconds for each answer and do not provide clues.
3. If the resident specifically asks for clues (e.g., "Is it bingo day?") respond by saying, "I need to know if you can answer this question without any help from me."

Draft

C0300: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

Coding Instructions for C0300A, Able to Report Correct Year

- **Code 0, missed by >5 years or no answer:** if the resident's answer is incorrect and is greater than 5 years from the current year or the resident chooses not to respond or the answer is nonsensical.
- **Code 1, missed by 2-5 years:** if the resident's answer is incorrect and is within 2 to 5 years from the current year.
- **Code 2, missed by 1 year:** if the resident's answer is incorrect and is within one year from the current year.
- **Code 3, correct:** if the resident states the correct year.

Examples

1. The date of interview is May 5, 2023. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 2023.

   Coding: C0300A would be **coded 3, correct.**
   Rationale: 2023 is the current year at the time of this interview.

2. The date of interview is June 16, 2023. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 2020.

   Coding: C0300A would be **coded 1, missed by 2-5 years.**
   Rationale: 2020 is within 2 to 5 years of 2023.

3. The date of interview is January 10, 2023. The resident, responding to the statement, "Please tell me what year it is right now," states that it is 1923.

   Coding: C0300A would be **coded 0, missed by more than 5 years.**
   Rationale: Even though the '23 part of the year would be correct, 1923 is more than 5 years from 2023.

4. The date of interview is April 1, 2023. The resident, responding to the statement, "Please tell me what year it is right now," states that it is "'23". The interviewer asks, "Can you tell me the full year?" The resident still responds "'23," and the interviewer asks again, "Can you tell me the full year, for example, nineteen-eighty-two." The resident states, "2023."

   Coding: C0300A would be **coded 3, correct.**
   Rationale: Even though '23 is partially correct, the only correct answer is the exact year. The resident must state "2023," not "'23" or "1823" or "1923."

Draft

C0300: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

Coding Instructions for C0300B, Able to Report Correct Month

Count the current day as day 1 when determining whether the response was accurate within 5 days or missed by 6 days to 1 month.

- **Code 0, missed by >1 month or no answer:** if the resident's answer is incorrect by more than 1 month or if the resident chooses not to answer the item or the answer is nonsensical.
- **Code 1, missed by 6 days to 1 month:** if the resident's answer is accurate within 6 days to 1 month.
- **Code 2, accurate within 5 days:** if the resident's answer is accurate within 5 days, count current date as day 1.

Coding Tips

- In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the resident's response in the margin and go back later to count days if you are unsure whether the date given is within 5 days.

Examples

1. The date of interview is June 25, 2023. The resident, responding to the question, "What month are we in right now?" states that it is June.

   Coding: C0300B would be **coded 2, accurate within 5 days.**
   Rationale: The resident correctly stated the month.

2. The date of interview is June 28, 2023. The resident, responding to the question, "What month are we in right now?" states that it is July.

   Coding: C0300B would be **coded 2, accurate within 5 days.**
   Rationale: The resident correctly stated the month within 5 days, even though the correct month is June. June 28th (day 1) + 4 more days is July 2nd, so July is within 5 days of the interview.

3. The date of interview is June 25, 2023. The resident, responding to the question, "What month are we in right now?" states that it is July.

   Coding: C0300B would be **coded 1, missed by 6 days to 1 month**.
   Rationale: The resident missed the correct month by six days. June 25th (day 1) + 5 more days = June 30th. Therefore, the resident's answer is incorrect within 6 days to 1 month.

DRAFT

C0300: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

4. The date of interview is June 30, 2023. The resident, responding to the question, "What month are we in right now?" states that it is August.

   Coding: C0300B would be **coded 0, missed by more than 1 month**.
   Rationale: The resident missed the month by more than 1 month.

Coding Instructions for C0300C. Able to Report Correct Day of the Week

- **Code 0, incorrect, or no answer:** if the answer is incorrect or the resident chooses not to answer the item or the answer is nonsensical.
- **Code 1, correct:** if the answer is correct.

Examples

1. The day of interview is Monday, June 27, 2023. The interviewer asks: "What day of the week is it today?" The resident responds, "It's Monday."

   Coding: C0300C would be **coded 1, correct**.
   Rationale: The resident correctly stated the day of the week.

2. The day of interview is Monday, June 27, 2023. The resident, responding to the question, "What day of the week is it today?" states, "Tuesday."

   Coding: C0300C would be **coded 0, incorrect**.
   Rationale: The resident incorrectly stated the day of the week.

3. The day of interview is Monday, June 27, 2023. The resident, responding to the question, "What day of the week is it today?" states, "Today is a good day."

   Coding: C0300C would be **coded 0, incorrect**.
   Rationale: The resident did not answer the question correctly.

Draft

C0400: Recall

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code ☐ **A. Able to recall "sock"**
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐ **B. Able to recall "blue"**
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐ **C. Able to recall "bed"**
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

Item Rationale

Health-related Quality of Life

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize individual function and decrease frustration for those residents who respond.

Planning for Care

- Care plans should maximize use of cueing for resident who respond to recall cues. This will enhance independence.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-4 and C-5.

1. Ask the resident the following: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
2. Allow up to 5 seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after 5 seconds, provide a category cue (refer to "Steps for Assessment," page C-8 for the definition of category cue). Category cues should be used only after the resident is unable to recall one or more of the three words.
4. Allow up to 5 seconds after category cueing for each missed word to be recalled.

Coding Instructions

*For **each** of the three words the resident is asked to remember:*

- **Code 0, no—could not recall:** if the resident cannot recall the word even after being given the category cue or if the resident responds with a nonsensical answer or chooses not to answer the item.
- **Code 1, yes, after cueing:** if the resident requires the category cue to remember the word.
- **Code 2, yes, no cue required:** if the resident correctly remembers the word spontaneously without cueing.

Draft

C0400: Recall (cont.)



Coding Tips

- If on the first try (without cueing), the resident names multiple items in a category, one of which is correct, they should be coded as correct for that item.
- If, however, the interviewer gives the resident the cue and the resident then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Examples

1. The resident is asked to recall the three words that were initially presented. The resident chooses not to answer the question and states, "I'm tired, and I don't want to do this anymore."

   Coding: C0400A-C0400C would be **coded 0, no—could not recall**, could not recall for each of the three words.
   Rationale: Choosing not to answer a question often indicates an inability to answer the question, so refusals are **coded 0, no—could not recall**. This is the most accurate way to score cognitive function, even though, on occasion, residents might choose not to answer for other reasons.

2. The resident is asked to recall the three words. The resident replies, "Socks, shoes, and bed." The examiner then cues, "One word was a color." The resident says, "Oh, the shoes were blue."

   Coding: C0400A, sock, would be **coded 2, yes, no cue required.**
   Rationale: The resident's initial response to the question included "sock." They are given credit for this response, even though they also listed another item in that category (shoes), because they were answering the initial question, without cueing.
   Coding: C0400B, blue, would be **coded 1, yes, after cueing.**
   Rationale: The resident did not recall spontaneously but did recall after the category cue was given. Responses that include the word in a sentence are acceptable.
   Coding: C0400C, bed, would be **coded 2, yes, no cue required.**
   Rationale: The resident independently recalled the item on the first attempt.

3. The resident is asked to recall the three words. The resident answers, "I don't remember." The assessor then says, "One word was something to wear." The resident says, "Clothes." The assessor then says, "OK, one word was a color." The resident says, "Blue." The assessor then says, "OK, the last word was a piece of furniture." The resident says, "Couch."

   Coding: C0400A, sock, would be **coded 0, no—could not recall.**
   Rationale: The resident did not recall the item, even with a cue.
   Coding: C0400B, blue, would be **coded 1, yes, after cueing.**
   Rationale: The resident did recall after being given the cue.
   Coding: C0400C, bed, would be **coded 0, no—could not recall.**
   Rationale: The resident did not recall the item, even with a cue.

DRAFT

C0400: Recall (cont.)



4. The resident is asked to recall the three words. The resident says, "I don't remember." The assessor then says, "One word was something to wear." The resident says, "Hat, shirt, pants, socks, shoe, belt."

Coding: C0400A, sock, would be **coded 0, no—could not recall.**

Rationale: After getting the category cue, the resident named more than one item (i.e., a laundry list of items) in the category. The resident's response is coded as incorrect, even though one of the items was correct, because the resident did not demonstrate recall and likely named the item by chance.

C0500: BIMS Summary Score

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Item Rationale

Health-related Quality of Life

- The total score:
  - — Allows comparison with future and past performance.
  - — Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
  - — Provides staff with a more reliable estimate of resident function and allows staff interactions with residents that are based on more accurate impressions about resident ability.

Planning for Care

- The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance. The final determination of the level of impairment should be made by the resident's physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance:

  The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:

  13-15: cognitively intact

  8-12: moderately impaired

  0-7: severe impairment

Draft

C0500: BIMS Summary Score (cont.)

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
- Care plans can be more individualized based upon reliable knowledge of resident function.

Steps for Assessment

After completing C0200-C0400:

1. Add up the values for all questions from C0200 through C0400.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.

Coding Instructions

Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.

- If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and the Staff Assessment for Mental Status is completed.
- To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips below for residents who choose not to participate at all.
- **Code 99, unable to complete interview:** if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, ***or*** (c) if any but not all of the BIMS items are coded with a dash (—).
  - Note: a 0 score does not mean the BIMS was incomplete. For the BIMS to be incomplete, a resident must choose not to answer or must give completely unrelated, nonsensical responses to four or more items. If one or more of the 0s in C0200–C0300 are due to incorrect answers, the interview should continue.

Coding Tips

- Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, **BIMS Summary Score**, and complete the Staff Assessment for Mental Status.
- *If all of the BIMS items are coded with a dash, then C0500, BIMS Summary Score must also be coded with a dash.*

DRAFT

C0500: BIMS Summary Score (cont.)

Examples

1. The resident's scores on items C0200-C0400 were as follows:

C0200 (repetition)	3
C0300A (year)	2
C0300B (month)	2
C0300C (day)	1
C0400A (recall "sock")	2
C0400B (recall "blue")	2
C0400C (recall "bed")	0

Coding: C0500 would be **coded 12** (Sum of C0200–C0400C). C0600. Should the Staff Assessment for Mental Status be Conducted? is **coded as 0, No,** and the skip pattern is followed.

2. The resident's scores on items C0200–C0400C were as follows:

C0200 (repetition)	2
C0300A (year)	2
C0300B (month)	2
C0300C (day)	1
C0400A (recall "sock")	0
C0400B (recall "blue")	0
C0400C (recall "bed")	0

Coding: C0500 would be **coded 07** (Sum of C0200–C0400C). C0600. Should the Staff Assessment for Mental Status be Conducted? is **coded as 0, No,** and the skip pattern is followed.

3. The resident's score on items C0200–C0400C were as follows:

C0200 (repetition)	0 (no response provided)
C0300A (year)	0 (nonsensical response provided)
C0300B (month)	0 (nonsensical response provided)
C0300C (day)	0 (no response provided and the interview was stopped)
C0400A (recall "sock")	(—)
C0400B (recall "blue")	(—)
C0400C (recall "bed")	(—)

Coding: C0500 would be **coded 99, resident was unable to complete the interview**.

Rationale: The interview was stopped because the resident did not respond to two questions and provided nonsensical responses to two questions. Since the resident did not attempt to answer two questions and did not provide relevant answers to two questions, the BIMS interview is considered incomplete.

C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted?

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function using the BIMS is preferred as it decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium. However, a minority of residents are unable or unwilling to participate in the BIMS.
- Mental status can vary among persons unable to communicate or who do not complete the interview.
  - — Therefore, report of observed behavior is needed for persons unable to complete the BIMS interview.
  - — When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered.

Planning for Care

- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
  - — This remains true for persons who are unable to communicate or to complete the BIMS.
- Specific aspects of cognitive impairment, when identified, can direct nursing interventions to facilitate greater independence and function.

Steps for Assessment

1. Review whether **BIMS Summary Score** item (C0500), is **coded 99**, unable to complete interview.

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C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted? (cont.)

Coding Instructions

- **Code 0, no:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.
- **Code 1, yes:** if the resident chooses not to participate in the BIMS or if four or more items were **coded 0** because the resident chose not to answer or gave a nonsensical response. Continue to C0700, Short-term Memory OK, to perform the Staff Assessment for Mental Status. Note: C0500 should be **coded 99**.

Coding Tips

- If a resident is scored 00 on C0500, the Staff Assessment for Mental Status should not be completed. **00** is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items.

C0700-C1000: Staff Assessment of Mental Status Item

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. Memory OK
1. Memory problem

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. Memory OK
1. Memory problem

C0900. Memory/Recall Ability

↓ Check all that the resident was normally able to recall

☐ A. Current season

☐ B. Location of own room

☐ C. Staff names and faces

☐ D. That they are in a nursing home/hospital swing bed

☐ Z. None of the above were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life
0. Independent - decisions consistent/reasonable
1. Modified independence - some difficulty in new situations only
2. Moderately impaired - decisions poor; cues/supervision required
3. Severely impaired - never/rarely made decisions

Draft

C0700-C1000: Staff Assessment of Mental Status Item (cont.)

Item Rationale

Health-related Quality of Life

- Cognitive impairment is prevalent among some groups of residents, but not all residents are cognitively impaired.
- Many persons with memory problems can function successfully in a structured, routine environment.
- Residents may appear to be cognitively impaired because of communication challenges or lack of interaction but may be cognitively intact.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities, and therapies may not be offered.

Planning for Care

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
- The level and specific areas of impairment affect daily function and care needs. By identifying specific aspects of cognitive impairment, nursing interventions can be directed toward facilitating greater function.
- Probing beyond first, perhaps mistaken, impressions is critical to accurate assessment and appropriate care planning.

C0700: Short-term Memory OK

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. Memory OK
1. Memory problem

Item Rationale

Health-related Quality of Life

- To assess the mental state of residents who cannot be interviewed, an intact 5-minute recall ("short-term memory OK") indicates greater likelihood of normal cognition.
- An observed "memory problem" should be taken into consideration in Planning for Care.

Draft

C0700: Short-term Memory OK (cont.)

Planning for Care

- Identified memory problems typically indicate the need for:
  - Assessment and treatment of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect, or
  - possible evaluation for other problems with thinking
  - additional nursing support
  - at times frequent prompting during daily activities
  - additional support during recreational activities.

Steps for Assessment

1. Determine the resident's short-term memory status by asking them:
   - to describe an event 5 minutes after it occurred if you can validate the resident's response, or
   - to follow through on a direction given 5 minutes earlier.
2. Observe how often the resident has to be re-oriented to an activity or instructions.
3. Staff members also should observe the resident's cognitive function in varied daily activities.
4. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
5. Ask direct care staff across all shifts and family or significant others about the resident's short-term memory status.
6. Review the medical record for clues to the resident's short-term memory during the look-back period.

Coding Instructions

Based on all information collected regarding the resident's short-term memory during the 7-day look-back period, identify and code according to the most representative level of function.

- **Code 0, memory OK:** if the resident recalled information after 5 minutes.
- **Code 1, memory problem:** if the most representative level of function shows the absence of recall after 5 minutes.

Coding Tips

- If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard "no information" code (a dash, "-") to indicate that the information is not available because it could not be assessed.

Draft

C0700: Short-term Memory OK (cont.)

Example

1. A resident has just returned from the activities room where they and other residents were playing bingo. You ask them if they enjoyed themself playing bingo, but they return a blank stare. When you ask them if they were just playing bingo, they say, "no." **Code 1, memory problem.**

   Coding: C0700, would be **coded 1, memory problem.**
   Rationale: The resident could not recall an event that took place within the past 5 minutes.

C0800: Long-term Memory OK

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. Memory OK
1. Memory problem

Item Rationale

Health-related Quality of Life

- An observed "long-term memory problem" may indicate the need for emotional support, reminders, and reassurance. It may also indicate delirium if this represents a change from the resident's baseline.
- An observed "long-term memory problem" should be taken into consideration in Planning for Care.

Planning for Care

- Long-term memory problems indicate the need for:
  - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect, or
  - possible evaluation for other problems with thinking
  - additional nursing support
  - at times frequent prompting during daily activities
  - additional support during recreational activities.

Steps for Assessment

1. Determine resident's long-term memory status by engaging in conversation, reviewing memorabilia (photographs, memory books, keepsakes, videos, or other recordings that are meaningful to the resident) with the resident or observing response to family who visit.
2. Ask questions for which you can validate the answers from review of the medical record, general knowledge, the resident's family, etc.
   - Ask the resident, "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?"

Draft

C0800: Long-term Memory OK (cont.)

3. Observe if the resident responds to memorabilia or family members who visit.
4. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
5. Ask direct care staff across all shifts and family or significant others about the resident's memory status.
6. Review the medical record for clues to the resident's long-term memory during the look-back period.

Coding Instructions

- **Code 0, memory OK:** if the resident accurately recalled long past information.
- **Code 1, memory problem:** if the resident did not recall long past information or did not recall it correctly.

Coding Tips

- If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff were unable to make a determination based on observation of the resident, use the standard "no information" code (a dash, "**-**"), to indicate that the information is not available because it could not be assessed.

C0900: Memory/Recall Ability

C0900. Memory/Recall Ability	
↓	Check all that the resident was normally able to recall
☐	A. Current season
☐	B. Location of own room
☐	C. Staff names and faces
☐	D. That they are in a nursing home/hospital swing bed
☐	Z. **None of the above** were recalled

Item Rationale

Health-related Quality of Life

- An observed "memory/recall problem" with these items may indicate:
  - — cognitive impairment and the need for additional support with reminders to support increased independence; or
  - — delirium, if this represents a change from the resident's baseline.

Planning for Care

- An observed "memory/recall problem" with these items may indicate the need for:
  - — Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or
  - — possible evaluation for other problems with thinking;
  - — additional signs, directions, pictures, verbal reminders to support the resident's independence;

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C0900: Memory/Recall Ability (cont.)

— an evaluation for acute delirium if this represents a change over the past few days to weeks;

— an evaluation for chronic delirium if this represents a change over the past several weeks to months; or

— additional nursing support;

— the need for emotional support, reminders and reassurance to reduce anxiety and agitation.

Steps for Assessment

1. Ask the resident about each item. For example, "What is the current season? Is it fall, winter, spring, or summer?" "What is the name of this place?" If the resident is not in their room, ask, "Will you show me to your room?" Observe the resident's ability to find the way.
2. For residents with limited communication skills, in order to determine the most representative level of function, ask direct care staff across all shifts and family or significant other about recall ability.
   - Ask whether the resident gave indications of recalling these subjects or recognizing them during the look-back period.
3. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
4. Review the medical record for indications of the resident's recall of these subjects during the look-back period.

Coding Instructions

*For each item that the resident recalls, check the corresponding answer box. If the resident recalls none, check **none of above.***

- **Check C0900A, current season:** if resident is able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
- **Check C0900B, location of own room:** if resident is able to locate and recognize own room. It is not necessary for the resident to know the room number, but they should be able to find the way to the room.
- **Check C0900C, staff names and faces:** if resident is able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but they should recognize that the person is a staff member and not the resident's child, etc.
- **Check C0900D, that they are in a nursing home/hospital swing bed:** if resident is able to determine that they are currently living in a nursing home. To check this item, it is not necessary that the resident be able to state the name of the nursing home, but they should be able to refer to the nursing home by a term such as a "home for older people," a "hospital for the elderly," "a place where people who need extra help live," etc.
- **Check C0900Z, none of above was recalled.**

Draft

C1000: Cognitive Skills for Daily Decision Making

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Item Rationale

Health-related Quality of Life

- An observed "difficulty with daily decision making" may indicate:
  - — underlying cognitive impairment and the need for additional coaching and support or
  - — possible anxiety or depression.

Planning for Care

- An observed "difficulty with daily decision making" may indicate the need for:
  - — a more structured plan for daily activities and support in decisions about daily activities,
  - — encouragement to participate in structured activities, or
  - — an assessment for underlying delirium and medical evaluation.

DEFINITION

DAILY DECISION MAKING

Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.

Steps for Assessment

1. Review the medical record. Consult family and direct care staff across all shifts. Observe the resident.
2. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
3. The intent of this item is to record what the resident is doing (performance). Focus on whether or not the resident is actively making these decisions and not whether staff believes the resident might be capable of doing so.
4. Focus on the resident's actual performance. Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision making, whatever their level of capability may be, the resident should be coded as impaired performance in decision making.

Draft

C1000: Cognitive Skills for Daily Decision Making (cont.)

Coding Instructions

Record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.

- **Code 0, independent:** if the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values.
- **Code 1, modified independence:** if the resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations.
- **Code 2, moderately impaired:** if the resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- **Code 3, severely impaired:** if the resident's decision making was severely impaired; the resident never (or rarely) made decisions.

Coding Tips

- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be **coded 3, severely impaired**. If the resident makes decisions, although poorly, **code 2, moderately impaired**.
- A resident's considered decision to exercise their right to decline treatment or recommendations by interdisciplinary team members should **not** be captured as impaired decision making in Item C1000, **Cognitive Skills for Daily Decision Making**.

Examples

1. Resident B seems to have severe cognitive impairment and is non-verbal. They usually clamp their mouth shut when offered a bite of food.
2. Resident C does not generally make conversation or make their needs known, but replies "yes" when asked if they would like to take a nap.

Coding: For the above examples, Item C1000 would be **coded 3, severe impairment.**

Rationale: In both examples, the residents are primarily non-verbal and do not make their needs known, but they do give basic verbal or non-verbal responses to simple gestures or questions regarding care routines. More information about how the residents function in the environment is needed to definitively answer the questions. From the limited information provided it appears that their communication of choices is limited to very particular circumstances, which would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week on the MDS. If such decisions are more frequent or involved more activities, the resident may be only moderately impaired or better.

Draft

C1000: Cognitive Skills for Daily Decision Making (cont.)

3. A resident makes their own decisions throughout the day and is consistent and reasonable in their decision-making except that they constantly walk away from the walker they have been using for nearly 2 years. Asked why they don't use their walker, they reply, "I don't like it. It gets in my way, and I don't want to use it even though I know all of you think I should."

   Coding: C1000 would be **coded 0, independent.**

   Rationale: This resident is making and expressing understanding of their own decisions, and their decision is to decline the recommended course of action – using the walker. Other decisions they made throughout the look-back period were consistent and reasonable.

4. A resident routinely participates in coffee hour on Wednesday mornings, and often does not need a reminder. Due to renovations, however, the meeting place was moved to another location in the facility. The resident was informed of this change and was accompanied to the new location by the activities director. Staff noticed that the resident was uncharacteristically agitated and unwilling to engage with other residents or the staff. They eventually left and were found sitting in the original coffee hour room. Asked why they came back to this location, they responded, "the aide brought me to the wrong room, I'll wait here until they serve the coffee."

   Coding: C1000 would be **coded 1, modified independent.**

   Rationale: The resident is independent under routine circumstances. However, when the situation was new or different, they had difficulty adjusting.

5. Resident G enjoys congregate meals in the dining room and is friendly with the other residents at their table. Recently, they have started to lose weight. They appear to have little appetite, rarely eat without reminders and willingly give their food to other residents at the table. Resident G requires frequent cueing from staff to eat and supervision to prevent them from sharing their food.

   Coding: C1000 would be **coded 2, moderately impaired.**

   Rationale: The resident is making poor decisions by giving their food away. They require cueing to eat and supervision to be sure that they are eating the food on their plate.

Draft

C1310: Signs and Symptoms of Delirium (from CAM©)

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐ **Is there evidence of an acute change in mental status** from the resident's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

Enter Codes in Boxes ↓

☐ B. **Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

☐ C. **Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ D. **Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Item Rationale

Health-related Quality of Life

- Delirium is associated with:
  - — increased mortality,
  - — functional decline,
  - — development or worsening of incontinence,
  - — behavior problems,
  - — withdrawal from activities
  - — rehospitalizations and increased length of nursing home stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

Planning for Care

- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection is essential in order to identify and treat or eliminate the cause.

Draft

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

Steps for Assessment

1. Observe resident behavior during the **BIMS** items (C0200-C0400) for the signs and symptoms of delirium. Some experts suggest that increasing the frequency of assessment (as often as daily for new admissions) will improve the level of detection.
2. If the **Staff Assessment for Mental Status** items (C0700-C1000) were completed instead of the BIMS, ask staff members who conducted the interview about their observations of signs and symptoms of delirium.
3. Review medical record documentation during the 7-day look-back period to determine the resident's baseline status, fluctuations in behavior, and behaviors that might have occurred during the 7-day look-back period that were not observed during the BIMS.
4. Observe the resident's behavior during interactions and consult with other staff, family members/caregivers, and others in a position to observe the resident's behavior during the 7-day look-back period.

DEFINITION

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

Additional guidance on the signs and symptoms of delirium can be found in Appendix C.

Coding Instructions for C1310A, Acute Mental Status Change

- **Code 0, no:** if there is no evidence of acute mental status change from the resident's baseline.
- **Code 1, yes:** if resident has an alteration in mental status observed in the observation period that represents an acute change from baseline.

Coding Tips

- Examples of acute mental status change:
  - — A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
  - — A resident who is normally quiet and content suddenly becomes restless or noisy.
  - — A resident who is usually able to find their way around their living environment begins to get lost.

Examples

1. The resident was admitted to the nursing home 4 days ago. Their family reports that they were alert and oriented prior to admission. During the BIMS interview, they are lethargic and incoherent.

   Coding: Item C1310A would be **coded 1, yes.**
   Rationale: There is an acute change of the resident's behavior from alert and oriented (family report) to lethargic and incoherent during interview.

Draft

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

2. The nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to their dead spouse, tearing off their clothes, and being completely disoriented to time, person, and place.

Coding: Item C1310A would be **coded 1, yes.**
Rationale: The new behaviors represent an acute change in mental status.

Steps for Assessment for C1310B, Inattention

1. Assess attention separately from level of consciousness. Evidence of inattention may be found during the resident interview, in the medical record, or from family or staff reports of inattention during the 7-day look-back period.
2. An additional step to identify difficulty with attention is to ask the resident to count backwards from 20.

Coding Instructions for C1310B, Inattention

- **Code 0, behavior not present:** if the resident remains focused during the interview and all other sources agree that the resident was attentive during other activities.
- **Code 1, behavior continuously present, did not fluctuate:** if the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary during the look-back period. All sources must agree that inattention was consistently present to select this code.
- **Code 2, behavior present, fluctuates:** if inattention is noted during the interview or any source reports that the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied during interview or during the look-back period or if information sources disagree in assessing level of attention.

DEFINITIONS

INATTENTION
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look- back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.

DRAFT

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

Examples

1. The resident tries to answer all questions during the BIMS. Although they answer several items incorrectly and respond "I don't know" to others, they pay attention to the interviewer. Medical record and staff indicate that this is their consistent behavior.

   Coding: Item C1310B would be **coded 0, behavior not present.**
   Rationale: The resident remained focused throughout the interview and this was constant during the look-back period.

2. Questions during the BIMS must be frequently repeated because the resident's attention wanders. This behavior occurs throughout the interview and medical records and staff agree that this behavior is consistently present. The resident has a diagnosis of dementia.

   Coding: Item C1310B would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: The resident's attention consistently wandered throughout the 7-day look-back period. The resident's dementia diagnosis does not affect the coding.

3. During the BIMS interview, the resident was not able to focus on all questions asked and their gaze wandered. However, several notes in the resident's medical record indicate that the resident was attentive when staff communicated with them, and family confirmed this.

   Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
   Rationale: Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, C1310B **cannot be coded as 0, Behavior not present.**

4. The resident is dazedly staring at the television for the first several questions. When you ask a question, they look at you momentarily but do not answer. Midway through questioning, they seem to pay more attention and try to answer.

   Coding: Item C1310B would be **coded 2, behavior present, fluctuates.**
   Rationale: Resident's attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2.**

DRAFT

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

Coding Instructions for C1310C, Disorganized Thinking

DEFINITION

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, or incoherent speech.

- **Code 0, behavior not present:** if all sources agree that the resident's thinking was organized and coherent, even if answers were inaccurate or wrong.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident's responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the resident unpredictably switched from subject to subject.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other data sources, the resident's responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.

Examples

1. The interviewer asks the resident, who is often confused, to give the date, and the response is: "Let's go get the sailor suits!" The resident continues to provide irrelevant or nonsensical responses throughout the interview, and medical record and staff indicate this is constant.

   Coding: C1310C would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: All sources agree that the disorganized thinking is constant.

2. The resident responds that the year is 1837 when asked to give the date. The medical record and staff indicate that the resident is never oriented to time but has coherent conversations. For example, staff reports they often discuss their passion for baseball.

   Coding: C1310C would be **coded 0, behavior not present.**
   Rationale: The resident's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. The resident was able to tell the interviewer their name, the year and where they were. They were able to talk about the activity they just attended and the residents and staff that also attended. Then the resident suddenly asked the interviewer, "Who are you? What are you doing in my child's home?"

   Coding: C1310C would be **coded 2, behavior present, fluctuates.**
   Rationale: The resident's thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be **coded 2**.

DRAFT

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

Coding Instructions for C1310D, Altered Level of Consciousness

- **Code 0, behavior not present:** if all sources agree that the resident was alert and maintained wakefulness during conversation, interview(s), and activities.
- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident was consistently lethargic (difficult to keep awake), stuporous (very difficult to arouse and keep aroused), vigilant (startles easily to any sound or touch), or comatose.
- **Code 2, behavior present, fluctuates:** if, during the interview or according to other sources, the resident varied in levels of consciousness. For example, was at times alert and responsive, while at other times resident was lethargic, stuporous, or vigilant. Also code as fluctuating if information sources disagree.

DEFINITIONS

ALTERED LEVEL OF CONSCIOUSNESS

VIGILANT – startles easily to any sound or touch;

LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch;

STUPOR – very difficult to arouse and keep aroused for the interview;

COMATOSE – cannot be aroused despite shaking and shouting.

Coding Tips

- A diagnosis of coma or stupor does not have to be present for staff to note the behavior in this section.

Examples

1. Resident is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and staff report during the 7-day look-back period consistently noted that the resident was alert.

   Coding: C1310D would be **coded 0, behavior not present.**
   Rationale: All evidence indicates that the resident is alert during conversation, interview(s) and activities.

2. The resident is lying in bed. They arouse to soft touch but are only able to converse for a short time before their eyes close, and they appear to be sleeping. Again, they arouse to voice or touch but only for short periods during the interview. Information from other sources indicates that this was their condition throughout the look-back period.

   Coding: C1310D would be **coded 1, behavior continuously present, does not fluctuate.**
   Rationale: The resident's lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.

Draft

C1310: Signs and Symptoms of Delirium (from CAM©) (cont.)

3. Resident is usually alert, oriented to time, place, and person. Today, at the time of the BIMS interview, resident is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.

Coding: C1310D would be **coded 2, behavior present, fluctuates.**
Rationale: The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2, fluctuating**.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

Draft

SECTION D: MOOD

Intent: The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies.

D0100: Should Resident Mood Interview Be Conducted?

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

Item Rationale

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder.

Planning for Care

- Symptom-specific information from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan.
- If a resident cannot communicate, then **Staff Mood Interview** (D0500 A-J) should be conducted, unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to D0700. Social Isolation.

D0100: Should Resident Mood Interview Be Conducted? (cont.)

Steps for Assessment

1. Interact with the resident using their preferred language. Be sure they can hear you and/or have access to their preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine whether the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©), unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to D0700. Social Isolation.
3. Review Language item (A1110) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1110 = 1).
    - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©), unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to D0700. Social Isolation.
- **Code 1, yes:** if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Continue to item D0150, Resident Mood Interview (PHQ-2 to 9©).

Coding Tips and Special Populations

- 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.
- D0100 serves as a gateway item for the Resident Mood Interview (PHQ-2 to 9©) and D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). The assessor will complete the Staff Assessment only when D0100 is coded 0, No. The assessor does not complete the Staff Assessment based on resident performance during the Resident Mood Interview.
- If the resident needs an interpreter, every effort should be made to have an interpreter present for the PHQ-2 to 9© interview. If it is not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0600, unless the assessment being completed is a stand-alone Part A PPS Discharge; if that is the case, then skip to D0700. Social Isolation.
- Includes residents who use American Sign Language (ASL).

Draft

D0100: Should Resident Mood Interview Be Conducted? (cont.)

- If the resident interview was not conducted within the look-back period of the ARD, item D0100 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 of Resident Mood items (D0500) if the resident interview should have been conducted but was not done, or if the assessment being completed is a stand-alone Part A PPS Discharge assessment.
- Resident refusal or unwillingness to participate in the interview would result in Item D0100 being coded 1, Yes, and code 9, No response being entered in Column 1. Symptom Presence. Assessors should proceed to Item D0700, Social Isolation in the case of resident refusal or unwillingness to participate.

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



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

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

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.

If yes in column 1, then ask the resident: *"About* ***how often*** *have you been bothered by this?"*

Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

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

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.		
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

Draft

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

Item Rationale

Health-related Quality of Life

- It is important to note that coding the presence of clinical signs and symptoms of depressed mood does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis based on these findings; they simply record the presence or absence of specific clinical signs and symptoms of depressed mood. Facility staff should recognize these signs and symptoms and consider them when developing the resident's individualized care plan.
- Depression can be associated with:
  - — psychological and physical distress,
  - — decreased participation in therapy and activities,
  - — decreased functional status, and
  - — poorer outcomes.
- Mood disorders are common in nursing homes and are often underdiagnosed and undertreated.

DEFINITION

PATIENT HEALTH QUESTIONNAIRE (PHQ-2 to 9©)
A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

Planning for Care

- Findings suggesting mood distress could lead to:
  - — identifying causes and contributing factors for symptoms and
  - — identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.

Steps for Assessment

1. Interview any resident when D0100 = 1.
2. Conduct the interview in a private setting.
3. If an interpreter is used during resident interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the resident's responses.
4. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
5. Be sure the resident can hear you.
   - Residents with a hearing impairment should be interviewed using their usual communication devices/techniques, as applicable, during the interview.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
6. If you are administering the PHQ-2 to 9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.
7. Explain the reason for the interview before beginning.

Draft

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

Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

8. Explain and /or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident comprehend the response choices.
   Suggested language: "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."
9. Ask the first two questions of the Resident Mood Interview (PHQ-2 to 9©).
   Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"

   For each of the questions:
   - Read the item as it is written.
   - Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for themself what "tired" means; the item should be scored based on the resident's interpretation.
   - Each question **must be** asked in sequence to assess Symptom Presence (column 1) and Symptom Frequency (column 2) before proceeding to the next question.
   - Enter code 9 in Column 1 and leave Column 2 blank if the resident was unable or chose not to complete the assessment or responded nonsensically. A **nonsensical** response is one that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated (e.g., when asked the question about "poor appetite or overeating," the resident answers, "I always win at poker.").
   - For a **yes** response, ask the resident to tell you how often they were bothered by the symptom over the last 2 weeks. Use the response choices in D0150 Column 2, Symptom Frequency. Start by asking the resident the number of days that they were bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).
10. Determine whether to ask the remaining seven questions (D0150C to D0150I) of the Resident Mood Interview (PHQ-2 to 9©). Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions (D0150A and D0150B) of the Resident Mood Interview.
    - If **both** D0150A1 and D0150B1 are coded 9, OR **both** D0150A2 and D0150B2 are coded 0 or 1, **end** the PHQ interview; otherwise continue.
      — If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank,** then end the PHQ-2©, leave D0160, Total Severity Score blank, and skip to D0700, Social Isolation.
      — If **both** D0150A2 and D0150B2 are **coded 0 or 1**, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.

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

- For all other scenarios, proceed to ask the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160, Total Severity Score.

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if resident indicates symptoms listed are not present. Enter 0 in Column 2 as well.
- **Code 1, yes:** if resident indicates symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the resident was unable or chose not to complete the assessment or responded nonsensically. Leave Column 2, Symptom Frequency, blank.
- Enter a Dash in Column 1 if the symptom presence was not assessed.

Coding Instructions for Column 2. Symptom Frequency

Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

- **Code 0, never or 1 day:** if the resident indicates that during the past 2 weeks they have never been bothered by the symptom or have only been bothered by the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that during the past 2 weeks they have been bothered by the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates during the past 2 weeks they have been bothered by the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates during the past 2 weeks they have been bothered by the symptom for 12-14 days.

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents.
- If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the PHQ-2©, leave D0160, Total Severity Score blank, and skip to D0700, Social Isolation.
- If Column 1 equals 0, enter 0 in Column 2.
- If Column 1 equals 9 or dash, leave Column 2 blank.
- For question D0150I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,

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

  - Experienced interviewers have found that most residents who are having this feeling appreciate the opportunity to express it.
  - Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the resident is already feeling.
  - The best interviewing approach is to ask the question openly and without hesitation.

- If the resident uses their own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using their own words, ask them to tell you how often they were bothered by that symptom.
- Select only one frequency response per item.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (e.g., item D0150F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Residents may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers.

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
  - **Example:** Say, "That's interesting, now I need to know…"; "Let's get back to…"; "I understand, can you tell me about…."
    - Validate your understanding of what the resident is saying by asking for clarification.
  - **Example:** Say, "I think I hear you saying that…"; "Let's see if I understood you correctly."; "You said…. Is that right?"
- If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
  - **Example:** Say, "Would you say [name symptom] bothered you more than half the days in the past 2 weeks?"
    - If the resident says "yes," show the cue card and ask whether it bothered them nearly every day (12-14 days) or on half or more of the days (7-11 days).
    - If the resident says "no," show the cue card and ask whether it bothered them several days (2-6 days) or never or 1 day (0-1 day).

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

- Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered them, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
  - "What do you mean?"
  - "Tell me what you have in mind."
  - "Tell me more about that."
  - "Please be more specific."
  - "Give me an example."
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
  - **Example:** Item D0150E, **Poor Appetite or Overeating**. The resident responds "the food is always cold and it just doesn't taste like it does at home. The doctor won't let me have any salt."
    - Possible interviewer response: "You're telling me the food isn't what you eat at home and you can't add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?"
  - **Example:** Item D0150A, **Little Interest or Pleasure in Doing Things**. The resident, when asked how often they have been bothered by little interest or pleasure in doing things, responds, "There's nothing to do here, all you do is eat, bathe, and sleep. They don't do anything I like to do."
    - Possible interview response: "You're saying there isn't much to do here and I want to come back later to talk about some things you like to do. Thinking about how you've been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things."
  - **Example:** Item D0150B, **Feeling Down, Depressed, or Hopeless**. The resident, when asked how often they have been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you were here?"
    - Possible interview response: "You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?"

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

- If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a resident has moderate cognitive impairment but can respond to simple, direct questions.
  - **Example:** Item D0150E, **Poor Appetite or Overeating**.
    - You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
  - **Example:** Item D0150C, **Trouble Falling or Staying Asleep, or Sleeping Too Much**.
    - You can break the item down as follows: "How often are you having problems falling asleep?" (pause for response) "How often are you having problems staying asleep?" (pause for response) "How often do you feel you are sleeping too much?"
  - **Example:** Item D0150H, **Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual**.
    - You can simplify this item by asking: "How often are you having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you felt so fidgety or restless that you move around a lot more than usual?"

Examples

1. Assessor: "Over the past 2 weeks, have you been bothered by any of the following problems? Little interest or pleasure in doing things?"

   Resident: "I'm not interested in doing much. I just don't feel like it. I used to enjoy visiting with friends, but I don't do that much anymore. I'm just not interested."

   Assessor: "In the past 2 weeks, how often would you say you have been bothered by this? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days?

   Resident: "7-11 days."

   Coding: D0150A1 (Symptom Presence) would be **coded 1, yes** and D0150A2 (Symptom Frequency) would be **coded 2, 7-11 days**.

   Rationale: The resident indicates that they have lost interest in activities that they previously enjoyed. The resident indicates that the symptom has bothered them 7-11 days in the past 2 weeks.

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

2. Assessor: "Over the past 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?"

   Resident: "Television? I used to like watching the news. I can't concentrate on that anymore."

   Assessor: "In the past 2 weeks, how often have you been bothered by having difficulty concentrating on things like television? Would you say never or 1 day, 2-6 days, 7-11 days, or 12-14 days?

   Resident: "I'd say every day. It bothers me every day."

   Coding: D0150G1 (Symptom Presence) would be **coded 1, yes** and D0150G2 (Symptom Frequency) would be **coded 3, 12-14 days**.

   Rationale: The resident states that they have trouble concentrating and that this bothers them every day.

D0160: Total Severity Score

D0160. Total Severity Score

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

Item Rationale

Health-related Quality of Life

- The **Total Severity Score** is a summary of the frequency scores on the PHQ-2 to 9© that indicates the extent of potential depression symptoms.
- The **Total Severity Score** does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up.

Planning for Care

- The PHQ-2 to 9© **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.
- Responses to PHQ-2 to 9© can indicate possible depression if the full PHQ-2 to 9© is completed (i.e., interview is not stopped after D0150B due to responses). Responses can be interpreted as follows:
  - Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the assessment period.

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D0160: Total Severity Score (cont.)

— Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the assessment period.

— In addition, PHQ-2 to 9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:

1-4: minimal depression
5-9: mild depression
10-14: moderate depression
15-19: moderately severe depression
20-27: severe depression

Steps for Assessment

After completing D0150 A–I

1. Add the numeric scores across all frequency items in **Resident Mood Interview** (D0150) Column 2.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
3. The maximum resident score is 27 (3 x 9).

Coding Instructions

- If only the PHQ-2© is completed because both D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 blank, then end the PHQ-2©, leave D0160, Total Severity Score blank, and skip to D0700, Social Isolation.
- If only the PHQ-2© is completed because **both** D0150A2 and D0150B2 **are scored 0 or 1**, add the numeric scores from these two frequency items and enter the value in D0160.
- If the PHQ-9© was completed (that is, D0150C–I were not blank due to the responses in D0150A and B) **and** if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©, add the numeric scores from D0150A2–D0150I2, following the instructions in Appendix E, and enter in D0160.
- If symptom frequency in items D0150A2 through D0150I2 is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as "99," do not complete the **Staff Assessment of Mood**, and skip to D0700, Social Isolation.
- Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or "**99**" if symptom frequency is blank for 3 or more items).
- The software will calculate the **Total Severity Score**. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-2 to 9© Total Severity Score Scoring Rules.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0150-D0160) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

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

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that they feel bad about self, are a failure, or have let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

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D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

Item Rationale

Health-related Quality of Life

- Persons unable to complete the PHQ-2 to 9© **Resident Mood Interview** may still have a mood disorder.
- The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.
- It is important to note that coding the presence of clinical signs and symptoms of depressed mood does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis as a result of the outcomes of the PHQ-2 to 9© or the PHQ-9-OV©; they simply record the presence or absence of specific clinical signs and symptoms of depressed mood.
- Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-2 to 9© **Resident Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

- When staff determine the resident is not interviewable (i.e., D0100 = 0, No), scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

Steps for Assessment

Conduct the interviews during the 7-day look-back period based on the ARD.

1. Interview staff from all shifts who know the resident best. Conduct the staff interview in a location that protects resident privacy.
2. Many of the same administration techniques outlined above for the PHQ-2 to 9© **Resident Mood Interview** and Interviewing Tips & Techniques can be followed when staff are interviewed.
3. Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.
4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation.
5. If frequency cannot be determined by staff interview because the resident has been in the facility for less than 2 weeks, talk to family or significant other and review transfer records to inform the selection of a frequency code.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

Examples of Staff Responses That Indicate Need for Follow-up Questioning with the Staff Member

1. **D0500A, Little Interest or Pleasure in Doing Things**
   - The resident doesn't really do much here.
   - The resident spends most of the time in their room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
   - They're 95—what can you expect?
   - How would you feel if you were here?
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
   - Their back hurts when they lie down.
   - They urinate a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
   - They're 95—they're always saying they're tired.
   - They're having a bad spell with their COPD right now.
5. **D0500E, Poor Appetite or Overeating**
   - They have not wanted to eat much of anything lately.
   - They have a voracious appetite, more so than last week.
6. **D0500F, Indicating That They Feel Bad about Self, Are a Failure, or Have Let Self or Family Down**
   - They do get upset when there's something they can't do now because of their stroke.
   - They get embarrassed when they can't remember something they think they should be able to.
7. **D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television**
   - They say there's nothing good on TV.
   - They never watch TV.
   - They can't see to read a newspaper.
8. **D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite—Being So Fidgety or Restless That They Have Been Moving Around a Lot More than Usual**
   - Their arthritis slows them down.
   - They're bored and always looking for something to do.

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D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

9. **D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self**
   - They say God should take them already.
   - They complain that people were not meant to live like this.
10. **D0500J, Being Short-Tempered, Easily Annoyed**
   - They're OK if you know how to approach them.
   - They can snap but usually when their pain is bad.
   - Not with me.
   - They're irritable.

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.
- **Code 1, yes:** if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency**.

Coding Instructions for Column 2. Symptom Frequency

- **Code 0, never or 1 day:** if staff indicate that the resident has never or has experienced the symptom on only 1 day.
- **Code 1, 2-6 days (several days):** if staff indicate that the resident has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if staff indicate that the resident has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if staff indicate that the resident has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- Ask the staff member being interviewed to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., "nearly every day" or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.
- If the staff member has difficulty selecting between two frequency responses, code for the **higher** frequency.
- If the resident has been in the facility for less than 2 weeks, also talk to the family or significant other and review transfer records to inform selection of the frequency code.

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D0600: Total Severity Score

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

Item Rationale

Health-related Quality of Life

- Review Item Rationale for D0160, **Total Severity Score**.
- The PHQ-9-OV© is adapted to allow the assessor to interview staff and identify a **Total Severity Score** for potential depressive symptoms.

Planning for Care

- The score can be communicated among health care providers and used to track symptoms and how they are changing over time.
- The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression.

Steps for Assessment

After completing the Staff Assessment of Resident Mood:

1. Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2.
2. Maximum score is 30 (3 × 10).

Coding Instructions

The interview is successfully completed if the staff members were able to answer the frequency responses of at least 8 out of 10 items on the PHQ-9-OV©.

- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9-OV© Total Severity Score Scoring Rules.

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D0600: Total Severity Score (cont.)

Coding Tips and Special Populations

- Responses to PHQ-9-OV© can indicate possible depression. Responses can be interpreted as follows:
  - Major Depressive Syndrome is suggested if—of the 10 items, 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
  - Minor Depressive Syndrome is suggested if—of the 10 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
  - In addition, PHQ-9-OV© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:

    1-4: minimal depression

    5-9: mild depression

    10-14: moderate depression

    15-19: moderately severe depression

    20-30: severe depression

D0700: Social Isolation



D0700. Social Isolation

Enter Code ☐

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

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

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D0700: Social Isolation (cont.)

Item Rationale

Health-related Quality of Life

- Social isolation tends to increase with age and is a risk factor for physical and mental illness and a predictor of mortality.

Planning for Care

- Programs to increase residents' social engagement should be designed and implemented, while also taking into account individual needs (e.g., disability, language) and preferences (e.g., cultural practices).
- Assessing social isolation can facilitate the identification of residents who may feel lonely and therefore may benefit from engagement efforts.
- Resident engagement in social interactions and activities of interest can greatly enhance quality of life. A resident's individualized care plan should address activity planning if the resident states that they sometimes, often, or always feel lonely or isolated.

DEFINITION

SOCIAL ISOLATION

Refers to an actual or perceived lack of contact with other people, such as living alone or residing in a remote area.

Steps for Assessment

This item is intended to be a resident self-report item. No other source should be used to identify the response.

1. Ask the resident, "How often do you feel lonely or isolated from those around you?"

Coding Instructions

- **Code 0, Never:** if the resident indicates never feeling lonely or isolated from others.
- **Code 1, Rarely:** if the resident indicates rarely feeling lonely or isolated from others.
- **Code 2, Sometimes:** if the resident indicates sometimes feeling lonely or isolated from others.
- **Code 3, Often:** if the resident indicates often feeling lonely or isolated from others.
- **Code 4, Always:** if the resident indicates always feeling lonely or isolated from others.
- **Code 7, Resident declines to respond:** if the resident declines to respond.
- **Code 8, Resident unable to respond:** if the resident is unable to respond.

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D0700: Social Isolation (cont.)



Examples

1. The resident is speaking with the social worker about being admitted for extended rehabilitation and is hoping to see their family later on in the day. When asked how often the resident feels lonely or isolated from those around them, the resident replies that they live with their child and their child's family but don't always feel like being around so much activity and stay in their room alone. As a result, they report that they sometimes feel lonely or isolated even though others are almost always home.

   Coding: D0700 would be coded **2, Sometimes**.

   Rationale: The resident states they sometimes feel lonely or isolated from those around them because they sometimes stay alone in their room.

2. The resident, upon being admitted to the facility, is asked about how often they feel lonely or isolated from those around them. They state that because they don't have many family members left who live close by and they see their friends only a couple of times a month, they often feel isolated. They are hoping that being in the facility will help them feel less isolated and plan to attend activities regularly.

   Coding: D0700 would be coded **3, Often**.

   Rationale: The resident states that because the family members they have don't live close by and their friends only visit a couple of times a month that they often feel isolated.

3. During the observation period of resident F's annual assessment, they are asked how often they feel lonely or isolated from those around them. Resident F responds that, even though they go to activities and have a few friends, they still feel alone. When asked how often they feel alone, Resident F responds every day.

   Coding: D0700 would be coded **4, Always**.

   Rationale: Resident F stated that they feel alone (i.e., lonely) every day when asked.

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SECTION E: BEHAVIOR

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident themself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.

This section focuses on the resident's actions, not the intent of their behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent (e.g., "Resident A doesn't really mean to hurt anyone. They're just frightened."). Resident intent should **not** be taken into account when coding for items in this section.

E0100: Potential Indicators of Psychosis

E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
☐	A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- Psychotic symptoms may be associated with
  - — delirium,
  - — dementia,
  - — adverse drug effects,
  - — psychiatric disorders, and
  - — hearing or vision impairment.
- Hallucinations and delusions may
  - — be distressing to residents and families,
  - — cause disability,
  - — interfere with delivery of medical, nursing, rehabilitative and personal care, and
  - — lead to dangerous behavior or possible harm.

DEFINITIONS

HALLUCINATION
The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.

DELUSION
A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.

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E0100: Potential Indicators of Psychosis (cont.)

Planning for Care

- Reversible **and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress**.

Steps for Assessment

1. Review the resident's medical record for the 7-day look-back period.
2. Interview staff members and others who have had the opportunity to observe the resident in a variety of situations during the 7-day look-back period.
3. Observe the resident during conversations and the structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations, or the expression of false beliefs (delusions).
4. Clarify potentially false beliefs:
    - When a resident expresses a belief that is plausible but alleged by others to be false (e.g., history indicates that the resident's spouse died 20 years ago, but the resident states their spouse has been visiting them every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.
    - When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. Do not, however, challenge the resident.
    - The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed.

Coding Instructions

Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.

- **Check E0100A, hallucinations:** if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
- **Check E0100B, delusions:** if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary.
- **Check E0100Z, none of the above:** if no hallucinations or delusions were present in the last 7 days.

E0100: Potential Indicators of Psychosis (cont.)

Coding Tips and Special Populations

- If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, **do not** code it as a delusion.
- If a resident expresses a false belief but easily accepts a reasonable alternative explanation, **do not** code it as a delusion. If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, **code as a delusion**.

Examples

1. A resident carries a doll, which they believe is their baby, and the resident appears upset. When asked about this, they report they are distressed from hearing their baby crying and think that the baby is hungry and they want to get the baby a bottle.

   Coding: E0100A would be **checked** and E0100B would be **checked.**
   Rationale: The resident believes the doll is a baby, which is a delusion, and they hear the doll crying, which is an auditory hallucination.

2. A resident reports that they heard a gunshot. In fact, there was a loud knock on the door. When this is explained to them, they accept the alternative interpretation of the loud noise.

   Coding: E0100Z would be **checked.**
   Rationale: They misinterpreted a real sound in the external environment. Because they are able to accept the alternative explanation for the cause of the sound, their report of a gunshot is not a fixed false belief and is therefore not a delusion.

3. A resident is found speaking aloud in their room. When asked about this, they state that they are answering a question posed to them by an individual in front of them. Staff note that no one is present and that no other voices can be heard in the environment.

   Coding: E0100A would be **checked.**
   Rationale: The resident reports auditory and visual sensations that occur in the absence of any external stimulus. Therefore, this is a hallucination.

4. A resident announces that they must leave to go to work, because they are needed in their office right away. In fact, they have been retired for 15 years. When reminded of this, they continue to insist that they must get to their office.

   Coding: E0100B would be **checked.**
   Rationale: The resident adheres to the belief that they still work, even after being reminded about their retirement status. Because the belief is held firmly despite an explanation of the real situation, it is a delusion.

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E0100: Potential Indicators of Psychosis (cont.)

5. A resident believes they must leave the facility immediately because their parents are waiting for them to return home. Staff know that, in reality, their parents are deceased and gently remind them that their parents are no longer living. In response to this reminder, the resident acknowledges, "Oh yes, I remember now. My parents passed away years ago."

   Coding: E0100Z would be **checked.**

   Rationale: The resident's initial false belief is readily altered with a simple reminder, suggesting that their mistaken belief is due to forgetfulness (i.e., memory loss) rather than psychosis. Because it is not a firmly held false belief, it does not fit the definition of a delusion.

E0200: Behavioral Symptom—Presence & Frequency

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Enter Code ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)

Enter Code ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)

Enter Code ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

Item Rationale

Health-related Quality of Life

- New onset of behavioral symptoms warrants prompt evaluation, assurance of resident safety, relief of distressing symptoms, and compassionate response to the resident.
- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.

Planning for Care

- Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems—and may therefore require treatment planning and intervention—from those that are not problematic.
- These behaviors may indicate unrecognized needs, preferences, or illness.
- Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact.

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E0200: Behavioral Symptom—Presence & Frequency (cont.)

- Subsequent assessments and documentation can be compared to baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment

1. Review the medical record for the 7-day look-back period.
2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident.
3. Observe the resident in a variety of situations during the 7-day look-back period.

Coding Instructions

- **Code 0, behavior not exhibited:** if the behavioral symptoms were not present in the last 7 days. Use this code if the symptom has never been exhibited or if it previously has been exhibited but has been absent in the last 7 days.
- **Code 1, behavior of this type occurred 1-3 days:** if the behavior was exhibited 1-3 days of the last 7 days, regardless of the number or severity of episodes that occur on any one of those days.
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the behavior was exhibited 4-6 of the last 7 days, regardless of the number or severity of episodes that occur on any of those days.
- **Code 3, behavior of this type occurred daily:** if the behavior was exhibited daily, regardless of the number or severity of episodes that occur on any of those days.

Coding Tips and Special Populations

- Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
- Code as present, even if staff have become used to the behavior or view it as typical or tolerable.
- Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care.
- Item E0200C does not include wandering.

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E0200: Behavioral Symptom—Presence & Frequency (cont.)

Examples

1. Every morning, a nursing assistant tries to help a resident who is unable to dress themself. On the last 4 out of 6 mornings, the resident has hit or scratched the nursing assistant during attempts to dress them.

   Coding: E0200A would be **coded 2, behavior of this type occurred 4-6 days, but less than daily.**
   Rationale: Scratching the nursing assistant was a physical behavior directed toward others.

2. A resident has previously been found rummaging through the clothes in their roommate's dresser drawer. This behavior has not been observed by staff or reported by others in the last 7 days.

   Coding: E0200C would be **coded 0, behavior not exhibited.**
   Rationale: The behavior did not occur during the look-back period.

3. A resident throws their dinner tray at another resident who repeatedly spit food at them during dinner. This is a single, isolated incident.

   Coding: E0200A would be **coded 1, behavior of this type occurred 1-3 days of the last 7 days.**
   Rationale: Throwing a tray was a physical behavior directed toward others. Although a possible explanation exists, the behavior is noted as present because it occurred.

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E0300: Overall Presence of Behavioral Symptoms

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?

0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

Item Rationale

To determine whether or not additional items E0500, **Impact on Resident**, and E0600, **Impact on Others,** are required to be completed.

Steps for Assessment

1. Review coding for item E0200 and follow these coding instructions:

Coding Instructions

- **Code 0, no:** if E0200A, E0200B, and E0200C all are coded 0, not present. Skip to **Rejection of Care—Presence & Frequency** item (E0800).
- **Code 1, yes:** if any of E0200A, E0200B, or E0200C were coded 1, 2, or 3. Proceed to complete **Impact on Resident** item (E0500), and **Impact on Others** item (E0600).

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E0500: Impact on Resident

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ A. Put the resident at significant risk for physical illness or injury?
0. No
1. Yes

Enter Code ☐ B. Significantly interfere with the resident's care?
0. No
1. Yes

Enter Code ☐ C. Significantly interfere with the resident's participation in activities or social interactions?
0. No
1. Yes

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 impact the resident's risk for significant injury, interfere with care or their participation in activities or social interactions.

Planning for Care

- Identification of the impact of the behaviors noted in E0200 may require treatment planning and intervention.
- Subsequent assessments and documentation can be compared to a baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the medical record, staff interviews across all shifts and disciplines, interviews with others who had close interactions with the resident and previous observations of the behaviors identified in E0200 for the 7-day look-back period.
2. Code E0500A, E0500B, and E0500C based on **all** of the behavioral symptoms coded in E0200.
3. Determine whether those behaviors put the resident at significant risk of physical illness or injury, whether the behaviors significantly interfered with the resident's care, and/or whether the behaviors significantly interfered with the resident's participation in activities or social interactions.

Coding Instructions for E0500A. Did Any of the Identified Symptom(s) Put the Resident at Significant Risk for Physical Illness or Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed the resident at clinically significant risk for a physical illness or injury.
- **Code 1, yes:** if any of the identified behavioral symptom(s) placed the resident at clinically significant risk for a physical illness or injury, even if no injury occurred.

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E0500: Impact on Resident (cont.)

Coding Instructions for E0500B. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Care?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly interfered with the resident's care.
- **Code 1, yes:** if any of the identified behavioral symptom(s) impeded the delivery of essential medical, nursing, rehabilitative or personal care, including but not limited to assistance with activities of daily living, such as bathing, dressing, feeding, or toileting.

Coding Instructions for E0500C. Did Any of the Identified Symptom(s) Significantly Interfere with the Resident's Participation in Activities or Social Interactions?

- **Code 0, no:** if none of the identified symptom(s) significantly interfered with the resident's participation in activities or social interactions.
- **Code 1, yes:** if any of the identified behavioral symptom(s) significantly interfered with or decreased the resident's participation or caused staff not to include residents in activities or social interactions.

Coding Tips and Special Populations

- For E0500A, code based on whether the risk for physical injury or illness is known to occur commonly under similar circumstances (i.e., with residents who exhibit similar behavior in a similar environment). Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability, or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0500B, code if the impact of the resident's behavior is impeding the delivery of care to such an extent that necessary or essential care (medical, nursing, rehabilitative or personal that is required to achieve the resident's goals for health and well-being) cannot be received safely, completely, or in a timely way without more than a minimal accommodation, such as simple change in care routines or environment.
- For E0500C, code if the impact of the resident's behavior is limiting or keeping the resident from engaging in solitary activities or hobbies, joining groups, or attending programmed activities or having positive social encounters with visitors, other residents, or staff.

Examples

1. A resident frequently grabs and scratches staff when they attempt to change their soiled brief, digging their nails into staff members' skin. This makes it difficult to complete the care task.

   Coding: E0500B would be **coded 1, yes**.
   Rationale: This behavior interfered with delivery of essential personal care.

E0500: Impact on Resident (cont.)

2. During the last 7 days, a resident with vascular dementia and severe hypertension, hits staff during incontinent care making it very difficult to change them. Six out of the last seven days the resident refuses all their medication including their antihypertensive. The resident closes their mouth and shakes their head and will not take it even if re-approached multiple times.

   Coding: E0500A and E0500B would both be **coded 1, yes.**

   Rationale: The behavior interfered significantly with delivery of their medical and nursing care and put them at clinically significant risk for physical illness.

3. A resident paces incessantly. When staff encourage them to sit at the dinner table, they return to pacing after less than a minute, even after cueing and reminders. They are so restless that they cannot sit still long enough to feed themself or receive assistance in obtaining adequate nutrition.

   Coding: E0500A and E0500B would both be **coded 1, yes.**

   Rationale: This behavior significantly interfered with personal care (i.e., feeding) and put the resident at risk for malnutrition and physical illness.

4. A resident repeatedly throws their markers and card on the floor during bingo.

   Coding: E0500C would be **coded 1, yes.**

   Rationale: This behavior interfered with their ability to participate in the activity.

5. A resident with severe dementia has continuous outbursts while awake despite all efforts made by staff to address the issue, including trying to involve the resident in prior activities of choice.

   Coding: E0500C would be **coded 1, yes.**

   Rationale: The staff determined the resident's behavior interfered with the ability to participate in any activities.

E0600: Impact on Others

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ A. Put others at significant risk for physical injury?
0. No
1. Yes

Enter Code ☐ B. Significantly intrude on the privacy or activity of others?
0. No
1. Yes

Enter Code ☐ C. Significantly disrupt care or living environment?
0. No
1. Yes

Draft

E0600: Impact on Others (cont.)

Item Rationale

Health-related Quality of Life

- Behaviors identified in item E0200 put others at risk for significant injury, intrude on their privacy or activities and/or disrupt their care or living environments. The impact on others is coded here in item E0600.

Planning for Care

- Identification of the behaviors noted in E0200 that have an impact on others may require treatment planning and intervention.
- Subsequent assessments and documentation can be compared with a baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment

1. Consider the previous review of the clinical record, staff interviews across all shifts and disciplines, interviews with others who had close interactions with the resident and previous observations of the behaviors identified in E0200 for the 7-day look-back period.
2. To code E0600, determine if the behaviors identified put others at significant risk of physical illness or injury, intruded on their privacy or activities, and/or interfered with their care or living environments.

Coding Instructions for E0600A. Did Any of the Identified Symptom(s) Put Others at Significant Risk for Physical Injury?

- **Code 0, no:** if none of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code 1, yes:** if any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.

Coding Instructions for E0600B. Did Any of the Identified Symptom(s) Significantly Intrude on the Privacy or Activity of Others?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly intruded on the privacy or activity of others.
- **Code 1, yes:** if any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities (not organized or run by staff). Includes coming in uninvited, invading, or forcing oneself on others' private activities.

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E0600: Impact on Others (cont.)

Coding Instructions for E0600C. Did Any of the Identified Symptom(s) Significantly Disrupt Care or the Living Environment?

- **Code 0, no:** if none of the identified behavioral symptom(s) significantly disrupted delivery of care or the living environment.
- **Code 1, yes:** if any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

Coding Tips and Special Populations

- For E0600A, code based on whether the behavior placed others at significant risk for physical injury. Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0600B, code based on whether the behavior violates other residents' privacy or interrupts other residents' performance of activities of daily living or limits engagement in or enjoyment of informal social or recreational activities to such an extent that it causes the other residents to experience distress (e.g., displeasure or annoyance) or inconvenience, whether or not the other residents complain.
- For E0600C, code based on whether the behavior interferes with staff ability to deliver care or conduct organized activities, interrupts receipt of care or participation in organized activities by other residents, and/or causes other residents to experience distress or adverse consequences.

Examples

1. A resident appears to intentionally stick their cane out when another resident walks by.

   Coding: E0600A would be **coded 1, yes**; E0600B and E0600C would be **coded 0, no.**
   Rationale: The behavior put the other resident at risk for falling and physical injury. You may also need to consider coding B and C depending on the specific situation in the environment or care setting.

2. A resident, when sitting in the hallway outside the community activity room, continually yells, repeating the same phrase. The yelling can be heard by other residents in hallways and activity/recreational areas but not in their private rooms.

   Coding: E0600A would be **coded 0, no**; E0600B and E0600C would be **coded 1, yes.**
   Rationale: The behavior does not put others at risk for significant injury. The behavior does create a climate of excessive noise, disrupting the living environment and the activity of others.

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E0600: Impact on Others (cont.)

3. A resident repeatedly enters the rooms of other residents and rummages through their personal belongings. The other residents do not express annoyance.

   Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**
   Rationale: This is an intrusion and violates other residents' privacy regardless of whether they complain or communicate their distress.

4. When eating in the dining room, a resident frequently grabs food off the plates of other residents. Although the other resident's food is replaced, and the behavior does not compromise their nutrition, other residents become anxious in anticipation of this recurring behavior.

   Coding: E0600A would be **coded 0, no**; E0600B and E0600C would be **coded 1, yes.**
   Rationale: This behavior violates other residents' privacy as it is an intrusion on the personal space and property (food tray). In addition, the behavior is pervasive and disrupts the staff's ability to deliver nutritious meals in dining room (an organized activity).

5. A resident tries to seize the telephone out of the hand of another resident who is attempting to complete a private conversation. Despite being asked to stop, the resident persists in grabbing the telephone and insisting that they want to use it.

   Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**
   Rationale: This behavior is an intrusion on another resident's private telephone conversation.

6. A resident begins taunting two residents who are playing an informal card game, yelling that they will "burn in hell" if they don't stop "gambling."

   Coding: E0600A and E0600C would be **coded 0, no**; E0600B would be **coded 1, yes.**
   Rationale: The behavior is intruding on the other residents' game. The game is not an organized facility event and does not involve care. It is an activity in which the two residents wanted to engage.

7. A resident yells continuously during an exercise group, diverting staff attention so that others cannot participate in and enjoy the activity.

   Coding: E0600A and E0600B would be **coded 0, no**; E0600C would be **coded 1, yes.**
   Rationale: This behavior disrupts the delivery of physical care (exercise) to the group participants and creates an environment of excessive noise.

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E0600: Impact on Others (cont.)

8. A resident becomes verbally threatening in a group discussion activity, frightening other residents. In response to this disruption, staff terminate the discussion group early to avoid eliciting the behavioral symptom.

   Coding: E0600A and E0600B would be **coded 0, no**; E0600C would be **coded 1, yes.**

   Rationale: This behavior does not put other residents at risk for significant injury. However, the behavior restricts full participation in the organized activity, and limits the enjoyment of other residents. It also causes fear, thereby disrupting the living environment.

E0800: Rejection of Care—Presence & Frequency

E0800. Rejection of Care - Presence & Frequency

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

Enter Code ☐

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

- Goals for health and well-being reflect the resident's wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.
- The resident's care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational to the clinician. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment."
- It is really a matter of resident choice. When rejection/decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident's choice. Education is provided and the resident's choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.
- A resident might reject/decline care because the care conflicts with their preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.
- Care rejection may be manifested by verbally declining, statements of refusal, or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care.

E0800: Rejection of Care—Presence & Frequency (cont.)

- This type of behavior interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.
- A resident's rejection of care might be caused by an underlying neuropsychiatric, medical, or dental problem. This can interfere with needed care that is consistent with the resident's preferences or established care goals. In such cases, care rejection behavior may be a problem that requires assessment and intervention.

DEFINITIONS

REJECTION OF CARE
Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.

INTERFERENCE WITH CARE
Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.

Planning for Care

- Evaluation of rejection of care assists the nursing home in honoring the resident's care preferences in order to meet their desired health care goals.
- Follow-up assessment should consider:
  - whether established care goals clearly reflect the resident's preferences and goals and
  - whether alternative approaches could be used to achieve the resident's care goals.
- Determine whether a previous discussion identified an objection to the type of care or the way in which the care was provided. If so, determine approaches to accommodate the resident's preferences.

Steps for Assessment

1. Review the medical record.
2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period.
3. Review the record and consult staff to determine whether the rejected care is needed to achieve the resident's preferences and goals for health and well-being.
4. Review the medical record to find out whether the care rejection behavior was previously addressed and documented in discussions or in care planning with the resident, family, or significant other and determined to be an informed choice consistent with the resident's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.
5. If the resident exhibits behavior that appears to communicate a rejection of care (and that rejection behavior has not been previously determined to be consistent with the resident's values or goals), ask them directly whether the behavior is meant to decline or refuse care.

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E0800: Rejection of Care—Presence & Frequency (cont.)

- If the resident indicates that the intention is to decline or refuse, then ask them about the reasons for rejecting care and about their goals for health care and well-being.
- If the resident is unable or unwilling to respond to questions about their rejection of care or goals for health care and well-being, then interview the family or significant other to ascertain the resident's health care preferences and goals.

Coding Instructions

- **Code 0, behavior not exhibited:** if rejection of care consistent with goals was not exhibited in the last 7 days.
- **Code 1, behavior of this type occurred 1-3 days:** if the resident rejected care consistent with goals 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the resident rejected care consistent with goals 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.
- **Code 3, behavior of this type occurred daily:** if the resident rejected care consistent with goals daily in the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days.

Coding Tips and Special Populations

- The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker.
- Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and determined to be consistent with the resident's values, preferences, or goals. Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

Examples

1. A resident with heart failure who recently returned to the nursing home after surgical repair of a hip fracture is offered physical therapy and declines. They say that they get too short of breath when they try to walk even a short distance, making physical therapy intolerable. They do not expect to walk again and does not want to try. Their physician has discussed this with them and has indicated that their prognosis for regaining ambulatory function is poor.

   Coding: E0800 would be **coded 0, behavior not exhibited.**

   Rationale: This resident has communicated that they consider physical therapy to be both intolerable and futile. The resident discussed this with their physician. Their choice to not accept physical therapy treatment is consistent with their values and goals for health care. Therefore, this would **not** be coded as rejection of care.

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E0800: Rejection of Care—Presence & Frequency (cont.)

2. A resident informs the staff that they would rather receive care at home, and the next day they call for a taxi and exits the nursing facility. When staff try to persuade them to return, they firmly state, "Leave me alone. I always swore I'd never go to a nursing home. I'll get by with my visiting nurse service at home again." They are not exhibiting signs of disorientation, confusion, or psychosis and has never been judged incompetent.

   Coding: E0800 would be **coded 0, behavior not exhibited.**
   Rationale: Their departure is consistent with their stated preferences and goals for health care. Therefore, this is **not** coded as care rejection.

3. A resident goes to bed at night without changing out of the clothes they wore during the day. When a nursing assistant offers to help them get undressed, they decline, stating that they prefer to sleep in their clothes tonight. The clothes are wet with urine. This has happened 2 of the past 7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

   Coding: E0800 would be **coded 1, behavior of this type occurred 1-3 days.**
   Rationale: The resident's care rejection behavior is not consistent with their values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

4. A resident chooses not to eat supper one day, stating that the food causes them diarrhea. They say they know they need to eat and do not wish to compromise their nutrition, but they are more distressed by the diarrhea than by the prospect of losing weight.

   Coding: E0800 would be **coded 1, behavior of this type occurred 1-3 days.**
   Rationale: Although choosing not to eat is consistent with the resident's desire to avoid diarrhea, it is also in conflict with their stated goal to maintain adequate nutrition.

5. A resident is given their antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. This resident's assessment indicates that they do not have any swallowing problems. This happened on each of the last 4 days. The resident's advance directive indicates that they would choose to take antibiotics to treat a potentially life-threatening infection.

   Coding: E0800 would be **coded 2, behavior of this type occurred 4-6 days, but less than daily.**
   Rationale: The behavioral rejection of antibiotics prevents the resident from achieving their stated goals for health care listed in their advance directives. Therefore, the behavior is coded as care rejection.

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E0800: Rejection of Care—Presence & Frequency (cont.)

6. A resident who recently returned to the nursing home after surgery for a hip fracture is offered physical therapy and declines. They state that they want to walk again but is afraid of falling. This occurred on 4 days during the look-back period.

   Coding: E0800 would be **coded 2, behavior of this type occurred 4-6 days.**
   Rationale: Even though the resident's health care goal is to regain their ambulatory status, their fear of falling results in rejection of physical therapy and interferes with their rehabilitation. This would be coded as rejection of care.

7. A resident who previously ate well and prided themself on following a healthy diet has been refusing to eat every day for the past 2 weeks. They complain that the food is boring and that they feel full after just a few bites. They say they want to eat to maintain their weight and avoid getting sick, but they cannot push themself to eat anymore.

   Coding: E0800 would be **coded 3, behavior of this type occurred daily.**
   Rationale: The resident's choice not to eat is not consistent with their goal of weight maintenance and health. Choosing not to eat may be related to a medical condition such as a disturbance of taste sensation, gastrointestinal illness, endocrine condition, depressive disorder, or medication side effects.

E0900: Wandering—Presence & Frequency

E0900. Wandering - Presence & Frequency

Has the resident wandered?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Item Rationale

Health-related Quality of Life

- Wandering may be a pursuit of exercise or a pleasurable leisure activity, or it may be related to tension, anxiety, agitation, or searching.

Planning for Care

- It is important to assess for reason for wandering. Determine the frequency of its occurrence, and any factors that trigger the behavior or that decrease the episodes.
- Assess for underlying tension, anxiety, psychosis, drug-induced psychomotor restlessness, agitation, or unmet need (e.g., for food, fluids, toileting, exercise, pain relief, sensory or cognitive stimulation, sense of security, companionship) that may be contributing to wandering.

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E0900: Wandering—Presence & Frequency (cont.)

Steps for Assessment

1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period.
   - Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to their physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes they must find their parent, who staff know is deceased).
2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period.

Coding Instructions for E0900

- **Code 0, behavior not exhibited:** if wandering was not exhibited during the 7-day look-back period. Skip to **Change in Behavior or Other Symptoms** item (E1100).
- **Code 1, behavior of this type occurred 1-3 days:** if the resident wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 2, behavior of this type occurred 4-6 days, but less than daily:** if the resident wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).
- **Code 3, behavior of this type occurred daily:** if the resident wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer **Wandering—Impact** item (E1000).

Coding Tips and Special Populations

- Pacing (repetitive walking with a driven/pressured quality) within a constrained space is not included in wandering.
- Wandering may occur even if resident is in a locked unit.
- Traveling via a planned course to another specific place (such as going to the dining room to eat a meal or to an activity) is not considered wandering.

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E1000: Wandering—Impact

Answer this item only if E0900, Wandering—Presence & Frequency, was coded 1 (behavior of this type occurred 1-3 days), 2 (behavior of this type occurred 4-6 days, but less than daily), or 3 (behavior of this type occurred daily).

E1000. Wandering - Impact

Enter Code ☐ **A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place** (e.g., stairs, outside of the facility)?

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

Enter Code ☐ **B. Does the wandering significantly intrude on the privacy or activities of others?**

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

Item Rationale

Health-related Quality of Life

- Not all wandering is harmful.
- Some residents who wander are at potentially higher risk for entering an unsafe situation.
- Some residents who wander can cause significant disruption to other residents.

Planning for Care

- Care plans should consider the impact of wandering on resident safety and disruption to others.
- Care planning should be focused on minimizing these issues.
- Determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety if wandering places the resident at risk.
- Determine when wandering requires interventions to reduce unwanted intrusions on other residents or disruption of the living environment.

Steps for Assessment

1. Consider the previous review of the resident's wandering behaviors identified in E0900 for the 7-day look-back period.
2. Determine whether those behaviors put the resident at significant risk of getting into potentially dangerous places and/or whether wandering significantly intrudes on the privacy or activities of others based on clinical judgment for the individual resident.

Coding Instructions for E1000A. Does the Wandering Place the Resident at Significant Risk of Getting to a Potentially Dangerous Place?

- **Code 0, no:** if wandering does not place the resident at significant risk.
- **Code 1, yes:** if the wandering places the resident at significant risk of getting to a dangerous place (e.g., wandering outside the facility where there is heavy traffic) or encountering a dangerous situation (e.g., wandering into the room of another resident with dementia who is known to become physically aggressive toward intruders).

E1000: Wandering—Impact (cont.)

Coding Instructions for E1000B. Does the Wandering Significantly Intrude on the Privacy or Activities of Others?

- **Code 0, no:** if the wandering does not intrude on the privacy or activity of others.
- **Code 1, yes:** if the wandering intrudes on the privacy or activities of others (i.e., if the wandering violates other residents' privacy or interrupts other residents' performance of activities of daily living or limits engagement in or enjoyment of social or recreational activities), whether or not the other resident complains or communicates displeasure or annoyance.

Examples

1. A resident wanders away from the nursing home in their pajamas at 3 a.m. When staff members talk to them, they insist they looking for their spouse. This elopement behavior had occurred when they were living at home, and on one occasion they became lost and were missing for 3 days, leading their family to choose nursing home admission for their personal safety.

   Coding: E1000A would be **coded 1, yes.**
   Rationale: Wandering that results in elopement from the nursing home places the resident at significant risk of getting into a dangerous situation.

2. A resident wanders away from the nursing facility at 7 a.m. Staff find them crossing a busy street against a red light. When staff try to persuade them to return, they become angry and say, "My boss called, and I have to get to the office." When staff remind them that they have been retired for many years, they continue to insist that they must get to work.

   Coding: E1000A would be **coded 1, yes.**
   Rationale: This resident's wandering is associated with elopement from the nursing home and into a dangerous traffic situation. Therefore, this is coded as placing the resident at significant risk of getting to a place that poses a danger. In addition, delusions would be checked in item E0100.

3. A resident propels themself in their wheelchair into the room of another resident, blocking the door to the other resident's bathroom.

   Coding: E1000B would be **coded 1, yes.**
   Rationale: Moving about in this manner with the use of a wheelchair meets the definition of wandering, and the resident has intruded on the privacy of another resident and has interfered with that resident's ability to use the bathroom.

E1100: Change in Behavior or Other Symptoms

E1100. Change in Behavior or Other Symptoms
Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

E1100: Change in Behavior or Other Symptoms (cont.)

Item Rationale

Health-related Quality of Life

- Change in behavior may be an important indicator of
  - a change in health status or a change in environmental stimuli,
  - positive response to treatment, and
  - adverse effects of treatment.

Planning for Care

- If behavior is worsening, assessment should consider whether it is related to
  - new health problems, psychosis, or delirium;
  - worsening of pre-existing health problems;
  - a change in environmental stimuli or caregivers that influences behavior; and
  - adverse effects of treatment.
- If behaviors are improved, assessment should consider what interventions should be continued or modified (e.g., to minimize risk of relapse or adverse effects of treatment).

Steps for Assessment

1. Review responses provided to items E0100-E1000 on the current MDS assessment.
2. Compare with responses provided on prior MDS assessment.
3. Taking all of these MDS items into consideration, make a global assessment of the change in behavior from the most recent to the current MDS.
4. Rate the overall behavior as same, improved, or worse.

Coding Instructions

- **Code 0, same:** if overall behavior is the same (unchanged).
- **Code 1, improved:** if overall behavior is improved.
- **Code 2, worse:** if overall behavior is worse.
- **Code 3, N/A:** if there was no prior MDS assessment of this resident.

Coding Tips

- For residents with multiple behavioral symptoms, it is possible that different behaviors will vary in different directions over time. That is, one behavior may improve while another worsens or remains the same. Using clinical judgment, this item should be rated to reflect the overall direction of behavior change, estimating the net effects of multiple behaviors.

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E1100: Change in Behavior or Other Symptoms (cont.)

Examples

1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on the unit 2 of the last 7 days but has not attempted to exit the unit. Because the resident is no longer attempting to exit the unit, they are at decreased risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.

   Coding: E1100 would be **coded 1, improved.**

   Rationale: Although one component of this resident's wandering behavior is worse because it has begun to intrude on the privacy of others, it is less frequent and less dangerous (without recent elopement) and is therefore improved overall since the last assessment. The fact that the behavior requires less intense surveillance or intervention by staff also supports the decision to rate the overall behavior as improved.

2. At the time of the last assessment, the resident was ambulatory and would threaten and hit other residents daily. They recently suffered a hip fracture and is not ambulatory. They are not approaching, threatening, or assaulting other residents. However, the resident is now combative when staff try to assist with dressing and bathing, and is hitting staff members daily.

   Coding: E1100 would be **coded 0, same.**

   Rationale: Although the resident is no longer assaulting other residents, they have begun to assault staff. Because the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

3. On the prior assessment, a resident with Alzheimer's disease was reported to wander on 2 out of 7 days and has responded well to redirection. On the most recent assessment, it was noted that the resident has been wandering more frequently for 5 out of 7 days and has also attempted to elope from the building on two occasions.

   This behavior places the resident at significant risk of personal harm. The resident has been placed on more frequent location checks and has required additional redirection from staff. They were also provided with an elopement bracelet so that staff will be alerted if the resident attempts to leave the building. The intensity required of staff surveillance because of the dangerousness and frequency of the wandering behavior has significantly increased.

   Coding: E1100 would be **coded 2, worse.**

   Rationale: Because the danger and the frequency of the resident's wandering behavior have increased and there were two elopement attempts, the overall behavior is rated as worse.

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SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

Intent: The intent of items in this section is to obtain information regarding the resident's preferences for their daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive.

F0300: Should Interview for Daily and Activity Preferences Be Conducted?

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

Item Rationale

Health-related Quality of Life

- Most residents capable of communicating can answer questions about what they like.
- Obtaining information about preferences directly from the resident, sometimes called "hearing the resident's voice," is the most reliable and accurate way of identifying preferences.
- If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences.

Planning for Care

- Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident.
- Interviews allow the resident's voice to be reflected in the care plan.
- Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning.

Steps for Assessment

1. Interact with the resident using their preferred language. Be sure they can hear you and/or has access to their preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. There may be times when, due to medical or psychiatric conditions, a resident has difficulty communicating and understanding. When conducting resident interviews, providers are to assess and use their clinical judgment to determine the best time in which to attempt to conduct the resident interview. Providers are to attempt to conduct the interview with all conscious residents.

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F0300: Should Interview for Daily and Activity Preferences Be Conducted? (cont.)

The determination as to whether or not a resident interview is conducted is not based on the response to item B0700, Makes Self Understood. Instead, the resident interview is attempted, and is only terminated based on the response or lack of response to the resident interview questions/statements according to the coding instructions provided for the interview which would render the interview incomplete.

3. If the resident is unable to complete the resident interview, attempt to conduct the interview with a family member or significant other. If neither a family member nor significant other is available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
4. Conduct the interview during the observation period.
5. Review Language item (A1110) 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.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences).
- **Code 1, yes:** if the resident interview should be conducted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences).

Coding Tips and Special Populations

- If the resident needs an interpreter, every effort should be made to have an interpreter present for the MDS clinical interview. If it is not possible for a needed interpreter to be present on the day of the interview, **and** a family member or significant other is not available for interview, **code F0300 = 0** to indicate interview not attempted, and complete the Staff Assessment of Daily and Activity Preferences (F0800) instead of the interview with the resident (F0400 and F0500).
- If the resident interview was not conducted within the look-back period of the ARD, item F0300 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 of Daily and Activity Preferences items (F0700–F0800) if the resident interview should have been conducted, but was not done.

F0400: Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:

1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice
9. No response or non-responsive

Enter Codes in Boxes

- ☐ ***A.*** *how important is it to you to* ***choose what clothes to wear?***
- ☐ ***B.*** *how important is it to you to* ***take care of your personal belongings or things?***
- ☐ ***C.*** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
- ☐ ***D.*** *how important is it to you to* ***have snacks available between meals?***
- ☐ ***E.*** *how important is it to you to* ***choose your own bedtime?***
- ☐ ***F.*** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
- ☐ ***G.*** *how important is it to you to* ***be able to use the phone in private?***
- ☐ ***H.*** *how important is it to you to* ***have a place to lock your things to keep them safe?***

Item Rationale

Health-related Quality of Life

- Individuals who live in nursing homes continue to have distinct lifestyle preferences.
- A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms.
- Resident responses that something is important but that they can't do it or have no choice can provide clues for understanding pain, perceived functional limitations, and perceived environmental barriers.

Planning for Care

- Care planning should be individualized and based on the resident's preferences.
- Care planning and care practices that are based on resident preferences can lead to
  - — improved mood,
  - — enhanced dignity, and
  - — increased involvement in daily routines and activities.
- Incorporating resident preferences into care planning is a dynamic, collaborative process. Because residents may adjust their preferences in response to events and changes in status, the preference assessment tool is intended as a first step in an ongoing dialogue between care providers and the residents. Care plans should be updated as residents' preferences change, paying special attention to preferences that residents state are important.

Steps for Assessment: Interview Instructions

1. Interview any resident not screened out by the **Should Interview for Daily and Activity Preferences Be Conducted?** item (F0300).
2. Conduct the interview in a private setting.

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F0400: Interview for Daily Preferences (cont.)



3. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be interviewed using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
5. Explain the reason for the interview before beginning.

   Suggested language: "I'd like to ask you a few questions about your daily routines. The reason I'm asking you these questions is that the staff here would like to know what's important to you. This helps us plan your care around your preferences so that you can have a comfortable stay with us. Even if you're only going to be here for a few days, we want to make your stay as personal as possible."
6. Explain the interview response choices. While explaining, also show the resident a clearly written list of the response options, for example a cue card**.**

   Suggested language: "I am going to ask you how important various activities and routines are to you **while you are in this home.** I will ask you to answer using the choices you see on this card [read the answers while pointing to cue card]: 'Very Important,' 'Somewhat important,' 'Not very important,' 'Not important at all,' or 'Important, but can't do or no choice.'"

   Explain the "Important, but can't do or no choice" response option.

   Suggested language: "Let me explain the 'Important, but can't do or no choice' answer. You can select this answer if something would be important to you, but because of your health or because of what's available in this nursing home, you might not be able to do it. So, if I ask you about something that is important to you, but you don't think you're able to do it now, answer 'Important, but can't do or no choice.' If you choose this option, it will help us to think about ways we might be able to help you do those things."
7. Residents may respond to questions
   - verbally,
   - by pointing to their answers on the cue card, OR
   - by writing out their answers.
8. If resident cannot report preferences, then interview family or significant others.

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F0400: Interview for Daily Preferences (cont.)



Coding Instructions

- **Code 1, very important:** if resident, family, or significant other indicates that the topic is "very important."
- **Code 2, somewhat important:** if resident, family, or significant other indicates that the topic is "somewhat important."
- **Code 3, not very important:** if resident, family, or significant other indicates that the topic is "not very important."

DEFINITION

NONSENSICAL RESPONSE
Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being rated.

- **Code 4, not important at all:** if resident, family, or significant other indicates that the topic is "not important at all."
- **Code 5, important, but can't do or no choice:** if resident, family, or significant other indicates that the topic is "important," but that they are physically unable to participate, or have no choice about participating while staying in nursing home because of nursing home resources or scheduling.
- **Code 9, no response or non-responsive:**
  - If resident, family, or significant other refuses to answer or says they do not know.
  - If resident does not give an answer to the question for several seconds and does not appear to be formulating an answer.
  - If resident provides an incoherent or nonsensical answer that does not correspond to the question.

Coding Tips and Special Populations

- The interview is considered incomplete if the resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500. If the interview is stopped because it is considered incomplete, and there is no family member or significant other to assist in completing the interview, fill the remaining F0400 and F0500 items with a 9 and proceed to F0600, Daily Activity Preferences Primary Respondent.
- The resident, family member or significant other is being asked about current preferences while in the nursing home but is not limited to a 7-day period to convey what these preferences are.
- The facility is still obligated to complete the interview within the observation period.

Draft

F0400: Interview for Daily Preferences (cont.)



Interviewing Tips and Techniques

- Sometimes respondents give long or indirect answers to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
- For these questions, it is appropriate to explore resident, family and/or significant other's answers and try to understand the reason.

Examples for F0400A, How Important Is It to You to Choose What Clothes to Wear (including hospital gowns or other garments provided by the facility)?

1. Resident answers, "It's very important. I've always paid attention to my appearance."

   Coding: F0400A would be **coded 1, very important**.

2. Resident replies, "I leave that up to the nurse. You have to wear what you can handle if you have a stiff leg."

   Interviewer echoes, "You leave it up to the nurses. Would you say that, while you are here, choosing what clothes to wear is [pointing to cue card] very important, somewhat important, not very important, not important at all, or that it's important, but you can't do it because of your leg?"

   Resident responds, "Well, it would be important to me, but I just can't do it."

   Coding: F0400A would be **coded 5, important, but can't do or no choice.**

Examples for F0400B, How Important Is It to You to Take Care of Your Personal Belongings or Things?

1. Resident answers, "It's somewhat important. I'm not a perfectionist, but I don't want to have to look for things."

   Coding: F0400B would be **coded 2, somewhat important**.

2. Resident answers, "All my important things are at home."

   Interviewer clarifies, "Your most important things are at home. Do you have any other things while you're here that you think are important to take care of yourself?"

   Resident responds, "Well, my son brought me this CD player so that I can listen to music. It is very important to me to take care of that."

   Coding: F0400B would be **coded 1, very important.**

DEFINITION

PERSONAL BELONGINGS OR THINGS
Possessions such as eyeglasses, hearing aids, clothing, jewelry, books, toiletries, knickknacks, pictures.

F0400: Interview for Daily Preferences (cont.)

Examples for F0400C, How Important Is It to You to Choose between a Tub Bath, Shower, Bed Bath, or Sponge Bath?

1. Resident answers, "I like showers."

   Interviewer clarifies, "You like showers. Would you say that choosing a shower instead of other types of bathing is very important, somewhat important, not very important, not important at all, or that it's important, but you can't do it or have no choice?"

   The resident responds, "It's very important."

   Coding: F0400C would be **coded 1, very important.**

2. Resident answers, "I don't have a choice. I like only sponge baths, but I have to take shower two times a week."

   The interviewer says, "So how important is it to you to be able to choose to have a sponge bath while you're here?"

   The resident responds, "Well, it is very important, but I don't always have a choice because that's the rule."

   Coding: F0400C would be **coded 5, important, but can't do or no choice.**

Example for F0400D, How Important Is It to You to Have Snacks Available between Meals?

1. Resident answers, "I'm a diabetic, so it's very important that I get snacks."

   Coding: F0400D would be **coded 1, very important.**

Draft

F0400: Interview for Daily Preferences (cont.)



Example for F0400E, How Important Is It to You to Choose Your Own Bedtime?

1. Resident answers, "At home I used to stay up and watch TV. But here I'm usually in bed by 8. That's because they get me up so early."

   Interviewer echoes and clarifies, "You used to stay up later, but now you go to bed before 8 because you get up so early. Would you say it's [pointing to cue card] very important, somewhat important, not very important, not important at all, or that it's important, but you don't have a choice about your bedtime?"

   Resident responds, "I guess it would be important, but I can't do it because they wake me up so early in the morning for therapy and by 8 o'clock at night, I'm tired."

   Coding: F0400E would be **coded 5, important, but can't do or no choice**.

Example for F0400F, How Important Is It to You to Have Your Family or a Close Friend Involved in Discussions about Your Care?

1. Resident responds, "They're not involved. They live in the city. They've got to take care of their own families."

   Interviewer replies, "You said that your family and close friends aren't involved right now. When you think about what you would prefer, would you say that it's very important, somewhat important, not very important, not important at all, or that it is important but you have no choice or can't have them involved in decisions about your care?"

   Resident responds, "It's somewhat important."

   Coding: F0400F would be **coded 2, somewhat important**.

Example for F0400G, How Important Is It to You to Be Able to Use the Phone in Private?

1. Resident answers "That's not a problem for me, because I have my own room. If I want to make a phone call, I just shut the door."

   Interviewer echoes and clarifies, "So, you can shut your door to make a phone call. If you had to rate how important it is to be able to use the phone in private, would you say it's very important, somewhat important, not very important, or not important at all?"

   Resident responds, "Oh, it's very important."

   Coding: F0400G would be **coded 1, very important**.

DEFINITION

PRIVATE TELEPHONE CONVERSATION

A telephone conversation on which no one can listen in, other than the resident.

Draft

F0400: Interview for Daily Preferences (cont.)

Example for F0400H, How Important Is It to You to Have a Place to Lock Your Things to Keep Them Safe?

1. Resident answers, "I have a safe deposit box at my bank, and that's where I keep family heirlooms and personal documents."

   Interviewer says, "That sounds like a good service. While you are staying here, how important is it to you to have a drawer or locker here?"

   Resident responds, "It's not very important. I'm fine with keeping all my valuables at the bank."

   Coding: F0400H would be **coded 3, not very important.**

F0500: Interview for Activity Preferences

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:

1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice
9. No response or non-responsive

Enter Codes in Boxes

☐	***A.*** *how important is it to you to* ***have books, newspapers, and magazines to read?***
☐	***B.*** *how important is it to you to* ***listen to music you like?***
☐	***C.*** *how important is it to you to* ***be around animals such as pets?***
☐	***D.*** *how important is it to you to* ***keep up with the news?***
☐	***E.*** *how important is it to you to* ***do things with groups of people?***
☐	***F.*** *how important is it to you to* ***do your favorite activities?***
☐	***G.*** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
☐	***H.*** *how important is it to you to* ***participate in religious services or practices?***

Item Rationale

Health-related Quality of Life

- Activities are a way for individuals to establish meaning in their lives, and the need for enjoyable activities and pastimes does not change on admission to a nursing home.
- A lack of opportunity to engage in meaningful and enjoyable activities can result in boredom, depression, and behavior disturbances.
- Individuals vary in the activities they prefer, reflecting unique personalities, past interests, perceived environmental constraints, religious and cultural background, and changing physical and mental abilities.

Draft

F0500: Interview for Activity Preferences (cont.)



Planning for Care

- These questions will be useful for designing individualized care plans that facilitate residents' participation in activities they find meaningful.
- Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing informal dialogue between the care provider and resident.
- As with daily routines, responses may provide insights into perceived functional, emotional, and sensory support needs.

Coding Instructions

- **See Coding Instructions on page F-4.**
  Coding approach is identical to that for daily preferences.

Coding Tips and Special Populations

- **See Coding Tips on page F-5.**
  Coding tips include those for daily preferences.
- Include Braille and or audio recorded material when coding items in F0500A.

Interviewing Tips and Techniques

- **See Interview Tips and Techniques on page F-5.**
  Coding tips and techniques are identical to those for daily preferences.

DEFINITIONS

READ
Script, Braille, or audio recorded written material.

NEWS
News about local, state, national, or international current events.

KEEP UP WITH THE NEWS
Stay informed by reading, watching, or listening.

NEWSPAPERS AND MAGAZINES
Any type, such as journalistic, professional, and trade publications in script, Braille, or audio recorded format.

Draft

F0500: Interview for Activity Preferences (cont.)

Examples for F0500A, How Important Is It to You to Have Books (Including Braille and Audio-recorded Format), Newspapers, and Magazines to Read?

1. Resident answers, "Reading is very important to me."

   Coding: F0500A would be **coded 1, very important**.

2. Resident answers, "They make the print so small these days. I guess they are just trying to save money."

   Interviewer replies, "The print is small. Would you say that having books, newspapers, and magazines to read is very important, somewhat important, not very important, not important at all, or that it is important but you can't do it because the print is so small?"

   Resident answers: "It would be important, but I can't do it because of the print."

   Coding: F0500A would be **coded 5, important, but can't do or no choice.**

Example for F0500B, How Important Is It to You to Listen to Music You Like?

1. Resident answers, "It's not important, because all we have in here is TV. They keep it blaring all day long."

   Interviewer echoes, "You've told me it's not important because all you have is a TV. Would you say it's not very important or not important at all to you to listen to music you like while you are here? Or are you saying that it's important, but you can't do it because you don't have a radio or CD player?"

   Resident responds, "Yeah. I'd enjoy listening to some jazz if I could get a radio."

   Coding: F0500B would be **coded 5, important, but can't do or no choice.**

Examples for F0500C, How Important Is It to You to Be Around Animals Such as Pets?

1. Resident answers, "It's very important for me NOT to be around animals. You get hair all around and I might inhale it."

   Coding: F0500C would be **coded 4, not important at all.**

2. Resident answers, "I'd love to go home and be around my own animals. I've taken care of them for years and they really need me."

   Interviewer probes, "You said you'd love to be at home with your own animals. How important is it to you to be around pets while you're staying here? Would you say it is [points to card] very important, somewhat important, not very important, not important at all, or is it important, but you can't do it or don't have a choice about it."

   Resident responds, "Well, it's important to me to be around my own dogs, but I can't be around them. I'd say important but can't do."

   Coding: F0500C would be **coded 5, Important, but can't do or no choice.**

   Rationale: Although the resident has access to therapeutic dogs brought to the nursing home, they do not have access to the type of pet that is important to them.

Draft

F0500: Interview for Activity Preferences (cont.)



Example for F0500D, How Important Is It to You to Keep Up with the News?

1. Resident answers, "Well, they are all so liberal these days, but it's important to hear what they are up to."

   Interviewer clarifies, "You think it is important to hear the news. Would you say it is [points to card] very important, somewhat important, or it's important but you can't do it or have no choice?"

   Resident responds, "I guess you can mark me somewhat important on that one."

   Coding: F0500D would be **coded 2, somewhat important.**

Example for F0500E, How Important Is It to You to Do Things with Groups of People?

1. Resident answers, "I've never really liked groups of people. They make me nervous."

   Interviewer echoes and clarifies, "You've never liked groups. To help us plan your activities, would you say that while you're here, doing things with groups of people is very important, somewhat important, not very important, not important at all, or would it be important to you but you can't do it because you feel nervous about it?"

   Resident responds, "At this point I'd say it's not very important."

   Coding: F0500E would be **coded 3, not very important.**

Examples for F0500F, How Important Is It to You to Do Your Favorite Activities?

1. Resident answers, "Well, it's very important, but I can't really do my favorite activities while I'm here. At home, I used to like to play board games, but you need people to play and make it interesting. I also like to sketch, but I don't have the supplies I need to do that here. I'd say important but no choice."

   Coding: F0500F would be **coded 5, important, but can't do or no choice.**

2. Resident answers, "I like to play bridge with my bridge club."

   Interviewer probes, "Oh, you like to play bridge with your bridge club. How important is it to you to play bridge while you are here in the nursing home?"

   Resident responds, "Well, I'm just here for a few weeks to finish my rehabilitation. It's not very important."

   Coding: F0500F would be **coded 3, not very important**.

Draft

F0500: Interview for Activity Preferences (cont.)

Example for F0500G, How Important Is It to You to Go Outside to Get Fresh Air When the Weather Is Good (Includes Less Temperate Weather if Resident Has Appropriate Clothing)?

1. Resident answers, "They have such a nice garden here. It's very important to me to go out there."

   Coding: F0500G would be **coded 1, very important.**

Examples for F0500H, How Important Is It to You to Participate in Religious Services or Practices?

1. Resident answers, "I'm Jewish. I'm Orthodox, but they have Reform services here. So I guess it's not important."

   Interviewer clarifies, "You're Orthodox, but the services offered here are Reform. While you are here, how important would it be to you to be able to participate in religious services? Would you say it is very important, somewhat important, not very important, not important at all, or would it be important to you but you can't or have no choice because they don't offer Orthodox services."

   Resident responds, "It's important for me to go to Orthodox services if they were offered, but they aren't. So, can't do or no choice."

   Coding: F0500I would be **coded 5, important, but can't do or no choice.**

2. Resident answers "My pastor sends taped services to me that I listen to in my room on Sundays. I don't participate in the services here."

   Interviewer probes, "You said your pastor sends you taped services. Would you say that it is very important, somewhat important, not very important, or not important at all, to you that you are able to listen to those tapes from your pastor?"

   Resident responds, "Oh, that's very important."

   Coding: F0500I would be **coded 1, very important**.

DEFINITIONS

OUTSIDE
Any outdoor area in the proximity of the facility, including patio, porch, balcony, sidewalk, courtyard, or garden.

PARTICIPATE IN RELIGIOUS SERVICES
Any means of taking part in religious services or practices, such as listening to services on the radio or television, attending services in the facility or in the community, or private prayer or religious study.

RELIGIOUS PRACTICES
Rituals associated with various religious traditions or faiths, such as washing rituals in preparation for prayer, following kosher dietary laws, honoring holidays and religious festivals, and participating in communion or confession.

F0600: Daily and Activity Preferences Primary Respondent

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items)

Item Rationale

- This item establishes the source of the information regarding the resident's preferences.

Coding Instructions

- **Code 1, resident:** if resident was the primary source for the preference questions in F0400 and F0500.
- **Code 2, family or significant other:** if a family member or significant other was the primary source of information for F0400 and F0500.
- **Code 9, interview could not be completed:** if F0400 and F0500 could not be completed by the resident, a family member, or a representative of the resident.

F0700: Should the Staff Assessment of Daily and Activity Preferences Be Conducted?

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete GG0100, Prior Functioning: Everyday Activities
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

Item Rationale

Health-related Quality of Life

- Resident interview is preferred as it most accurately reflects what the resident views as important. However, a small percentage of residents are unable or unwilling to complete the interview for Daily and Activity Preferences.
- Persons unable to complete the preference interview should still have preferences evaluated and considered.

Planning for Care

- Even though the resident was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors, and observing the resident's affect during the interview.

Steps for Assessment

1. Review resident, family, or significant other responses to F0400A-H and F0500A-H.

Draft

F0700: Should the Staff Assessment of Daily and Activity Preferences Be Conducted? (cont.)

Coding Instructions

- **Code 0, no:** if **Interview for Daily and Activity Preferences** items (F0400 and F0500) was completed by resident, family or significant other. Skip to and complete GG0100, Prior Functioning: Everyday Activities.
- **Code 1, yes:** if **Interview for Daily and Activity Preferences** items (F0400 through F0500) were not completed because the resident, family, or significant other was unable to answer 3 or more items (i.e. 3 or more items in F0400 through F0500 were coded as **9 or "-"**).

Coding Tips and Special Populations

- If the total number of unanswered questions in F0400 through F0500 is equal to 3 or more, the interview is considered incomplete.

F0800: Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply

☐	A.	Choosing clothes to wear
☐	B.	Caring for personal belongings
☐	C.	Receiving tub bath
☐	D.	Receiving shower
☐	E.	Receiving bed bath
☐	F.	Receiving sponge bath
☐	G.	Snacks between meals
☐	H.	Staying up past 8:00 p.m.
☐	I.	Family or significant other involvement in care discussions
☐	J.	Use of phone in private
☐	K.	Place to lock personal belongings
☐	L.	Reading books, newspapers, or magazines
☐	M.	Listening to music
☐	N.	Being around animals such as pets
☐	O.	Keeping up with the news
☐	P.	Doing things with groups of people
☐	Q.	Participating in favorite activities
☐	R.	Spending time away from the nursing home
☐	S.	Spending time outdoors
☐	T.	Participating in religious activities or practices
☐	Z.	None of the above

Draft

F0800: Staff Assessment of Daily and Activity Preferences (cont.)

Item Rationale

Health-related Quality of Life

- Alternate means of assessing daily preferences must be used for residents who cannot communicate. This ensures that information about their preferences is not overlooked.
- Activities allow residents to establish meaning in their lives. A lack of meaningful and enjoyable activities can result in boredom, depression, and behavioral symptoms.

Planning for Care

- Caregiving staff should use observations of resident behaviors to understand resident likes and dislikes in cases where the resident, family, or significant other cannot report the resident's preferences. This allows care plans to be individualized to each resident.

Steps for Assessment

1. Observe the resident when the care, routines, and activities specified in these items are made available to the resident.
2. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
3. If the resident appears happy or content (e.g., is involved, pays attention, smiles) during an activity listed in **Staff Assessment of Daily and Activity Preferences** item (F0800), then that item should be checked.

   If the resident seems to resist or withdraw when these are made available, then do not check that item.

Coding Instructions

Check all that apply in the last 7 days based on staff observation of resident preferences.

- **F0800A.** Choosing clothes to wear
- **F0800B.** Caring for personal belongings
- **F0800C.** Receiving tub bath
- **F0800D.** Receiving shower
- **F0800E.** Receiving bed bath
- **F0800F.** Receiving sponge bath
- **F0800G.** Snacks between meals
- **F0800H.** Staying up past 8:00 p.m.
- **F0800I.** Family or significant other involvement in care discussions
- **F0800J.** Use of phone in private
- **F0800K.** Place to lock personal belongings

Draft

F0800: Staff Assessment of Daily and Activity Preferences (cont.)

- **F0800L.** Reading books, newspapers, or magazines
- **F0800M.** Listening to music
- **F0800N.** Being around animals such as pets
- **F0800O.** Keeping up with the news
- **F0800P.** Doing things with groups of people
- **F0800Q.** Participating in favorite activities
- **F0800R.** Spending time away from the nursing home
- **F0800S.** Spending time outdoors
- **F0800T.** Participating in religious activities or practices
- **F0800Z.** None of the above

Draft

SECTION GG: FUNCTIONAL ABILITIES

Intent: This section includes items about functional abilities. It includes items focused on prior function, admission and discharge performance, performance throughout a resident's stay, mobility device use, and range of motion. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:

3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities.
1. **Dependent** - A helper completed all the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

Enter Codes in Boxes ↓		
☐	A.	**Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	B.	**Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	C.	**Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	D.	**Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Item Rationale

- Knowledge of the resident's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or their family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent:** if the resident completed the activities by themself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.
- **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- **Code 8, Unknown:** if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable:** if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

Draft

GG0100: Prior Functioning: Everyday Activities (cont.)

Coding Tips

- Record the resident's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the resident's ability is available after attempts to interview the resident or their family and after reviewing the resident's medical record, code as 8, Unknown.
- Completing the stair activity for GG0100C indicates that a resident went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker, or stair lift) and/or with or without some level of assistance.
- Going up and down a ramp is not considered going up and down stairs for coding GG0100C.

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** Resident T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, Resident T was independent in eating and using the toilet; however, Resident T required assistance for bathing and putting on and taking off their shoes and socks. The assistance needed was due to severe arthritic lumbar pain upon bending, which limited their ability to access their feet.

   Coding: GG0100A would be coded 2, Needed Some Help.
   Rationale: Resident T needed partial assistance from a helper to complete the activities of bathing and dressing. While Resident T did not need help for all self-care activities, they did need some help. Code 2 is used to indicate that Resident T needed some help for self-care.

2. **Self-Care:** Resident R was diagnosed with a progressive neurologic condition five years ago. They live in a long-term nursing facility and were recently hospitalized for surgery and have now been admitted to the SNF for skilled services. According to Resident R's spouse, prior to the surgery, Resident R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

   Coding: GG0100A would be coded 1, Dependent.
   Rationale: Resident R's spouse has reported that Resident R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.

3. **Indoor Mobility (Ambulation):** Approximately three months ago, Resident K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Resident K has been living at home with their spouse and developed aspiration pneumonia. After this most recent hospitalization, they were admitted to the SNF for a diagnosis of aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Resident K needed some assistance when walking.

DRAFT

GG0100: Prior Functioning: Everyday Activities (cont.)

Coding: GG0100B would be coded 2, Needed Some Help.

Rationale: While the resident experienced a cardiac event three months ago, they recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident's prior functioning is based on the time immediately before their most recent condition exacerbation that required acute care.

4. **Indoor Mobility (Ambulation):** Resident L had a stroke one year ago that resulted in their using a wheelchair to self-mobilize, as they were unable to walk. Resident L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

   Coding: GG0100B would be coded 9, Not Applicable.

   Rationale: The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

5. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by their recent admission to the SNF for rehabilitation, Resident V experienced severe knee pain upon ascending and particularly descending their internal and external stairs at home. Resident V required assistance from their spouse when using the stairs to steady them in the event their left knee would buckle. Resident V's spouse was interviewed about their spouse's functioning prior to admission, and the therapist noted Resident V's prior functional level information in their medical record.

   Coding: GG0100C would be coded 2, Needed Some Help.

   Rationale: Prior to admission, Resident V required some help in order to manage internal and external stairs.

6. **Stairs:** Resident P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to Resident P's family members requesting a return call. Resident P has not received any visitors since their admission. The medical record from their prior facility does not indicate Resident P's prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

   Coding: GG0100C would be coded 8, Unknown.

   Rationale: Attempts were made to seek information regarding Resident P's prior functioning; however, no information was available.

7. **Functional Cognition:** Resident K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Resident K has been admitted to the SNF for rehabilitation. Resident K's caregiver reports that when living at home, Resident K needed reminders to take their medications on time, manage their money, and plan tasks, especially when they were fatigued.

   Coding: GG0100D would be coded 2, Needed Some Help.

   Rationale: Resident K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.

Draft

GG0100: Prior Functioning: Everyday Activities (cont.)

8. **Functional Cognition:** Resident R had a stroke, resulting in a severe communication disorder. Their family members have not returned phone calls requesting information about Resident R's prior functional status, and their medical records do not include information about their functional cognition prior to the stroke.

   Coding: GG0100D would be coded 8, Unknown.

   Rationale: Attempts to seek information regarding Resident R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Check all that apply

☐	A.	Manual wheelchair
☐	B.	Motorized wheelchair and/or scooter
☐	C.	Mechanical lift
☐	D.	Walker
☐	E.	Orthotics/Prosthetics
☐	Z.	None of the above

Item Rationale

- Knowledge of the resident's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or their family or review the resident's medical records to determine the resident's use of prior devices and aids.

Coding Instructions

- Check all devices that apply.
- **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

- For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- GG0110C, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.

Draft

GG0110: Prior Device Use (cont.)

Example for Coding Prior Device Use

1. Resident M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. They are unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. They use a motorized wheelchair to mobilize.

   Coding: GG0110B would be checked.

   Rationale: Resident M used a motorized wheelchair prior to the current illness/injury.

GG0115: Functional Limitation in Range of Motion

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

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)

Intent: The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places them at risk of injury. When completing this item, staff members should refer to items in GG0130 and GG0170 and view the limitation in ROM, taking into account activities the resident is able to perform.

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION
Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

Item Rationale

Health-related Quality of Life

- Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living.

Planning for Care

- Individualized care plans should address possible reversible causes such as deconditioning and adverse side effects of medications or other treatments.

Draft

GG0115: Functional Limitation in Range of Motion (cont.)

Steps for Assessment

1. Review the medical record for references to functional range-of-motion limitation during the 7-day observation 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 three-step process:
   - Test the resident's upper and lower extremity ROM (See item 6 below for examples).
   - If the resident is noted to have limitation of upper- and/or lower-extremity ROM, review GG0130 and GG0170 and/or directly observe the resident to determine whether the limitation interferes with function or places the resident at risk for injury.
   - Code GG0115A and GG0115B as appropriate based on the above assessment.
4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
5. Staff member observations of various activities, including ADLs, may be used to determine whether any ROM limitations have an impact on the resident's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM, thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
   - Ask the resident to follow your verbal instructions for each movement.
   - Demonstrate each movement (e.g., ask the resident to do what you are doing).
   - Actively assist the resident with the movements by supporting their extremity and guiding it through the joint ROM.

   Lower Extremity—includes hip, knee, ankle, and foot

   While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up toward head) and extend (push toes down away from head) each foot. Then ask the resident to lift their leg one at a time, bending it at the knee to a right angle (90 degrees). Then ask the resident to slowly lower their leg and extend it flat on the mattress. If assessing lower-extremity ROM by observing the resident, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower-body clothing.

DRAFT

GG0115: Functional Limitation in Range of Motion (cont.)

Upper Extremity—includes shoulder, elbow, wrist, and fingers

For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct them to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper-extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

Coding Tips

- Do not look at limited ROM in isolation. You must determine whether the limited ROM has an impact on functional ability or places the resident at risk for injury. For example, if the resident has an amputation, it does not automatically mean that they are limited in function. A resident with an amputation may not have a particular joint in which a certain range of motion can be tested, however, that does not mean that the resident necessarily has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If a resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Coding Instructions for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

- **Code 0, no impairment:** if resident has full functional range of motion on the right and left side of upper/lower extremities.
- **Code 1, impairment on one side:** if resident has an upper- and/or lower-extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.
- **Code 2, impairment on both sides:** if resident has an upper- and/or lower-extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.

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GG0115: Functional Limitation in Range of Motion (cont.)

Examples for GG0115A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); GG0115B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. They are able to perform grooming activities (e.g., brush their teeth, comb their hair) with their right upper extremity and are also able to pivot to their wheelchair with the assistance of one person. They are, however, unable to voluntarily move their left side (limited arm, hand, and leg motion), as they have a flaccid left hemiparesis from a prior stroke.

   Coding: GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 1, lower-extremity impairment on one side.
   Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows the resident to be as independent as possible.

2. The resident had shoulder surgery and can't brush their hair with their right arm or raise their right arm above their head. The resident can brush their hair with their left arm and has no impairment on the lower extremities.

   Coding: GG0115A would be coded 1, upper-extremity impairment on one side. GG0115B would be coded 0, no impairment.
   Rationale: Impairment due to shoulder surgery affects only one side of their upper extremities.

3. The resident has a diagnosis of Parkinson's and ambulates with a shuffling gait. The resident has had three falls in the past quarter and often forgets their walker, which they need to ambulate. They have tremors of both upper extremities that make it very difficult for them to feed themself, brush their teeth, or write.

   Coding: GG0115A would be coded 2, upper-extremity impairment on both sides. GG0115B would be coded 2, lower-extremity impairment on both sides.
   Rationale: Impairment due to Parkinson's disease affects the resident's upper and lower extremities on both sides.

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GG0120: Mobility Devices

GG0120. Mobility Devices	
Check all that were normally used in the last 7 days ↓	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

Item Rationale

Health-related Quality of Life

- Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.

Planning for Care

- A resident's ability to move about their room, unit or nursing home may be directly related to the use of devices. It is critical that staff members assure that the resident's independence is optimized by making mobility devices available on a daily basis, if needed.

Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day observation 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 observation period.
3. Observe the resident during locomotion.

Coding Instructions

Record the type(s) of mobility devices the resident normally uses for locomotion (in room and in facility). Check all that apply:

- **Check GG0120A, Cane/crutch:** if the resident used a cane or crutch, including single-prong, tripod, quad cane, etc.
- **Check GG0120B, Walker:** if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.
- **Check GG0120C, Wheelchair (manual or electric):** if the resident normally sits in a wheelchair when moving about. Include wheelchairs that are 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.
- **Check GG0120D, Limb prosthesis:** if the resident used an artificial limb to replace a missing extremity.

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GG0120: Mobility Devices (cont.)

- **Check GG0120Z, None of the above:** if the resident used none of the mobility devices listed in GG0120 or locomotion did not occur during the observation period.

Examples

1. The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that they self-propel when leaving the unit because of their issues with endurance.

   Coding: GG0120A, Cane/crutch**,** and GG0120C, Wheelchair, would be checked.
   Rationale: The resident uses a quad cane in their room and on the unit and a wheelchair off the unit.

2. The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied, the resident is able to ambulate independently.

   Coding: GG0120D, Limb prosthesis**,** would be checked.
   Rationale: The resident uses a leg prosthesis for ambulating.

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GG0130: Self-Care (3-day assessment period) Admission

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

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

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

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GG0130: Self-Care (3-day assessment period) Discharge

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

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

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

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GG0130: Self-Care (OBRA/Interim)

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

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

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

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

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GG0130: Self-Care (cont.)

Item Rationale

Health-related Quality of Life

DEFINITION

ADL
Tasks related to personal care, such as any of the tasks listed in GG0130 and GG0170.

- Residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the facility.
- Most nursing home residents need some physical assistance and are at risk of further physical decline. The amount of assistance needed and the risk of decline vary from resident to resident.
- A wide range of physical, neurological, and psychological conditions and cognitive factors can adversely affect physical function.
- Dependence on others for ADL assistance can lead to feelings of helplessness, isolation, diminished self-worth, and loss of control over one's destiny.
- As inactivity increases, complications such as pressure ulcers, falls, contractures, depression, and muscle wasting may occur.

Planning for Care

- Individualized care plans should address strengths and weaknesses, possible reversible causes such as deconditioning, and adverse side effects of medications or other treatments. These may contribute to loss of self-sufficiency. In addition, some neurologic injuries such as stroke may continue to improve for months after an acute event.
- For some residents, cognitive deficits can limit ability or willingness to initiate or participate in self-care or restrict understanding of the tasks required to complete ADLs.
- Individualized care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.
- Many residents may require lower levels of assistance if they are provided with appropriate devices and aids, assisted with segmenting tasks, or given adequate time to complete a task while being provided with graduated prompting and assistance. This type of supervision requires skill, time, and patience.
- Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

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GG0130: Self-Care (cont.)

Steps for Assessment

1. Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
   - For residents in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.
     - **Note:** If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B and both columns are required. In these scenarios, do not complete Column 5. OBRA/Interim Performance.
   - For residents in a Medicare Part A stay, the assessment period for the Interim Payment Assessment (A0310B = 08) is the last 3 days (i.e., the ARD plus 2 previous calendar days).
   - For residents in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.
   - When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

DEFINITIONS

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

QUALIFIED CLINICIAN
Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

PRIOR TO THE BENEFIT OF SERVICES means prior to provision of any care by facility staff that would result in more independent coding.

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GG0130: Self-Care (cont.)

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. For residents in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the benefit of services in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

Coding Instructions

- When coding the resident's usual performance, use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by themself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
    - Code 04, Supervision or touching assistance: if the resident requires only verbal cueing to complete the activity safely.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

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GG0130: Self-Care (cont.)

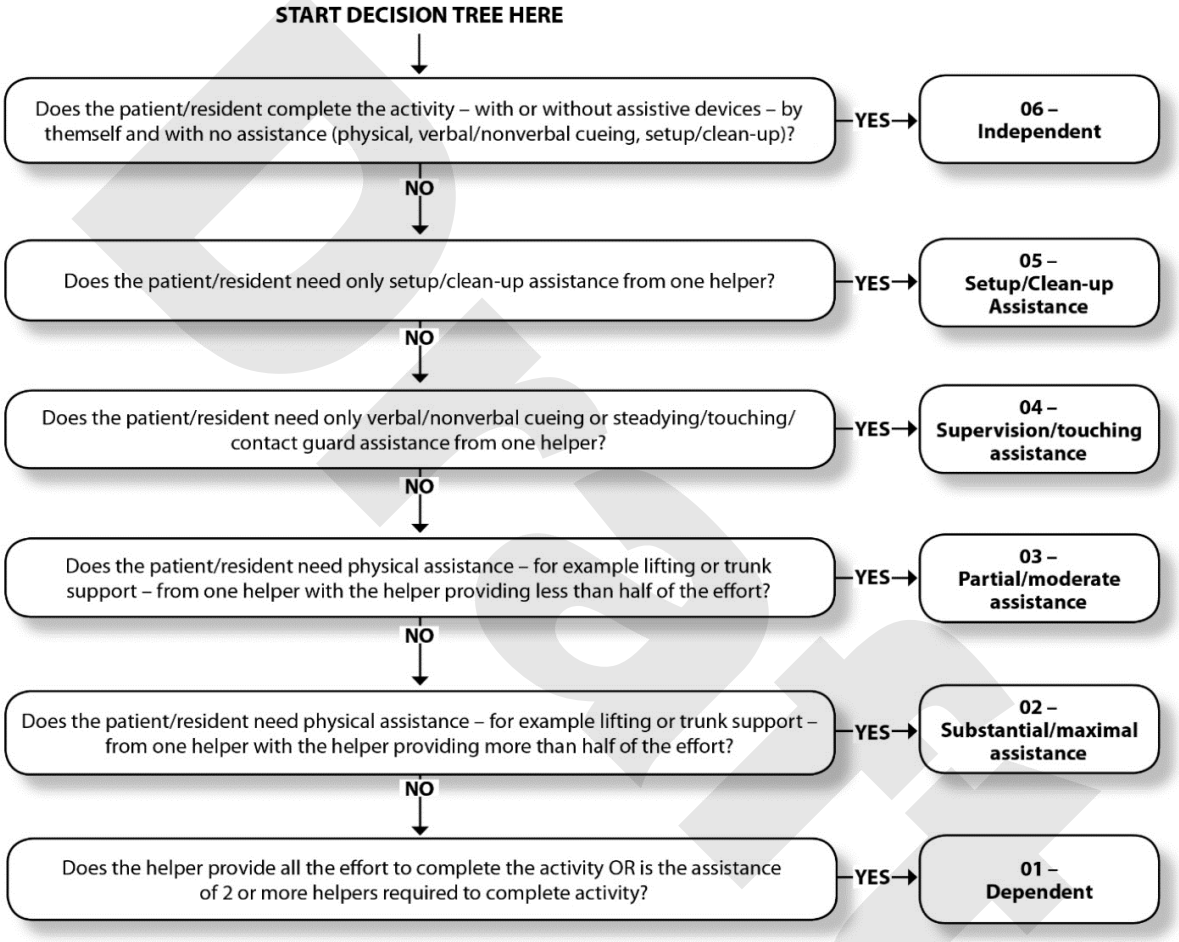
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
    - Code 01, Dependent: if two helpers are required for the safe completion of an activity, even if the second helper provides supervision/stand-by assist only and does not end up needing to provide hands-on assistance.
    - Code 01, Dependent: if a resident requires the assistance of two helpers to complete an activity (one to provide support to the resident and a second to manage the necessary equipment to allow the activity to be completed).
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.

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GG0130: Self-Care (cont.)

Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.



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GG0130: Self-Care (cont.)

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new resident and, under some circumstances, a returning resident and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.
  - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
  - For an OBRA Admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.
- **OBRA/Interim:** The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. OBRA assessments (A0310A = 01 – 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.
  - For Section GG on the IPA or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the resident's usual functional performance during the 3-day assessment period.
  - The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
  - For Section GG on OBRA assessments other than the Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days).

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GG0130: Self-Care (cont.)

- **Discharge:** The Part A PPS Discharge assessment is required to be completed as a standalone assessment when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay) and the resident remains in the facility. The Part A PPS Discharge assessment must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000). An OBRA Discharge assessment is required when the resident is discharged from the facility. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
  - For the PPS Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last 3 calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A plus 2 previous calendar days prior to the day of discharge from Medicare Part A.
  - On standalone OBRA Discharge assessments (i.e., A0310F = 10 or 11 AND A0310H = 0), code the resident's usual performance during last 3 days of their stay (i.e., A2000, Discharge Date plus 2 previous calendar days).

Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity; code as 09 if the activity is not applicable for the resident (the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation); code as 10 if the resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.

GG0130: Self-Care (cont.)

- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.
- Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance. A provider may need to use the entire assessment period to obtain the resident's usual performance.

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GG0130: Self-Care (cont.)

Coding Tips for GG0130A, Eating

- The intent of GG0130A, Eating is to assess the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- The administration of tube feedings and parenteral nutrition is not considered when coding this activity.
- The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition:
  - If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns.
  - If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
  - If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code Eating based on the amount of assistance the resident requires to eat and drink by mouth.
  - Assistance with tube feedings or parenteral nutrition is not considered when coding the item Eating.
- If a resident requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing.
- If a resident swallows safely without assistance, exclude swallowing from consideration when coding GG0130A, Eating.
- If the resident eats finger foods using their hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with their hands independently, for example, the resident would be coded as 06, Independent.
- For a resident taking only fluids by mouth, the item may be coded based on ability to bring liquid to the mouth and swallow liquid, once the drink is placed in front of the resident.

Examples for Coding Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

GG0130: Self-Care (cont.)

Examples for GG0130A, Eating

1. **Eating:** Resident S has multiple sclerosis, affecting their endurance and strength. Resident S prefers to feed themself as much as they are capable. During all meals, after eating three-fourths of the meal by themself, Resident S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed them the remainder of the meal.

   Coding: GG0130A would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

2. **Eating:** Resident M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Resident M's hand that supports the eating utensil within their hand. At the start of each meal Resident M can bring food and liquids to their mouth. Resident M then tires and the certified nursing assistant feeds them more than half of each meal.

   Coding: GG0130A would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

3. **Eating:** The dietary aide opens all of Resident S's cartons and containers on their food tray before leaving the room. There are no safety concerns regarding Resident S's ability to eat. Resident S eats the food themself, bringing the food to their mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

4. **Eating:** Resident H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears their throat due to difficulty with pharyngeal peristalsis. They require verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: Resident H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

5. **Eating:** Resident R is unable to eat by mouth since they had a stroke one week ago. They receive nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   Coding: GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not eat or drink by mouth at this time due to their recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to their recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

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GG0130: Self-Care (cont.)

Coding Tips for GG0130B, Oral hygiene

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.
- For a resident who is edentulous, code Oral hygiene based on the type and amount of assistance required from a helper to clean the resident's gums.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Resident S as they walk to the bathroom. The nurse applies toothpaste onto Resident S's toothbrush. Resident S then brushes their teeth at the sink in the bathroom without physical assistance or supervision. Once Resident S is done brushing their teeth and washing their hands and face, the nurse returns and provides steadying assistance as the resident walks back to their bed.

   Coding: GG0130B would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Resident S brushes their teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

2. **Oral hygiene:** At night, the certified nursing assistant provides Resident K water and toothpaste to clean their dentures. Resident K cleans their upper denture plate. Resident K then cleans half of their lower denture plate, but states they are tired and unable to finish cleaning their lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Resident K replaces the dentures in their mouth.

   Coding: GG0130B would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

3. **Oral hygiene:** Resident W is edentulous (without teeth) and their dentures no longer fit their gums. In the morning and evening, Resident W begins to brush their upper gums after the helper applies toothpaste onto their toothbrush. Resident W brushes their upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing their back upper gums and their lower gums.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The resident begins the activity. The helper completes the activity by performing more than half the effort.

4. **Oral hygiene:** Resident D has experienced a stroke. They can brush their teeth while sitting on the side of the bed, but when the certified nursing assistant hands them the toothbrush and toothpaste, they look up at them puzzled what to do next. The certified nursing assistant cues Resident D to put the toothpaste on the toothbrush and instructs them to brush their teeth. Resident D then completes the task of brushing their teeth.

   Coding: GG0130B would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing their teeth.

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GG0130: Self-Care (cont.)

Coding Tips for GG0130C, Toileting hygiene

- Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code the item Toileting hygiene based on the resident's need for assistance managing clothing and perineal cleansing.
- Includes:
  - Performing perineal hygiene.
  - Managing clothing (including undergarments and incontinence products, such as incontinence briefs or pads) before and after voiding or having a bowel movement.
  - Adjusting clothing relevant to the individual resident.
- If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving their bowels.
- When the resident requires different levels of assistance to perform toileting hygiene after voiding versus after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity.
- If a resident manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.
- If a resident has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.
  - For example, if the resident has an indwelling urinary catheter and has bowel movements, code Toileting hygiene based on the type and amount of assistance needed by the resident before and after moving their bowels. This may include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Resident J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Resident J pulls down their pants and underwear before sitting down on the commode. When Resident J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Resident J wipes their perineal area and pulls up their pants and underwear without assistance.

   Coding: GG0130C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

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GG0130: Self-Care (cont.)

2. **Toileting hygiene:** Resident J is morbidly obese and has a diagnosis of debility. They request the use of a bedpan when voiding or having bowel movements and require two certified nursing assistants to pull down their pants and underwear and mobilize them onto and off the bedpan. Resident J is unable to complete any of their perineal/perianal hygiene. Both certified nursing assistants help Resident J pull up their underwear and pants.

   Coding: GG0130C would be coded 01, Dependent.

   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

3. **Toileting hygiene:** Resident C has Parkinson's disease and significant tremors that cause intermittent difficulty for them to perform perineal hygiene after having a bowel movement in the toilet. They walk to the bathroom with close supervision and lower their pants, but ask the certified nursing assistant to help them with perineal hygiene after moving their bowels. They then pull up their pants without assistance.

   Coding: GG0130C would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by themself. Walking to the bathroom is not considered when scoring toileting hygiene.

4. **Toileting hygiene:** Resident Q has a progressive neurological disease that affects their fine and gross motor coordination, balance, and activity tolerance. They wear a hospital gown and underwear during the day. Resident Q uses a bedside commode as they steady themself in standing with one hand and initiates pulling down their underwear with the other hand but need assistance to complete this activity due to their coordination impairment. After voiding, Resident Q wipes their perineal area without assistance while sitting on the commode. When Resident Q has a bowel movement, a certified nursing assistant performs perineal hygiene as Resident Q needs to steady themself with both hands to stand for this activity. Resident Q is usually too fatigued at this point and requires full assistance to pull up their underwear.

   Coding: GG0130C would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.

Coding Tips for GG0130E, Shower/bathe self

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.
- Assessment of Shower/bathe self can take place in any location including a shower or bath or at a sink or in bed (i.e., full body sponge bath). Bathing can be assessed with the resident seated on a tub bench.
- Code 05, Setup or clean-up assistance, if the resident can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks.

GG0130: Self-Care (cont.)

- Code 05, Setup or clean-up assistance, if the only help the resident requires is assistance before the bathing activity to cover wounds or devices for water protection during bathing.
- If the resident cannot bathe their entire body because of a medical condition (e.g., a cast or a nonremovable dressing), then code Shower/bathe self based on the amount of assistance needed to complete the activity.

Examples for GG0130E, Shower/bathe self

1. **Shower/bathe self:** Resident J sits on a tub bench as they wash, rinse, and dry themself. A certified nursing assistant stays with them to ensure their safety, as Resident J has had instances of losing their sitting balance. The certified nursing assistant also provides lifting assistance as Resident J gets onto and off of the tub bench.

   Coding: GG0130E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as Resident J washes, rinses, and dries themself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** Resident E has a severe and progressive neurological condition that has affected their endurance as well as their fine and gross motor skills. They are transferred to the shower bench with partial/moderate assistance. Resident E showers while sitting on a shower bench and washes their arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of their body, as a result of Resident E's fatigue, to complete the activity. Resident E uses a hand-held showerhead to rinse themself but tires halfway through the task. The certified nursing assistant dries Resident E's entire body.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper assists Resident E with more than half of the task of showering, which includes bathing, rinsing, and drying their body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** Resident Y has limited mobility resulting from their multiple and complex medical conditions. They prefer to wash their body while sitting in front of the sink in their bathroom. A helper assists with washing, rinsing, and drying Resident Y's arms/hands, upper legs, lower legs, buttocks, and back.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper completed more than half the activity. Bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the resident's back.

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GG0130: Self-Care (cont.)

Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses themself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- If a resident requires assistance with dressing, including assistance with buttons, fasteners and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.
- For residents with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.

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GG0130: Self-Care (cont.)

- If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

- For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. **Upper body dressing:** Resident Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress their upper body. During the day, they require a certified nursing assistant only to place their clothing next to their bedside. Resident Y can now use compensatory strategies to put on their bra and top without any assistance. At night they remove their top and bra independently and put the clothes on the nightstand, and the certified nursing assistant puts them away in their dresser**.**

   Coding: GG0130F would be coded 05, Setup or clean-up assistance.

   Rationale: Resident Y dresses and undresses their upper body and requires a helper only to retrieve and put away their clothing, that is, setting up the clothing for their use. The description refers to Resident Y as "independent" (when removing clothes), but they need setup assistance, so they are not independent with regard to the entire activity of upper body dressing.

2. **Upper body dressing:** Resident Z wears a bra and a sweatshirt most days while in the SNF. They require assistance from a certified nursing assistant to initiate the threading of their arms into their bra. Resident Z completes the placement of the bra over their chest. The helper hooks the bra clasps. Resident Z pulls the sweatshirt over their arms, head, and trunk. When undressing, Resident Z removes the sweatshirt, with the helper assisting them with one sleeve. Resident Z slides the bra off, once it has been unclasped by the helper.

   Coding: GG0130F would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides assistance with threading Resident Z's arms into their bra and hooking and unhooking their bra clasps and assistance with removing one sleeve of the sweatshirt. Resident Z performs more than half of the effort.

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GG0130: Self-Care (cont.)

3. **Upper body dressing:** Resident K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. They place their left hand into one-third of their left sleeve of their shirt with much time and effort and are unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Resident K.

   Coding: GG0130F would be coded 02, Substantial/maximal assistance.

   Rationale: Resident K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

Examples for GG0130G, Lower body dressing

1. **Lower body dressing:** Resident D is required to follow hip precautions as a result of recent hip surgery. The occupational therapist in the acute care hospital instructed them in the use of adaptive equipment to facilitate lower body dressing. They require a helper to retrieve their clothing from the closet. Resident D uses their adaptive equipment to assist in threading their legs into their pants. Because of balance issues, Resident D needs the helper to steady them when standing to manage pulling on or pulling down their pants/undergarments. Resident D also needs some assistance to put on and take off their socks and shoes.

   Coding: GG0130G would be coded 04, Supervision or touching assistance.

   Rationale: A helper steadies Resident D when they are standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.

2. **Lower body dressing:** Resident M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. They have been issued a knee brace, to be worn during the day. Resident M threads their legs into their garments and pulls up and down their clothing to and from just below their hips. Only a little assistance from a helper is needed to pull up their garments over their hips. Resident M requires the helper to fasten their knee brace because of grasp and fine motor weakness.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper provides only a little assistance when Resident M is putting on their lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace they wear is considered when determining the help needed when coding lower body dressing.

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GG0130: Self-Care (cont.)

3. **Lower body dressing:** Resident R has peripheral neuropathy in their upper and lower extremities. Each morning, Resident R needs assistance from a helper to place their lower limb into, or to take it out of (don/doff), their lower limb prosthesis. They need no assistance to put on and remove their underwear or slacks.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Resident R's trunk or limbs, but provides less than half the effort for the task of lower body dressing.

Examples for GG0130H, Putting on/taking off footwear

1. **Putting on/taking off footwear:** Resident M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. They have made significant progress toward their independence and will be discharged to home tomorrow. Resident M wears an ankle-foot orthosis that they put on their foot and ankle after they put on their socks but before they put on their shoes. They always place their AFO, socks, and shoes within easy reach of their bed. While sitting on the bed, they need to bend over to put on and take off their AFO, socks, and shoes, and they occasionally lose their sitting balance, requiring staff to place their hands on them to maintain their balance while performing this task.

   Coding: GG0130H would be coded 04, Supervision or touching assistance.

   Rationale: Resident M puts on and takes off their AFO, socks, and shoes by themself; however, because of occasional loss of balance, they need a helper to provide touching assistance when they are bending over.

2. **Putting on/taking off footwear:** Resident F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. They require setup for retrieving their socks and shoes, which they prefer to keep in the closet. Resident F often drops their shoes and socks as they attempt to put them onto their feet or as they take them off. Often a certified nursing assistant must first thread their socks or shoes over their toes, and then Resident F can complete the task. Resident F needs the certified nursing assistant to initiate taking off their socks and unstrapping the fasteners on their shoes.

   Coding: GG0130H would be coded 02, Substantial/maximal assistance.

   Rationale: A helper provides Resident F with assistance in initiating putting on and taking off their footwear because of their limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

GG0130: Self-Care (cont.)

Coding Tips for GG0130I, Personal hygiene

- Complete GG0130I when A0310A = 01 – 06 or A0310F = 10 or 11.
- Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene).

Examples for GG0130I, Personal hygiene

1. A certified nursing assistant takes Resident L's comb, razor, and shaving cream from the drawer and places them at the bathroom sink. Resident L combs their hair and shaves daily. During the observation period, they required cueing to complete their shaving tasks.

   Coding: GG01301 would be coded 04, Supervision or touching assistance.
   Rationale: A certified nursing assistant placed grooming devices at sink for the resident's use and provided cueing during the observation period.

2. Resident J is unable to brush and style their hair or wash and dry their face due to elbow pain. A certified nursing assistant completes these tasks for them.

   Coding: GG0130I would be coded 02, Substantial/moderate assistance.
   Rationale: Resident J was unable to complete their personal hygiene and required a certified nursing assistant to complete their personal hygiene tasks during the assessment period. The certified nursing assistant provided more than half the effort to complete the personal hygiene tasks.

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GG0130: Self-Care (cont.)

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident's eating abilities:

   Nurse: "Please describe to me how Resident S eats their meals. Once the food and liquid are presented to them, do they use utensils to bring food to their mouth and swallow?"

   Certified nursing assistant: "No, I have to feed them."

   Nurse: "Do you always have to physically feed them or can they sometimes do some aspect of the eating activity with encouragement or cues to feed themself?"

   Certified nursing assistant: "No, they can't do anything by themself. I scoop up each portion of the food and bring the fork or spoon to their mouth. I try to encourage them to feed themself or to help guide the spoon to their mouth but they can't hold the fork. I even tried encouraging them to eat food they could pick up with their fingers, but they will not eat unless they are completely assisted for food and liquid."

   In this example, the nurse inquired specifically how Resident S requires assistance to eat their meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they may not have received enough information to make an accurate assessment of the assistance Resident S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

   Coding: GG0130A would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat their meals.

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident's oral hygiene routine:

   Nurse: "Does Resident K help with brushing their teeth?"

   Certified nursing assistant: "They can help clean their teeth."

   Nurse: "How much help do they need to brush their teeth?"

   Certified nursing assistant: "They usually get tired after starting to brush their upper teeth. I have to brush most of their teeth."

   In this example, the nurse inquired specifically how Resident K manages their oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident K received.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The certified nursing assistant provides more than half the effort to complete Resident K's oral hygiene.

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GG0170: Mobility (3-day assessment period) Admission

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

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	1. Admission Performance
	Enter Codes in Boxes ↓
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (3-day assessment period) Admission (cont.)

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

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	1. Admission Performance
	Enter Codes in Boxes ↓
L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
N.	**4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
O.	**12 steps:** The ability to go up and down 12 steps with or without a rail.
P.	**Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q1. Does the resident use a wheelchair and/or scooter? 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**
S.	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

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GG0170: Mobility (3-day assessment period) Discharge

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

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (3-day assessment period) Discharge (cont.)

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

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

	3. Discharge Performance Enter Codes in Boxes ↓
L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
N.	**4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
O.	**12 steps:** The ability to go up and down 12 steps with or without a rail.
P.	**Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Q3. Does the resident use a wheelchair and/or scooter?

0. **No** → Skip to H0100, Appliances
1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns

R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

RR3. Indicate the type of wheelchair or scooter used.

1. **Manual**
2. **Motorized**

S.	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

SS3. Indicate the type of wheelchair or scooter used.

1. **Manual**
2. **Motorized**

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GG0170: Mobility (OBRA/Interim)

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

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

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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GG0170: Mobility (OBRA/Interim) (cont.)

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

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

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
	Q5. Does the resident use a wheelchair and/or scooter?
☐	0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR5. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS5. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**

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GG0170: Mobility (cont.)

Item Rationale

- Residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the facility. Please review the item rationale for GG0130, Self-Care, for additional information about the importance of assessing ADLs, including information about health-related quality of life and planning for care.

Steps for Assessment

1. Assess the resident's mobility performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
   - For residents in a Medicare Part A stay, the admission assessment period is the first 3 days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. The admission assessment period for residents who are not in a Medicare Part A stay is the first 3 days of their stay starting with the date in A1600, Entry Date.
     - **Note:** If A0310B = 01 and A0310A = 01 – 06 indicating a 5-day PPS assessment combined with an OBRA assessment, the assessment period is the first 3 days of the stay beginning on A2400B and both columns are required. In these scenarios, do not complete Column 5. OBRA/Interim Performance.
   - For residents in a Medicare Part A stay, the assessment period for the Interim Payment Assessment (A0310B = 08) is the last 3 days (i.e., the ARD plus 2 previous calendar days).
   - For residents in a Medicare Part A stay, the discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days. For all other Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.
   - When completing an OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

DEFINITION

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

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GG0170: Mobility (cont.)

3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. For residents in a Medicare Part A stay, the admission functional assessment, when possible, should be conducted prior to the resident benefitting from treatment interventions in order to reflect the resident's true admission baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

Coding Instructions

- When coding the resident's usual performance, use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by themself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.

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GG0170: Mobility (cont.)

- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.
- For additional information on coding the resident's performance on the assessment instrument, refer to the Decision Tree on page GG-18.

Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay. Additionally, an OBRA Admission assessment (A0310A = 1) is required for a new resident and, under some circumstances, a returning resident and must be completed by the end of day 14. Please refer to Section 2.6 of this Manual for additional information about the OBRA Admission assessment.
    - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
    - For an OBRA Admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.

GG0170: Mobility (cont.)

- **OBRA/Interim:**
  - The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.
  - OBRA assessments (A0310A = 01 – 06) are required for residents in Medicare-certified, Medicaid-certified, or dually certified nursing homes and are outlined in Chapter 2 of this Manual.
  - For Section GG on the IPA or an OBRA assessment, providers will use the same 6-point scale and activity not attempted codes to assess the resident's usual functional status during the 3-day assessment period.
  - The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
  - For Section GG on OBRA assessments other than the Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the last 3 days (i.e., the ARD plus 2 previous calendar days).
- **Discharge:** The Part A PPS Discharge assessment is required to be completed as a standalone assessment when the resident's Medicare Part A stay ends (as documented in A2400C, End of Most Recent Medicare Stay) and the resident remains in the facility. The Part A PPS Discharge assessment must be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000). An OBRA Discharge assessment is required when the resident is discharged from the facility. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding Discharge assessments.
  - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.
  - On standalone OBRA Discharge assessments (i.e., A0310F = 10 or 11 AND A0310H = 0), code the resident's usual performance during last 3 days of their stay (i.e., A2000, Discharge Date plus 2 previous calendar days).

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GG0170: Mobility (cont.)

Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet and negotiates two turns.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, fall risk due to increased mobility activities).
- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG and should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.
- Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).

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GG0170: Mobility (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG is based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire assessment period to obtain the resident's usual performance.

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GG0170: Mobility (cont.)

Examples and Coding Tips

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Coding Tip for GG0170A, Roll left and right

- If the resident does not sleep in a bed, clinicians should assess bed mobility activities using the alternative furniture on which the resident sleeps (for example, a recliner).

Examples for GG0170A, Roll left and right

1. **Roll left and right:** Resident R has a history of skin breakdown. A nurse instructs them to turn onto their right side, providing step-by-step instructions to use the bedrail, bend their left leg, and then roll onto their right side. Resident R attempts to roll with the use of the bedrail, but indicates they cannot perform the task. The nurse then rolls them onto their right side. Next, Resident R is instructed to return to lying on their back, which they successfully complete. Resident R then requires physical assistance from the nurse to roll onto their left side and to return to lying on their back to complete the activity.

   Coding: GG0170A would be coded 02, Substantial/maximal assistance.
   Rationale: The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move Resident R's body weight to turn onto their right side. The nurse provides the same assistance when Resident R turns to their left side and when they return to their back. Resident R is able to return to lying on their back from their right side by themself.

2. **Roll left and right:** A physical therapist helps Resident K turn onto their right side by instructing them to bend their left leg and roll onto their right side. The physical therapist then instructs them on how to position their limbs to return to lying on their back and then to repeat a similar process for rolling onto their left side and then return to lying on their back. Resident K completes the activity without physical assistance from the physical therapist.

   Coding: GG0170A would be coded 04, Supervision or touching assistance.
   Rationale: The physical therapist provides verbal cues (i.e., instructions) to Resident K as they roll from their back to their right side and return to lying on their back, and then again as they perform the same activities with respect to their left side. The physical therapist does not provide any physical assistance.

GG0170: Mobility (cont.)

3. **Roll left and right:** Resident Z had a stroke that resulted in paralysis on their right side and is recovering from cardiac surgery. They require the assistance of two certified nursing assistants when rolling onto their right side and returning to lying on their back and also when rolling onto their left side and returning to lying on their back.

   Coding: GG0170A would be coded 01, Dependent.
   Rationale: Two certified nursing assistants are needed to help Resident Z roll onto their left and right side and back while in bed.

4. **Roll left and right:** Resident M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician's order allows them to roll onto their left hip as tolerated. A certified nursing assistant assists Resident M in rolling onto their right side by instructing them to bend their left leg while rolling to their right side. Resident M needs physical assistance from the certified nursing assistant to initiate their rolling right because of their left arm weakness when grasping the right bedrail to assist in rolling. Resident M returns to lying on their back without assistance and uses their right arm to grasp the left bedrail to slowly roll onto their left hip and then return to lying on their back.

   Coding: GG0170A would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

Examples for GG0170B, Sit to lying

1. **Sit to lying:** Resident H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on their right side. The helper lifts and positions Resident H's right leg. Resident H uses their arms to position their upper body and lowers themself to a lying position flat on their back.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Resident H's right leg and helps them position it as they move from a seated to a lying position; the helper performs less than half of the effort.

2. **Sit to lying:** Resident F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of their right hip and left and right wrists. The certified nursing assistant cradles and supports their trunk and right leg to transition Resident F from sitting at the side of the bed to lying flat on the bed. Resident F assists themself a small amount by bending their elbows and left leg while pushing their elbows and left foot into the mattress only to straighten their trunk while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

GG0170: Mobility (cont.)

3. **Sit to lying:** Resident H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on their right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Resident H each step of the sitting to lying activity. Resident H is then fully assisted to get from sitting to a lying position on the bed. Resident H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B would be coded 01, Dependent.

   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Sit to lying:** Resident F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). They can maneuver themself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   Coding: GG0170B would be coded 04, Supervision or touching assistance.

   Rationale: A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

5. **Sit to lying:** Resident A suffered multiple vertebral fractures due to a fall off a ladder. They require assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in their lower back. The therapist supports their trunk and lifts both legs to assist Resident A from sitting at the side of the bed to lying flat on the bed. Resident A assists themself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes resident transitions from lying on their back to sitting on the side of the bed without back support. The residents' ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.
- Back support refers to an object or person providing support for the resident's back.
- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

GG0170: Mobility (cont.)

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Resident B pushes up from the bed to get themself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Resident B scoots themself to the edge of the bed and lowers their feet onto the floor.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** Resident B pushes up on the bed to attempt to get themself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for them to sit upright. The occupational therapist provides additional lifting assistance as Resident B scoots themself to the edge of the bed and lowers their feet to the floor.

   Coding: GG0170C would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Resident P is being treated for sepsis and has multiple infected wounds on their lower extremities. Full assistance from the certified nursing assistant is needed to move Resident P from a lying position to sitting on the side of their bed because they usually have pain in their lower extremities upon movement.

   Coding: GG0170C would be coded 01, Dependent.
   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the resident.

4. **Lying to sitting on side of bed:** Resident P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Resident P's trunk as they get to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Resident P then scoots toward the edge of the bed and places both feet flat on the floor. Resident P completes most of the effort to get from lying to sitting on the side of the bed.

   Coding: GG0170C would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on side of bed.

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GG0170: Mobility (cont.)

Coding Tips for GG0170D, Sit to stand

- The activity includes the resident coming to a standing position from any sitting surface.
- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.
- If a full-body mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.
- Code as 05, Setup or clean-up assistance, if the only help a resident requires to complete the sit-to-stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle-foot orthosis.

Examples for GG0170D, Sit to stand

1. **Sit to stand:** Resident M has osteoarthritis and is recovering from sepsis. Resident M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Resident M's trunk.

   Coding: GG0170D would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance only.

2. **Sit to stand:** Resident L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist them to stand up from sitting in a chair.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Resident L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Resident B has complete tetraplegia and is currently unable to stand when getting out of bed. They transfer from their bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to their medical condition.

   Coding: GG0170D would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the resident's diagnosis of complete tetraplegia.

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GG0170: Mobility (cont.)

4. **Sit to stand:** Resident Z has amyotrophic lateral sclerosis with moderate weakness in their lower and upper extremities. Resident Z has prominent foot drop in their left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Resident Z's AFO and places the platform walker in front of them; Resident Z uses the walker to steady themself once standing. The certified nursing assistant provides lifting assistance to get Resident Z to a standing position and must also provide assistance to steady Resident Z's balance to complete the activity.

   Coding: GG0170D would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** Resident R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Resident R their crutches and helps them to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Resident R to a standing position but provides less than half the effort to complete the activity.

   Coding: GG0170D would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

Coding Tips for GG0170E, Chair/bed-to-chair transfer

- Depending on the resident's abilities, the transfer may be a stand-pivot, squat-pivot, or a slide board transfer.
- For item GG0170E, Chair/bed-to-chair transfer:
  - When assessing the resident moving from the chair/bed to the chair, the assessment begins with the resident sitting at the edge of the bed (or alternative sleeping surface) and ends with the resident sitting in a chair or wheelchair.
  - When assessing the resident moving from the chair to the bed, the assessment begins with the resident sitting in a chair or wheelchair and ends with the resident returning to sitting at the edge of the bed (or alternative sleeping surface).
  - The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.
- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.
- When possible, the transfer should be assessed in an environmental situation in which taking more than a few steps would not be necessary to complete the transfer.

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GG0170: Mobility (cont.)

Examples for GG0170E, Chair/bed-to-chair transfer

1. **Chair/bed-to-chair transfer:** Resident L had a stroke and currently is not able to walk. They use a wheelchair for mobility. When Resident L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Resident L can transfer into the wheelchair safely. Resident L had been observed several other times to determine any safety concerns, and it was documented that they transfer safely without the need for supervision. Resident L transfers into the wheelchair by themself (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E would be coded 05, Setup or clean-up assistance.
   Rationale: Resident L is not able to walk, so they transfer from their bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Resident L transfers safely and does not need supervision or physical assistance during the transfer.

2. **Chair/bed-to-chair transfer:** Resident C is sitting on the side of the bed. They stand and pivot into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Resident C only required verbal cues for safety, but usually Resident C requires touching assistance.

   Coding: GG0170E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer:** Resident F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and they recently underwent bilateral above-the-knee amputations. Resident F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Resident F from the bed to a wheelchair. Resident F is unable to assist in the transfer from their bed to the wheelchair.

   Coding: GG0170E would be coded 01, Dependent.
   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer:** Resident P has metastatic bone cancer, severely affecting their ability to use their lower and upper extremities during daily activities. Resident P is motivated to assist with their transfers from the side of their bed to the wheelchair. Resident P pushes themself up from the bed to begin the transfer while the therapist provides limited trunk support with weight-bearing assistance. Once standing, Resident P shuffles their feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance.

   Coding: GG0170E would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

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GG0170: Mobility (cont.)

5. **Chair/bed-to-chair transfer:** Resident U had their left lower leg amputated due to gangrene associated with their diabetes mellitus and they have reduced sensation and strength in their right leg. They have not yet received their below-the-knee prosthesis. Resident U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under their buttock. Resident U then attempts to scoot from the bed onto the transfer board. Resident U has reduced sensation in their hands and limited upper body strength, but assists with the transfer. The physical therapist assists them in side scooting by lifting their buttocks/trunk in a rocking motion across the transfer board and into the wheelchair.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

Coding Tips for GG0170F, Toilet transfer

- Toilet transfer includes the resident's ability to get on and off a toilet (with or without a raised toilet seat) or bedside commode.
- Toileting hygiene, clothing management, and transferring on and off a bedpan are not considered part of the Toilet transfer activity.
- Code as 05, Setup or clean-up assistance, if the resident requires a helper to position/set up the bedside commode before and/or after the resident's bed-to-commode transfers (place at an accessible angle/location next to the bed) and the resident does not require helper assistance during Toilet transfers.

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Resident T can transfer from the wheelchair onto the toilet by themself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Resident T completes the transfer from the toilet back to the wheelchair, they flip the footrests back down themself.

   Coding: GG0170F would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides setup assistance (moving the footrest out of the way) before Resident T can transfer safely onto the toilet.

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GG0170: Mobility (cont.)

2. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Resident Z lowers their underwear and then transfers onto the toilet. After voiding, Resident Z cleanses themself. They then stand up as the helper steadies them and Resident Z pulls up their underwear as the helper steadies them to ensure Resident Z does not lose their balance.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene and is not considered when rating the Toilet transfer item.

3. **Toilet transfer:** The therapist supports Resident M's trunk with a gait belt by providing weight-bearing as Resident M pivots and lowers themself onto the toilet.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

4. **Toilet transfer:** Resident W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Resident W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Resident W initiates lifting their buttocks from the bed and in addition requires some of their weight to be lifted by the certified nursing assistant to stand upright. Resident W then reaches and grabs onto the armrest of the bedside commode to steady themself. The certified nursing assistant provides weight-bearing assistance as they slowly rotate and lower Resident W onto the bedside commode.

   Coding: GG0170F would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

5. **Toilet transfer:** Resident H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Resident H prefers to use the bedside commode when moving their bowels. Due to their severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

   Coding: GG0170F would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

6. **Toilet transfer:** Resident S is on bedrest due to a medical complication. They use a bedpan for bladder and bowel management.

   Coding: GG0170F would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

GG0170: Mobility (cont.)

Coding Tips for GG0170FF, Tub/shower transfer

- Complete GG0170FF when A0310A = 01 – 06 or A0310F = 10 or 11.
- Tub/shower transfers involve the ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing activities in this item.

Examples for GG0170FF, Tub/shower transfer

1. During the observation period, Resident M took one shower. They received physical help from two staff members to get into and out of the shower.

   Coding: GG0170FF would be coded 01. Dependent.

   Rationale: Resident M required two staff members to assist with shower transfers during the observation period. This represents their usual performance of this activity during the observation period.

2. On Monday, Resident Q required trunk support from one certified nursing assistant to get into and out of the tub. On Wednesday, day 3 of the assessment period, Resident Q required trunk support from one certified nursing assistant to get into the tub and needed assistance lifting their legs during the transfer out of the tub. No other tub or shower transfers occurred during the observation period.

   Coding: GG0170FF would be coded 03. Partial/moderate assistance.

   Rationale: Resident Q participated in four tub transfers (two transfers into the tub and two transfers out of the tub) during the observation period. They required trunk support for three transfers and required the helper to lift their legs for one transfer. Because the helper performed less than half the effort for three of the four transfers, Resident Q's usual performance is 03. Partial/moderate assistance.

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GG0170: Mobility (cont.)

Coding Tips for GG0170G, Car transfer

- For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers.
- The Car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.
- If the resident remains in a wheelchair and does not transfer in and out of a car or van seat, then the activity is not considered completed, and the appropriate "activity not attempted" code would be used.
- The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the Car transfer activity.
- In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire assessment period, then use code 10, Not attempted due to environmental limitations.
- If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

Examples for GG0170G, Car transfer

1. **Car transfer:** Resident W uses a wheelchair and ambulates for only short distances. They require lifting assistance from a physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Resident W takes several steps during the transfer turn. Resident W lowers themself into the car seat with steadying assistance from the therapist. They lift their legs into the car with support from the therapist.

   Coding: GG0170G would be coded 02, Substantial/maximal assistance.

   Rationale: Although Resident W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer Resident W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During their rehabilitation stay Resident N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Resident N requires verbal reminders for safety and light touching assistance. The therapist instructs them on strategic hand placement while Resident N transitions to sitting in the car's passenger seat. The therapist opens and closes the door.

   Coding: GG0170G would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

GG0170: Mobility (cont.)

Coding Tips for GG0170I–GG0170L Walking Items

- Assessment of the walking activities starts with the resident in a standing position.
- A walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a resident.
- During a walking activity, a resident may take a brief standing rest break. If the resident needs to sit to rest during a Section GG walking activity, consider the resident unable to complete the walking activity and use the appropriate activity not attempted code.
- Clinicians can use clinical judgment to determine how the actual resident assessment of walking is conducted. If a clinician chooses to combine the assessment of multiple walking activities, the clinician should use clinical judgment to determine the type and amount of assistance needed for each individual activity.
- Use clinical judgment when assessing activities that overlap or occur sequentially to determine the type and amount of assistance needed for each individual activity.
- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- When coding GG0170 walking items, **do not** consider the resident's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- The turns included in item GG0170J, Walk 50 feet with two turns, are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).
- When coding GG0170K, Walk 150 feet, if the resident's environment does not accommodate a walk of 150 feet without turns, but the resident demonstrates the ability to walk, with or without assistance, 150 feet with turns without jeopardizing the resident's safety, code using the 6-point scale.
- When coding GG0170L, Walking 10 feet on uneven surfaces, the activity can be assessed inside or outside. Examples of uneven surfaces include uneven or sloping surfaces, turf, and gravel. Use clinical judgment to determine whether a surface is uneven.

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Resident C has resolving sepsis and has not walked in three weeks because of their medical condition. A physical therapist determines that it is unsafe for Resident C to use a walker, and the resident only walks using the parallel bars. On day 3 of the Admission assessment period, Resident C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

GG0170: Mobility (cont.)

Coding: GG0170I would be coded 88, Not attempted due to medical condition or safety concerns.
Rationale: When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident is unable to walk without the use of parallel bars because of their medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.

2. **Walk 10 feet:** Resident L had bilateral amputations three years ago, and prior to the current admission they used a wheelchair and did not walk. Currently Resident L does not use prosthetic devices and uses only a wheelchair for mobility. Resident L's care plan includes fitting and use of bilateral lower extremity prostheses.

   Coding: GG0170I would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
   Rationale: When assessing a resident for GG0170I, Walk 10 feet, consider the resident's status prior to the current episode of care and current assessment status. Use code 09, Not applicable, because Resident L did not walk prior to the current episode of care and did not walk during the assessment period.

3. **Walk 10 feet:** Resident C has Parkinson's disease and walks with a walker. A physical therapist must advance the walker for Resident C with each step. The physical therapist assists Resident C by physically initiating the stepping movement forward, advancing Resident C's foot, during the activity of walking 10 feet.

   Coding: GG0170I would be coded 02, Substantial/maximal assistance.
   Rationale: A helper provides more than half the effort as the resident completes the activity.

4. **Walk 10 feet:** Resident O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A physical therapist assistant guides and steadies the shaking, rolling walker forward while cueing Resident O to take larger steps. Resident O requires steadying at the beginning of the walk and progressively requires some of their weight to be supported for the last two feet of the 10-foot walk.

   Coding: GG0170I would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort required for the resident to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Resident O supported their own body weight with their arms and legs and propelled their legs forward for 8 of the 10 feet. The helper supported part of Resident O's weight only for 2 of the 10 feet; thus Resident O contributed more than half the effort.

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GG0170: Mobility (cont.)

5. **Walk 10 feet:** Resident U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned their stump sock and prosthesis, Resident U is assisted to stand and uses their rolling walker while walking. The nurse places their hand on Resident U's back to steady them toward the last half of their 10-foot walk.

   Coding: GG0170I would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance in order for the resident to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Resident W gets up from a sitting position to a standing position. After the therapist places Resident W's walker within reach, Resident W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while they walk.

   Coding: GG0170J would be coded 05, Setup or clean-up assistance.
   Rationale: Resident W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance).

2. **Walk 50 feet with two turns:** Resident P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Resident P turns.

   Coding: GG0170J would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.

3. **Walk 50 feet with two turns:** Resident L is unable to bear their full weight on their left leg. As they walk 60 feet down the hall with their crutches and make two turns, the certified nursing assistant supports their trunk providing weight-bearing assistance.

   Coding: GG0170J would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Resident T walks 50 feet with the therapist providing trunk support. They also require a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety. Resident T walks the 50 feet with two turns with the assistance of two helpers.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: Resident T requires two helpers to complete the activity.

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GG0170: Mobility (cont.)

5. **Walk 50 feet with two turns:** Resident U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Resident U is assisted to stand and, after walking 10 feet, requires progressively more help as they near the 50-foot mark. Resident U is unsteady and typically loses their balance when turning, requiring significant support to remain upright. The therapist provides significant trunk support for about 30 to 35 feet.

   Coding: GG0170J would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** Resident D walks down the hall using their walker and the certified nursing assistant usually needs to provide touching assistance to Resident D, who intermittently loses their balance while they use the walker.

   Coding: GG0170K would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance intermittently throughout the activity.

2. **Walk 150 feet:** Resident R has endurance limitations due to heart failure and has only walked about 30 feet during the assessment period. They have not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Resident R.

   Coding: GG0170K would be coded 88, Not attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item GG0170I.

   Rationale: The activity was not attempted. The resident did not complete the activity, and a helper cannot complete the activity for the resident. A resident who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.

3. **Walk 150 feet:** Resident T has an unsteady gait due to balance impairment. Resident T walks the length of the hallway using their quad cane in their right hand. The physical therapist supports their trunk, helping them to maintain their balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   Coding: GG0170K would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Resident W, who has Parkinson's disease, walks the length of the hallway using their rolling walker. The physical therapist provides trunk support and advances Resident W's right leg in longer strides with each step. The therapist occasionally prevents Resident W from falling as they lose their balance during the activity.

Draft

GG0170: Mobility (cont.)

Coding: GG0170K would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Example for GG0170L, Walking 10 feet on uneven surfaces

1. **Walking 10 feet on uneven surfaces:** Resident N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Resident N will need to be able to walk on the uneven and sloping surfaces of their driveway. During their SNF stay, a physical therapist takes Resident N outside to walk on uneven surfaces. Resident N requires the therapist's weight-bearing assistance less than half the time during walking in order to prevent Resident N from falling as they navigate walking 10 feet over uneven surfaces.

   Coding: GG0170L would be coded 03, Partial/moderate assistance.

   Rationale: Resident N requires a helper to provide weight-bearing assistance several times to prevent them from falling as they walk 10 feet on uneven surfaces. The helper contributes less than half the effort required for Resident N to walk 10 feet on uneven surfaces.

Coding Tips for GG0170M, 1 step (curb); GG0170N, 4 steps; and GG0170O, 12 steps

- Completing the stair activities indicates that a resident goes up and down the stairs, by any safe means, with or without any assistive devices (for example, railing or stair lift) and with or without some level of assistance. Getting to and from the stairs is not included when coding the curb or step activities.
- Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up the stairs and then down the stairs occurs sequentially, the resident may take a standing or seated rest break between ascending and descending the 4 steps or 12 steps.
- If a resident requires a helper to provide total assist (for example, the resident requires total assist from a helper to move up and down over a curb in their wheelchair), code as 01, Dependent.
- A resident who uses a wheelchair may be assessed going up and down stairs (including one step or curb) in a wheelchair. Code based on the type and amount of assistance required from the helper.
- If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction *of* no stair climbing*, they may be able to complete the stair activities safely by some other means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity. If, at the time of assessment, a resident is unable to complete the stair activities because of a physician prescribed bedrest, code the stair activity using the appropriate "activity not attempted" code*.

Draft

GG0170: Mobility (cont.)

- Assess the resident going up and down one step or up and down over a curb. If both are assessed, and the resident's performance going up and down over a curb is different from their performance going up and down one step (e.g., because the step has a railing), code GG0170M, 1 step (curb) based on the activity with which the resident requires the most assistance.
- If a resident's environment does not have 12 steps, the combination of going up and down 4 stairs three times consecutively in a safe manner is an acceptable alternative to comply with the intention and meet the requirements of this activity.
- *While a resident may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means, without taking more than a brief rest break in order to consider the stair activity completed.*

Example for GG0170M, 1 step (curb)

1. **1 step (curb):** Resident Z has had a stroke; they must be able to step up and down one step to enter and exit their home. A physical therapist provides standby assistance as they use their quad cane to support their balance in stepping up one step. The physical therapist provides steadying assistance as Resident Z uses their cane for balance and steps down one step.

   Coding: GG0170M would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance as Resident Z completes the activity of stepping up and down one step.

Example for GG0170N, 4 steps

1. **4 steps:** Resident J has lower body weakness, and a physical therapist provides steadying assistance when they ascend 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Resident J holds the stair railing.

   Coding: GG0170N would be coded 03, Partial/moderate assistance.
   Rationale: A helper provides touching assistance as Resident J ascends 4 steps. The helper provides trunk support (more than touching assistance) when they descend the 4 steps.

Example for GG0170O, 12 steps

1. **12 steps:** Resident Y is recovering from a stroke resulting in motor issues and poor endurance. Resident Y's home has 12 stairs, with a railing, and they need to use these stairs to enter and exit their home. Their physical therapist uses a gait belt around their trunk and supports less than half of the effort as Resident Y ascends and then descends 12 stairs.

   Coding: GG0170O would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the required effort in providing the necessary support for Resident Y as they ascend and descend 12 stairs.

Draft

GG0170: Mobility (cont.)

Coding Tips for GG0170P, Picking up object

- The activity includes the resident bending or stooping from a standing position to pick up a small object, such as a spoon, from the floor.
- Picking up the object must be assessed while the resident is in a standing position. If the resident is not able to stand, the activity did not occur, and the appropriate "not attempted" code would be used.
- If a standing resident is unable to pick up a small object from the floor, therefore requiring the helper to assist in picking up the object, code as 01, 02, or 03, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort, respectively.
- Assistive devices and adaptive equipment may be used, for example, a cane to support standing balance and/or a reacher to pick up the object.

Examples for GG0170P, Picking up object

1. **Picking up object:** Resident P has a neurologic condition that has resulted in balance problems. They want to be as independent as possible. Resident P lives with their spouse and will soon be discharged from the SNF. They tend to drop objects and have been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind Resident P of safety strategies when they bend to pick up objects from the floor, and the occupational therapist needs to steady them to prevent them from falling.

   Coding: GG0170P would be coded 04, Supervision or touching assistance.
   Rationale: A helper is needed to provide verbal cues and touching or steadying assistance when Resident P picks up an object because of their coordination issues.

2. **Picking up object:** Resident C has recently undergone a hip replacement. When they drop items they use a long-handled reacher that they have been using at home prior to admission. They are ready for discharge and can now ambulate with a walker without assistance. When they drop objects from their walker basket they require a certified nursing assistant to locate their long-handled reacher and bring it to them in order for them to use it. They do not need assistance to pick up the object after the helper brings them the reacher.

   Coding: GG0170P would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provides set-up assistance so that Resident C can use their long-handled reacher.

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GG0170: Mobility (cont.)

Coding Tips for GG0170Q, GG0170R, and GG0170S, Wheelchair Items

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair for self-mobilization prior to admission. Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety.
- If the resident used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment in GG0170Q1.

  The responses for gateway wheelchair items (GG0170Q1, GG0170Q3, and/or GG0170Q5) do not have to be the same on subsequent assessments. For example, the Admission assessment may indicate that the resident does not use a wheelchair but the subsequent assessment may indicate that the resident uses a wheelchair.
- If a wheelchair is used for transport purposes only, then GG0170Q1, GG0170Q3, and/or GG0170Q5, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between their room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.
- The turns included in item GG0170R (wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.
- If a resident's environment does not accommodate wheelchair or scooter use for 150 feet without turns, but the resident demonstrates the ability to mobilize a wheelchair or scooter with or without assistance for 150 feet with turns without jeopardizing the resident's safety, code GG0170S, Wheel 150 feet, using the 6-point scale.
- For GG0170S, Wheel 150 feet, a helper can assist a resident in completing the required distance in the wheelchair or in making turns if required. When a resident is unable to wheel the entire distance themself, the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

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GG0170: Mobility (cont.)

Example for GG0170Q1, Does the resident use a wheelchair/scooter?

1. **Does the resident use a wheelchair/scooter?** On admission, Resident T wheels themself using a manual wheelchair, but with difficulty due to their severe osteoarthritis and COPD.

   Coding: GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Resident T uses for GG0170RR1 is indicated as code 1, Manual.
   Rationale: The resident currently uses a wheelchair. Coding the resident's performance and the type of wheelchair (manual) is indicated.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair/scooter used

1. **Wheel 50 feet with two turns:** Resident M is unable to bear any weight on their right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Resident M from the bed into the wheelchair. Once in their wheelchair, Resident M propels themself about 60 feet down the hall using their left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R would be coded 06, Independent.
   Rationale: The resident wheels themself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

2. **Indicate the type of wheelchair/scooter used:** In the above example Resident M used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Resident M used a manual wheelchair during the assessment period.

3. **Wheel 50 feet with two turns:** Resident R is very motivated to use their motorized wheelchair with an adaptive throttle for speed and steering. Resident R has amyotrophic lateral sclerosis, and moving their upper and lower extremities is very difficult. The physical therapist assistant is required to walk next to Resident R for frequent readjustments of their hand position to better control the steering and speed throttle. Resident R often drives too close to corners, becoming stuck near doorways upon turning, preventing them from continuing to mobilize/wheel themself. The physical therapist assistant backs up Resident R's wheelchair for them so that they may continue mobilizing/wheeling themself.

   Coding: GG0170R would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns.

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GG0170: Mobility (cont.)

4. **Indicate the type of wheelchair/scooter used:** In the above example Resident R used a motorized wheelchair during the assessment period.

   Coding: GG0170RR would be coded 2, Motorized.
   Rationale: Resident R used a motorized wheelchair during the assessment period.

5. **Wheel 50 feet with two turns:** Resident V had a spinal tumor resulting in paralysis of their lower extremities. The physical therapist assistant provides verbal instruction for Resident V to navigate their manual wheelchair in their room and into the hallway while making two turns.

   Coding: GG0170R would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example Resident V used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Resident V used a manual wheelchair during the assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Resident R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into their room and then turning into their bathroom.

   Coding: GG0170R would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort to assist the resident to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example Resident R used a manual wheelchair during the assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Resident R used a manual wheelchair during the assessment period.

Examples for GG0170S, Wheel 150 feet and GG0170SS, Indicate the type of wheelchair/scooter used

1. **Wheel 150 feet:** Resident G always uses a motorized scooter to mobilize themself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

2. **Indicate the type of wheelchair/scooter used:** In the example above, Resident G uses a motorized scooter.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Resident G used a motorized scooter during the assessment period.

Draft

GG0170: Mobility (cont.)

3. **Wheel 150 feet:** Resident N uses a below-the-knee prosthetic limb. Resident N has peripheral neuropathy and limited vision due to complications of diabetes. Resident N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing themself within the community. Resident N is assessed for the activity of 150 feet wheelchair mobility. Resident N's usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: Resident N requires the helper to provide verbal cues for their safety when using a wheelchair for 150 feet.

4. **Indicate the type of wheelchair/scooter used:** In the above example Resident N used a manual wheelchair during the assessment period.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Resident N used a manual wheelchair during the assessment period.

5. **Wheel 150 feet:** Resident L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Resident L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. They occasionally need reminders to slow down around the turns and require assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

6. **Indicate the type of wheelchair/scooter used:** Resident L used a motorized wheelchair during the assessment period.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Resident L used a motorized wheelchair during the assessment period.

7. **Wheel 150 feet:** Resident M has had a mild stroke, resulting in muscle weakness in their right upper and lower extremities. Resident M uses a manual wheelchair. They usually can self-propel themself about 60 to 70 feet but need assistance from a helper to complete the distance of 150 feet.

   Coding: GG0170S would be coded 02, Substantial/Maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of wheel 150 feet.

8. **Indicate the type of wheelchair/scooter used:** In the above example, Resident M used a manual wheelchair during the assessment period.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Resident M used a manual wheelchair during the assessment period.

DRAFT

GG0170: Mobility (cont.)

9. **Wheel 150 feet:** Resident A has a cardiac condition with medical precautions that do not allow them to propel their own wheelchair. Resident A is completely dependent on a helper to wheel them 150 feet using a manual wheelchair.

   Coding: GG0170S would be coded 01, Dependent.
   Rationale: The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate the type of wheelchair/scooter used:** In the above example, Resident A is wheeled using a manual wheelchair during the assessment period.

    Coding: GG0170SS would be coded 1, Manual.
    Rationale: Resident A is assisted using a manual wheelchair during the assessment period.

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident's score for sit to lying and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Resident H moves themself from sitting on the side of the bed to lying flat on the bed. When they are sitting on the side of the bed, how do they move to lying on their back?"

   Certified nursing assistant: "They can lie down with some help."

   Nurse: "Please describe how much help they need and exactly how you help them."

   Certified nursing assistant: "I have to lift and position their right leg, but once I do that, they can use their arms to position their upper body."

   In this example, the nurse inquired specifically about how Resident H moves from a sitting position to a lying position. The nurse asked about physical assistance.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant lifts Resident H's right leg and helps them position it as they move from a sitting position to a lying position. The helper does less than half the effort.

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GG0170: Mobility (cont.)

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Resident L moves themself in bed. When they are in bed, how do they move from lying on their back to sitting up on the side of the bed?"

   Certified nursing assistant: "They can sit up by themself."

   Nurse: "They sit up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind them to check on the position of their arm that has limited movement and sensation as they move in the bed, but once I remind them to check their arm, they can do it themself."

   In this example, the nurse inquired specifically about how Resident L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident's sit to stand ability:

   Nurse: "Please describe how Resident L usually moves from sitting on the side of the bed or chair to a standing position. Once they are sitting, how do they get to a standing position?"

   Certified nursing assistant: "They need help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help they need for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "They need two people to assist them to stand up from sitting on the side of the bed or when they are sitting in a chair."

   In this example, the nurse inquired specifically about how Resident L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Resident L requires the assistance of two helpers to complete the activity.

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GG0170: Mobility (cont.)

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident's chair/bed-to-chair transfer ability:

   Nurse: "Please describe how Resident C moves into the chair from the bed. When they are sitting at the side of the bed, how much help do they need to move from the bed to the chair?"

   Certified nursing assistant: "They need me to help them move from the bed to the chair."

   Nurse: "Do they help with these transfers when you give them any instructions, setup, or physical help?"

   Certified nursing assistant: "Yes, they will follow some of my instructions to get ready to transfer, such as moving their feet from being spread out to placing them under their knees. I have to place the chair close to the bed and then I lift them because they are very weak. I then tell them to reach for the armrest of the chair. Resident C follows these directions and that helps a little in transferring them from the bed to the chair. They do help with the transfer."

   In this example, the nurse inquired specifically about how Resident C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident C received.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.

   Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

Draft

GG0170: Mobility (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident's toilet transfer assessment:

   Nurse: "I understand that Resident M usually uses a wheelchair to get to their toilet. Please describe how Resident M moves from their wheelchair to the toilet. How do they move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for them, but they do it with my help."

   Nurse: "Can you describe the amount of help in more detail?"

   Certified nursing assistant: "I have to give them a bit of a lift using a gait belt to get them to stand and then remind them to reach for the toilet grab bar while they pivot to the toilet. Sometimes, I have to remind them to take a step while they pivot to or from the toilet, but they do most of the effort themself."

   In this example, the nurse inquired specifically about how Resident M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident M received.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "How much help does Resident T need to walk 50 feet and make two turns once they are standing?"

   Certified nursing assistant: "They need help to do that."

   Nurse: "How much help do they need?"

   Certified nursing assistant: "They walk about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case they need to sit down."

   In this example, the nurse inquired specifically about how Resident T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident T received.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: Resident T requires two helpers to complete this activity.

DRAFT

GG0170: Mobility (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "Please describe how Resident D walks 150 feet in the corridor once they are standing."

   Certified nursing assistant: "They use a walker and some help."

   Nurse: "They use a walker and how much instructions or physical help do they need?"

   Certified nursing assistant: "I have to support them by holding onto the gait belt that is around their waist so that they don't fall. They do push the walker forward most of the time."

   Nurse: "Do you help with more than or less than half the effort?"

   Certified nursing assistant: "I have to hold onto their belt firmly when they walk because they frequently lose their balance when taking steps. Their balance gets worse the further they walk, but they are very motivated to keep walking. I would say I help them with more than half the effort."

   In this example, the nurse inquired specifically about how Resident D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident D received.

   Coding: GG0170K would be coded 02, Substantial/maximal assistance.

   Rationale: The certified nursing assistant provides trunk support that is more than half the effort as Resident D walks 150 feet.

Draft

GG0170: Mobility (cont.)

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Resident R uses a manual wheelchair. Describe to me how Resident R wheels themself 50 feet and makes two turns once they are seated in the wheelchair."

   Certified nursing assistant: "They wheel themself."

   Nurse: "They wheel themself without any instructions or physical help?"

   Certified nursing assistant: "Well yes, they need help to get around turns, so I have to help them and set them on a straight path, but once I do, they wheel themself."

   In this example, the nurse inquired specifically about how Resident R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident R received.

   Coding: GG0170R would be coded 03, Partial/Moderate assistance.

   Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Resident G usually uses an electric scooter for longer distances. Once they are seated in the scooter, do they need any help to mobilize themself at least 150 feet?"

   Certified nursing assistant: "They drive the scooter themself … they are very slow."

   Nurse: "They use the scooter themself without any instructions or physical help?"

   Certified nursing assistant: "That is correct."

   In this example, the nurse inquired specifically about how Resident G uses an electric scooter to mobilize themself 150 feet. If this nurse had not asked probing questions, they would not have received enough information to make an accurate assessment of the actual assistance Resident G received.

   Coding: GG0170S would be coded 06, Independent.

   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.

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SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.

H0100: Appliances

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**

Item Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote resident dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.

Planning for Care

- Care planning should include interventions that are consistent with the resident's goals and minimize complications associated with appliance use.

DEFINITIONS

INDWELLING CATHETER
A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

SUPRAPUBIC CATHETER
An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

NEPHROSTOMY TUBE
A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

Draft

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.
2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. Select **none of the above** if none of the appliances A-D were used in the past 7 days.*

- **H0100A,** indwelling catheter (including suprapubic catheter and nephrostomy tube)
- **H0100B,** external catheter
- **H0100C,** ostomy (including urostomy, ileostomy, and colostomy)
- **H0100D,** intermittent catheterization
- **H0100Z,** none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters and external urinary pouches are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterizations for urine specimen collection or other diagnostic exams (e.g., to measure post-void residual) during look-back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER
Device attached to the shaft of the penis like a condom or a receptacle pouch that fits around the labia majora and connected to a drainage bag.

OSTOMY
Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY
A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

ILEOSTOMY
A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

COLOSTOMY
A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

INTERMITTENT CATHETERIZATION
Insertion and removal of a catheter through the urethra for bladder drainage.

Draft

H0100: Appliances (cont.)

- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

H0200: Urinary Toileting Program

H0200. Urinary Toileting Program

Enter Code ☐

A. **Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or 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

Enter Code ☐

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

Enter Code ☐

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**

Item Rationale

Health-related Quality of Life

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
  - — determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - — completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
  - — implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.

Draft

H0200: Urinary Toileting Program (cont.)

- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence and changing their brief if needed and providing good skin care).

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial 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. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

DEFINITIONS

BLADDER REHABILITATION/ BLADDER RETRAINING
A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

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.

HABIT TRAINING/ SCHEDULED VOIDING
A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE
Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- **Code 0, no:** if for any reason the resident did not undergo a toileting trial. This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial. Skip to **Urinary Continence** item (H0300).
- **Code 1, yes:** for residents who underwent a trial of an individualized, resident-centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
- **Code 9, unable to determine:** if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- **Code 0, no improvement:** if the frequency of resident's urinary incontinence did not decrease during the toileting trial.
- **Code 1, decreased wetness:** if the resident's urinary incontinence frequency decreased, but the resident remained incontinent. There is no quantitative definition of improvement. However, the improvement should be clinically meaningful—for example, having at least one less incontinent void per day than before the toileting program was implemented.

DRAFT

H0200: Urinary Toileting Program (cont.)

- **Code 2, completely dry (continent):** if the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial. (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)
- **Code 9, unable to determine or trial in progress:** if the response to the toileting trial cannot be determined because information cannot be found or because the trial is still in progress.

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- **Code 1, yes:** for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
  - simply tracking continence status,
  - changing pads or wet garments, and
  - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
  - H0200A would be **coded 1, yes,**
  - H0200B would be **coded 9, unable to determine or trial in progress,** and
  - H0200C would be **coded 1, yes.**

Draft

H0200: Urinary Toileting Program (cont.)

Examples

1. Resident H has a diagnosis of advanced Alzheimer's disease. They are dependent on the staff for their ADLs, do not have the cognitive ability to void in the toilet or other appropriate receptacle, and are totally incontinent. Their voiding assessment/diary indicates no pattern to their incontinence. Their care plan states that due to their total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb their sleep.

   Coding: H0200A would be **coded as 0, no**. H0200B and H0200C would be skipped.

   Rationale: Based on this resident's voiding assessment/diary, there was no pattern to their incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no, skip to H0300, Urinary Continence.

2. Resident M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed them for a reversible cause of the incontinence and has evaluated their voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving their 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

   Coding: H0200A would be **coded as 1, yes.**

   H0200B would be **coded as 9, unable to determine or trial in progress.**

   H0200C would be **coded as 1, current toileting program or trial.**

   Rationale: Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.

Draft

H0300: Urinary Continence

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - — interfere with participation in activities,
  - — be socially embarrassing and lead to increased feelings of dependency,
  - — increase risk of long-term institutionalization,
  - — increase risk of skin rashes and breakdown,
  - — increase risk of repeated urinary tract infections, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

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

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
  - — bladder retraining, prompted voiding, or scheduled toileting.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the resident if they are capable of reliably reporting their continence. Speak with family members or significant others if the resident is not able to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

H0300: Urinary Continence (cont.)

Coding Instructions

- **Code 0, always continent:** if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Examples

1. An 86-year-old resident has had longstanding stress-type incontinence for many years. When they have an upper respiratory infection and are coughing, they involuntarily lose urine. However, during the current 7-day look-back period, the resident has been free of respiratory symptoms and has not had an episode of incontinence.

   Coding: H0300 would be **coded 0, always continent**.
   Rationale: Even though the resident has known intermittent stress incontinence, they were continent during the current 7-day look-back period.

DEFINITION

STRESS INCONTINENCE
Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

2. A resident with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

   Coding: H0300 would be **coded as 2, frequently incontinent.**
   Rationale: The resident had seven documented episodes of urinary incontinence during the look-back period. The criterion for "frequent" incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

DRAFT

H0300: Urinary Continence (cont.)

3. A resident with Parkinson's disease is severely immobile and cannot be transferred to a toilet. They are unable to use a urinal, and the incontinence is managed by the resident using adult briefs and bed pads that are regularly changed. They did not have a continent void during the 7-day look-back period.

   Coding: H0300 would be **coded as 3, always incontinent.**

   Rationale: The resident has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. Incontinence is managed by a "check and change" protocol.

4. A resident had one continent urinary void during the 7-day look-back period, after the nursing assistant assisted them to the toilet and helped with clothing. All other voids were incontinent.

   Coding: H0300 would be **coded as 2, frequently incontinent.**

   Rationale: The resident had at least one continent void during the look-back period. The reason for the continence does not enter into the coding decision.

H0400: Bowel Continence

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - — interfere with participation in activities,
  - — be socially embarrassing and lead to increased feelings of dependency,
  - — increase risk of long-term institutionalization,
  - — increase risk of skin rashes and breakdown, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

Draft

H0400: Bowel Continence (cont.)

- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if they are capable of reliably reporting their bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

Coding Tips and Special Populations

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Draft

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**

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences associated with incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skin care).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - 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.

Draft

H0500: Bowel Toileting Program (cont.)

Coding Instructions

- **Code 0, no:** if the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1, yes:** if the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0600: Bowel Patterns

H0600. Bowel Patterns

Enter Code ☐ **Constipation present?**

0. No
1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
  - — dehydration due to a medical condition or inadequate access to and intake of fluid, and
  - — side effects of medications.

DEFINITION

CONSTIPATION

If the resident has two or fewer bowel movements during the 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).

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period.
2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. Speak with family members or significant others if the resident is unable to report on bowel habits.
3. Ask direct care staff who routinely work with the resident on all shifts about problems with constipation.

DEFINITION

FECAL IMPACTION

A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

Draft

H0600: Bowel Patterns (cont.)

Coding Instructions

- **Code 0, no:** if the resident shows no signs of constipation during the look-back period.
- **Code 1, yes:** if the resident shows signs of constipation during the look-back period.

Coding Tips and Special Populations

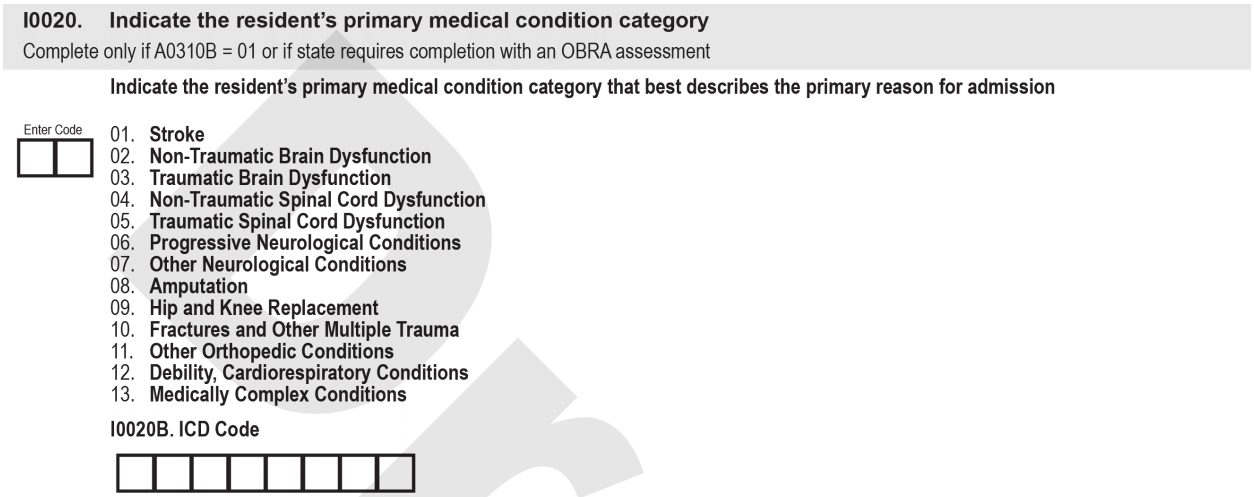
- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

Draft

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

I0020: Indicate the resident's primary medical condition category



I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

Item Rationale

Health-related Quality of Life

- Disease processes can have a significant adverse effect on residents' functional improvement.

Planning for Care

- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.

Steps for Assessment

1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Draft

I0020: Indicate the resident's primary medical condition category (cont.)

Coding Instructions

Complete only if A0310B = 01 or 08

- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
- When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
  - **Code 01, Stroke,** if the resident's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
  - **Code 02, Non-Traumatic Brain Dysfunction,** if the resident's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.
  - **Code 03, Traumatic Brain Dysfunction,** if the resident's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.
  - **Code 04, Non-Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
  - **Code 05, Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.
  - **Code 06, Progressive Neurological Conditions,** if the resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.
  - **Code 07, Other Neurological Conditions,** if the resident's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
  - **Code 08, Amputation,** if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.

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I0020: Indicate the resident's primary medical condition category (cont.)

- **Code 09, Hip and Knee Replacement,** if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.
- **Code 10, Fractures and Other Multiple Trauma,** if the resident's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
- **Code 11, Other Orthopedic Conditions,** if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.
- **Code 12, Debility, Cardiorespiratory Conditions,** if the resident's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
- **Code 13, Medically Complex Conditions,** if the resident's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

Examples of Primary Medical Condition

1. Resident K is a 67-year-old individual with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Resident K's history and physical by the admitting physician.

   Coding: I0020 would be coded **01, Stroke.** I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage).

   Rationale: The physician's history and physical documents the diagnosis stroke as the reason for Resident K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

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I0020: Indicate the resident's primary medical condition category (cont.)

2. Resident E is an 82-year-old individual who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Resident E's primary medical condition as total hip replacement (THR) in their medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

   Coding: I0020 would be coded **10, Fractures and Other Multiple Trauma.** I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).

   Rationale: Medical record documentation demonstrates that Resident E had a total hip replacement due to a hip fracture and required rehabilitation. Because they were admitted for rehabilitation as a result of the hip fracture and total hip replacement, Resident E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

3. Resident H is a 78-year-old individual with a history of hypertension and a hip replacement 2 years ago. There were admitted to an extended hospitalization for idiopathic pancreatitis. They had a central line placed during the hospitalization so they could receive TPN (total parenteral nutrition). They also received regular blood glucose monitoring and treatment with insulin when they became hyperglycemic. During their SNF stay, they are being transitioned from being NPO (nothing by mouth) and receiving their nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into Resident H's SNF medical record.

   Coding: I0020 would be coded **13, Medically Complex Conditions.** I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).

   Rationale: Resident H had hospital care for pancreatitis immediately prior to their SNF stay. Their principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of their central line does not change their care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

DRAFT

I: Active Diagnoses in the Last 7 Days

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ **I0100. Cancer** (with or without metastasis)

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and 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) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

- ☐ **I1100. Cirrhosis**
- ☐ **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ **I1300. Ulcerative Colitis, 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**

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)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ **I3800. Osteoporosis**
- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital 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. Non-Alzheimer's 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 or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

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I: Active Diagnoses in the Last 7 Days (cont.)

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **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)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

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 last 7 days

Other

I8000. Additional active diagnoses

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ ☐☐☐☐☐☐☐☐

B. _____ ☐☐☐☐☐☐☐☐

C. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

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I: Active Diagnoses in the Last 7 Days (cont.)

Item Rationale

Health-related Quality of Life

- Disease processes can have a significant adverse effect on an individual's health status and quality of life.

Planning for Care

- This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

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 does not use the active 7-day look-back period).

1. **Identify diagnoses:** The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the **last 60 days.**

   Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

   - Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally 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.

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.

DEFINITIONS

ACTIVE DIAGNOSES
Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

FUNCTIONAL LIMITATIONS
Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

NURSING MONITORING
Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).

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I: Active Diagnoses in the Last 7 Days (cont.)

- Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-12 for specific coding instructions for Item I2300 UTI.
- Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-12 for specific coding instructions).

- Document active diagnoses on the MDS as follows:
  - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
  - 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.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code's decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes end on the left.)
- If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

Cancer

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

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I: Active Diagnoses in the Last 7 Days (cont.)

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

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

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)

Metabolic

- **I2900,** diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)

Draft

I: Active Diagnoses in the Last 7 Days (cont.)

- **I3100,** hyponatremia
- **I3200,** hyperkalemia
- **I3300,** hyperlipidemia (e.g., hypercholesterolemia)
- **I3400,** thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

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)

Nutritional

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

Psychiatric/Mood Disorder

- **I5700,** anxiety disorder

Draft

I: Active Diagnoses in the Last 7 Days (cont.)

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

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

Other

- **I8000,** additional active diagnoses

Coding Tips

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
  - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
  - For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.
- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
  - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

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I: Active Diagnoses in the Last 7 Days (cont.)

- 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.
- Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

- **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.
- In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.
- **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.

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I: Active Diagnoses in the Last 7 Days (cont.)

— In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. 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.

— If the diagnosis of UTI 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).

— **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

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not

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I: Active Diagnoses in the Last 7 Days (cont.)

recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTIs and many other issues related to infections in LTC.
http://www.cdc.gov/hai/

- Item 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.

Examples of Active Disease

1. A resident is prescribed hydrochlorothiazide for hypertension. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.

   Coding: Hypertension item (I0700), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for a resident with atrial fibrillation to decrease the risk of embolic stroke. The resident requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

   Coding: Atrial fibrillation item (I0300), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

Draft

I: Active Diagnoses in the Last 7 Days (cont.)

3. A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

   Coding: Arthritis item (I3700), would be **checked**.
   Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

4. 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 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 of Inactive Diagnoses (do not code)

1. The admission history states that the resident had pneumonia 2 months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look back period.

   Coding: Pneumonia item (I2000), would **not be checked.**
   Rationale: The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

   Coding: CAD item (I0400), would **not be checked.**
   Rationale: The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Resident J fell and fractured their 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 them to their previous ambulation status, which had been independent without any devices. Although they received therapy services at that time, they now require assistance to stand from the chair and uses a walker. They also need 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, they have not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

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I: Active Diagnoses in the Last 7 Days (cont.)

4. The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

   Coding: Schizophrenia item (I6000), would **not be checked.**

   Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

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SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the management of pain, the presence of pain, pain frequency, effect of pain on sleep, and pain interference with therapy and day-to-day activities. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.

J0100: Pain Management

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**

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most residents should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions facilitates review of the effectiveness of pain management and revision of the plan if goals are not met.
- Residents may have more than one source of pain and will need a comprehensive, individualized management regimen.
- Most residents with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some residents with intermittent or mild pain may have orders for PRN dosing only.

DEFINITION

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 may lead to pain reduction.

Draft

J0100: Pain Management (cont.)

- Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens.
- Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Steps for Assessment

1. Review medical record to determine if a pain regimen exists.
2. Review the medical record and interview staff and direct caregivers to determine what, if any, pain management interventions the resident received any time during the last 5 days. Include information from all disciplines.

Coding Instructions for J0100A-C

Determine all interventions for pain provided to the resident any time in the last 5 days. Answer these items even if the resident currently denies pain.

Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen

- **Code 0, no:** if the medical record does not contain documentation that a scheduled pain medication was received.
- **Code 1, yes:** if the medical record contains documentation that a scheduled pain medication was received.

Coding Instructions for J0100B, Received PRN Pain Medication

- **Code 0, no:** if the medical record does not contain documentation that a PRN medication was received or offered.
- **Code 1, yes:** if the medical record contains documentation that a PRN medication was either received OR was offered but declined.

DEFINITIONS

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 nonpharmacological interventions include, but are not limited to, biofeedback, 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.

Draft

J0100: Pain Management (cont.)

Coding Instructions for J0100C, Received Non-medication Intervention for Pain

- **Code 0, no:** if the medical record does not contain documentation that a non-medication pain intervention was received.
- **Code 1, yes:** if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy.

Coding Tips

- Code only pain medication regimens without PRN pain medications in J0100A. Code receipt of PRN pain medications in J0100B.
- For J0100B code only residents with PRN pain medication regimens here. If the resident has a scheduled pain medication J0100A should be coded.

Examples

1. The resident's medical record documents that they received the following pain management in the last 5 days:
   - Hydrocodone/acetaminophen 5/500 1 tab PO every 6 hours. Discontinued on day 1 of the look-back period.
   - Acetaminophen 500mg PO every 4 hours. Started on day 2 of the look-back period.
   - Cold pack to left shoulder applied by PT BID. PT notes that resident reports significant pain improvement after cold pack applied.

     Coding: J0100A would be **coded 1, yes**.

     Rationale: Medical record indicated that resident received a scheduled pain medication in the last 5 days.

     Coding: J0100B would be **coded 0, no.**

     Rationale: No documentation was found in the medical record that resident received or was offered and declined any PRN medications in the last 5 days.

     Coding: J0100C would be **coded 1, yes.**

     Rationale: The medical record indicates that the resident received scheduled non-medication pain intervention (cold pack to the left shoulder) in the last 5 days.
2. The resident's medical record includes the following pain management documentation:
   - Morphine sulfate controlled-release 15 mg PO Q 12 hours: Resident refused every dose of medication in the last 5 days. No other pain management interventions were documented.

DRAFT

J0100: Pain Management (cont.)

Coding: J0100A would be **coded 0, no.**

Rationale: The medical record documented that the resident did not receive scheduled pain medication in the last 5 days. Residents may refuse scheduled medications; however, medications are not considered "received" if the resident refuses the dose.

Coding: J0100B would be **coded 0, no**.

Rationale: The medical record contained no documentation that the resident received or was offered and declined any PRN medications in the last 5 days.

Coding: J0100C would be **coded 0, no**.

Rationale: The medical record contains no documentation that the resident received non-medication pain intervention in the last 5 days.

J0200: Should Pain Assessment Interview Be Conducted?

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Item Rationale

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about pain directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying pain.

Planning for Care

- Interview allows the resident's voice to be reflected in the care plan.
- Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.

Draft

J0200: Should Pain Assessment Interview Be Conducted? (cont.)

Steps for Assessment

1. Interact with the resident using their preferred language. Be sure they can hear you and/or have access to their preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item J0800, Indicators of Pain or Possible Pain.
3. Review Language item (A1110) 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.

Coding Instructions

Attempt to complete the interview with all residents.

- **Code 0, no:** if the resident is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- **Code 1, yes:** if the resident is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence**.

Coding Tips and Special Populations

- 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 interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "—") entered in the Pain Assessment Interview items (J0300–J0600). Item J0700, Should the Staff Assessment for Pain be Conducted?, is coded 0, No.
- Do not complete the Staff Assessment for Pain items (J0800–J0850) if the Pain Assessment Interview should have been conducted but was not done.
- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate the Pain Assessment Interview was not attempted, skip the Pain Assessment Interview items (J0300–J0600), and complete the **Staff Assessment of Pain** item (J0800).

DRAFT

J0300–J0600: 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 J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐

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

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

J0510. Pain Effect on Sleep

Enter Code ☐

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

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

J0520. Pain Interference with Therapy Activities

Enter Code ☐

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

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

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

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

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

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**

Draft

J0300–J0600: Pain Assessment Interview (cont.)



Item Rationale

Health-related Quality of Life

- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively impaired residents.
- Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

Planning for Care

- Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.
- Resident self-report is the most reliable means for assessing pain.
- Pain assessment provides a basis for evaluation, treatment need, and response to treatment.
- Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications.
- Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.
- The assessment of pain is not associated with any particular approach to pain management. Since the use of opioids is associated with serious complications, an array of successful nonpharmacologic and nonopioid approaches to pain management may be considered. There are a range of pain management strategies that can be used, including but not limited to non-opioid analgesic medications, transcutaneous electrical nerve stimulation (TENS) therapy, supportive devices, acupuncture, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, and ultrasound.
- Pain assessment prompts discussion about factors that aggravate and alleviate pain.
- Similar pain stimuli can have varying impact on different individuals.
- Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.
- Pain intensity scales allow providers to evaluate whether pain is responding to pain medication regimen(s) and/or nonpharmacological intervention(s).

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J0300–J0600: Pain Assessment Interview (cont.)



Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

1. Interview any resident not screened out by the **Should Pain Assessment Interview be Conducted?** item (J0200).
2. The Pain Assessment Interview for residents consists of seven items: the primary question **Pain Presence** item (J0300) and six follow-up questions. If the resident is unable to answer the primary question on **Pain Presence** item J0300, skip to the **Staff Assessment for Pain** beginning with **Indicators of Pain or Possible Pain** item (J0800).
3. Conduct the interview in a private setting.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
6. 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."
7. Directly ask the resident each item in the Pain Assessment Interview in the order provided.
   - Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term "pain" but may report that they "hurt." Residents may use other terms such as "aching" or "burning" to describe pain.
8. If the resident chooses not to answer a particular item, accept their refusal, **code 9**, and move on to the next item.
9. If the resident is unsure about whether pain or the effects or interference of pain occurred in the last 5 days, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred in the last 5 days.

DEFINITION

PAIN

Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.

DRAFT

J0300: Pain Presence

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 J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

Steps for Assessment

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

DEFINITION

NONSENSICAL RESPONSE
Any unrelated, incomprehensible, or incoherent response that is not informative with respect to the item being coded.

Coding Instructions for J0300, Pain Presence

Code for the presence or absence of pain regardless of pain management efforts in the last 5 days.

- **Code 0, no:** if the resident responds "no" to having any pain or hurting in the last 5 days. **Code 0, no:** even if the reason for no pain is that the resident received pain management interventions. If coded 0, the pain interview is complete. Skip to **Shortness of Breath** item (J1100).
- **Code 1, yes:** if the resident responds "yes" to having any pain or hurting in the last 5 days. If coded 1, proceed to the Pain Assessment Interview.
- **Code 9, unable to answer:** if the resident is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the **Staff Assessment for Pain**.

Coding Tips

- Rates of self-reported pain are higher than observed rates. Although some observers have expressed concern that residents may not complain and may deny pain, the regular and objective use of self-report pain scales enhances residents' willingness to report.

Examples

1. When asked about pain, Resident S responds, "No. I have been taking the pain medication regularly, so fortunately I have had no pain."

   Coding: J0300 would be **coded 0, no**.

   Rationale: Resident S reports having no pain during the look-back period. Even though they received pain management interventions during the look-back period, the item is coded "No," because there was no pain.

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

   Coding: J0300 would be **coded 1, yes**.

   Rationale: Although Resident T's initial response is "no," the comments indicate that they have experienced pain (burning sensation) during the look-back period.

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J0300: Pain Presence (cont.)



3. When asked about pain, Resident G responds, "I was on a train in 1905."

   Coding: J0300 would be **coded 9, unable to respond.**

   Rationale: Resident G has provided a nonsensical answer to the question. The assessor will complete the **Staff Assessment for Pain**.

J0410: Pain Frequency



J0410. Pain Frequency

Enter Code ☐

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

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

Steps for Assessment

1. Ask the resident: "How much of the time have you experienced pain or hurting over the last 5 days?" Staff may present response options on a written sheet or cue card. This can help the resident respond to the items.
2. If the resident provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the resident's own comment and providing related response options. This interview approach frequently helps the resident clarify which response option they prefer.
3. If the resident, despite clarifying statement and repeating response options, continues to have difficulty selecting between two of the provided responses, then select the more frequent of the two.

Coding Instructions

Code for pain frequency over the last 5 days.

- **Code 1, Rarely or not at all:** if the resident responds "rarely" to the question.
- **Code 2, Occasionally:** if the resident responds "occasionally" to the question.
- **Code 3, Frequently:** if the resident responds "frequently" to the question.
- **Code 4, Almost constantly:** if the resident responds "almost constantly" to the question.
- **Code 9, Unable to answer:** if the resident is unable to respond, does not respond, or gives a nonsensical response.

DRAFT

J0410: Pain Frequency (cont.)

Coding Tips

- No predetermined definitions are offered to the resident related to frequency of pain.
  - The response should be based on the resident's interpretation of the frequency options.
  - Facility policy should provide standardized tools to use throughout the facility in assessing pain to ensure consistency in interpretation and documentation of the resident's pain.

Examples

1. When asked about pain, Resident C responds, "All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago."

   Coding: J0410 would be **coded 4, Almost constantly**.
   Rationale: Resident C describes pain that has occurred "all the time."

2. When asked about pain, Resident 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?"

   Resident J is still unable to choose between frequently and occasionally.

   Coding: J0410 would be **coded 3, Frequently**.
   Rationale: The interviewer appropriately echoed Resident J's comment and provided related response options to help them clarify which response they preferred. Resident J. remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.

3. When asked about pain, Resident K responds: "I can't remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away."

   The interviewer clarifies by echoing what Resident K said: "You've had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?"

   Resident K replies "Occasionally."

   Coding: J0410 would be **coded 2, Occasionally**.
   Rationale: After the interviewer clarified the resident's choice using echoing, the resident selected a response option.

DRAFT

J0410: Pain Frequency (cont.)

4. When asked about pain, Resident M responds, "I would say rarely. Since I started using the patch, I don't have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day."

Coding: J0410 would be **coded 1, Rarely or not at all**.

Rationale: Resident M selected the "Rarely or not at all" response option.

J0510: Pain Effect on Sleep

J0510. Pain Effect on Sleep

Enter Code ☐

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

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

Steps for Assessment

1. Read the question and response choices exactly as they are written.
2. No predetermined definitions are offered to the resident. The resident's response should be based on their interpretation of frequency response options.
3. If the resident's response does not lead to a clear 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, "Over the past 5 days, how much of the time 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?" The assessor can then narrow down responses with additional follow-up questions about the frequency.

Coding Instructions

Code for pain effect on sleep over the last 5 days.

- **Code 1, Rarely or not at all:** if the resident responds that pain has rarely or not at all made it hard to sleep over the past 5 days.
- **Code 2, Occasionally:** if the resident responds that pain has occasionally made it hard to sleep over the past 5 days.
- **Code 3, Frequently:** if the resident responds that pain has frequently made it hard to sleep over the past 5 days.
- **Code 4, Almost constantly:** if the resident responds that pain has almost constantly made it hard to sleep over the past 5 days.
- **Code 8, Unable to answer:** if the resident is unable to answer the question, does not respond or gives a nonsensical response.

DRAFT

J0510: Pain Effect on Sleep (cont.)



Coding Tips

- This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.
- If the resident reports they had pain over the past 5 days and the pain does not interfere with their sleep (e.g., because the resident is using pain management strategies successfully)**, code 1, Rarely or not at all**.

Examples

1. When asked, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" the resident replied, "I've had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. The pain hasn't kept me from sleeping at all."

   Coding: J0510 would be **coded 1, Rarely or not at all**.
   Rationale: The resident reports pain has been present over the past 5 days but that they have had no sleep problems related to pain.

2. When asked, "Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?" the resident responded, "All the time. It's been hard for me to sleep all the time. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

   Coding: J0510 would be **coded 4, Almost constantly**.
   Rationale: The resident reports pain-related sleep problems "all the time" over the past 5 days, so the most applicable response is "Almost constantly."

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J0520: Pain Interference with Therapy Activities

J0520. Pain Interference with Therapy Activities

Enter Code ☐

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

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

Steps for Assessment

1. Read the question and response choices as written.

Coding Instructions

Code for pain interference with therapy activities over the last 5 days.

- **Code 0, Does not apply:** if the resident responds that they did not participate in rehabilitation therapy for reasons unrelated to pain (e.g., therapy not needed, unable to schedule) over the past 5 days.
- **Code 1, Rarely or not at all:** if the resident responds that pain has rarely or not at all limited their participation in rehabilitation therapy sessions over the past 5 days.
- **Code 2, Occasionally:** if the resident responds that pain has occasionally limited their participation in rehabilitation therapy sessions over the past 5 days.
- **Code 3, Frequently:** if the resident responds that pain has frequently limited their participation in rehabilitation therapy sessions over the past 5 days.
- **Code 4, Almost constantly:** if the resident responds that pain has almost constantly limited their participation in rehabilitation therapy sessions over the past 5 days.
- **Code 8, Unable to answer:** if the resident is unable to answer the question, does not respond, or gives a nonsensical response.

DEFINITION

REHABILITATION THERAPY
Special healthcare services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

Coding Tips

- This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.

DRAFT

J0520: Pain Interference with Therapy Activities (cont.)



- Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff or the resident carrying out a prescribed therapy program without staff members present.
- Rehabilitation therapies do not include restorative nursing programs.

Example

1. When asked, "Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?" the resident responded, "Since the surgery a week ago, the pain has made it hard to even get out of bed. I try to push myself, but the pain frequently limits how much I can do with my therapist."

   Coding: J0520 would be **coded 3, Frequently**.
   Rationale: The resident reports that pain frequently limited participation in therapies over the past 5 days.

J0530: Pain Interference with Day-to-Day Activities



J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

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

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

Steps for Assessment

1. Read the question and response choices as written.

Coding Instructions

Code for pain interference with day-to-day activities over the last 5 days.

- **Code 1, Rarely or not at all:** if the resident responds that pain has rarely or not at all limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.
- **Code 2, Occasionally:** if the resident responds that pain has occasionally limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.
- **Code 3, Frequently:** if the resident responds that pain has frequently limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.
- **Code 4, Almost constantly:** if the resident responds that pain has almost constantly limited their day-to-day activities (excluding rehabilitation therapy sessions) over the past 5 days.

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J0530: Pain Interference with Day-to-Day Activities (cont.)



- **Code 8, Unable to answer:** if the resident is unable to answer the question, does not respond, or gives a nonsensical response.

Coding Tips

- This item should be coded based on the resident's interpretation of the provided response options for frequency. If the resident is unable to decide between two options, then the assessor should code for the option with the higher frequency.

Examples

1. When asked, "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" the resident responded, "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."

   Coding: J0530 would be **coded 1, Rarely or not at all**.
   Rationale: The resident reports that pain has not limited their participation in day-to-day activities over the past 5 days.

2. When asked, "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?" the resident responded, "The pain has made it hard to do pretty much anything. Even getting out of bed to brush my teeth has been hard. I haven't been able to talk to my family because the pain is so bad. It's just constant. I'd say it constantly limits what I do."

   Coding: J0530 would be **coded 4, Almost constantly**.
   Rationale: The resident reports that pain has constantly limited their participation in other activities over the past 5 days.

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J0600: Pain Intensity



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**

Steps for Assessment

1. You may use either the **Numeric Rating Scale** item (J0600A) or the **Verbal Descriptor Scale** item (J0600B) to interview the resident about pain intensity.
   - For each resident, try to use the same scale used on prior assessments.
2. If the resident is unable to answer using one scale, the other scale should be attempted.
3. Record **either** the **Numeric Rating Scale** item **or** the **Verbal Descriptor Scale** item. Leave the response for the unused scale blank.
4. Read the question and item choices slowly. While reading, you may show the resident the response options (the **Numeric Rating Scale** or **Verbal Descriptor Scale**) clearly printed on a piece of paper, such as a cue card. Use large, clear print.
   - For the **Numeric Rating Scale**, say, "Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine."
   - For **Verbal Descriptor Scale**, say, "Please rate the intensity of your worst pain over the last 5 days."
5. The resident may provide a verbal response, point to the written response, or both.

Coding Instructions for J0600A. Numeric Rating Scale (00-10)

Enter the two digit number (00-10) indicated by the resident as corresponding to the intensity of their worst pain over the last 5 days, where zero is no pain, and 10 is the worst pain imaginable.

- Enter 99 if unable to answer.
- If the Numeric Rating Scale is not used, leave the response box blank.

Coding Instructions for J0600B. Verbal Descriptor Scale

- **Code 1, mild:** if resident indicates that their pain is "mild."
- **Code 2, moderate:** if resident indicates that their pain is "moderate."
- **Code 3, severe:** if resident indicates that their pain is "severe."
- **Code 4, very severe, horrible:** if resident indicates that their pain is "very severe or horrible."

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J0600: Pain Intensity (cont.)



- **Code 9, unable to answer:** if resident is unable to answer, chooses not to respond, does not respond or gives a nonsensical response.
- If the **Verbal Descriptor Scale** is not used, leave the response box blank.

Examples for J0600A. Numeric Rating Scale (00-10)

1. The nurse asks Resident T to rate their pain on a scale of 0 to 10. Resident T states that they are not sure, because they have shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds Resident T to think about all the pain they had over the last 5 days and select the number that describes their worst pain. They report that their pain is a "6."

   Coding: J0600A would be **coded 06**.
   Rationale: The resident said their pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.

2. The nurse asks Resident S to rate their pain, reviews use of the scale, and provides the 0 to 10 visual aid. Resident S says, "My pain doesn't have any numbers." The nurse explains that the numbers help the staff understand how severe their pain is and repeats that the "0" end is no pain and the "10" end is the worst pain imaginable. Resident S replies, "I don't know where it would fall."

   Coding: Item J0600A would be **coded 99, unable to answer.** The interviewer would go on to ask about pain intensity using the **Verbal Descriptor Scale** item (J0600B).
   Rationale: The resident was unable to select a number or point to a location on the 0-10 scale that represented their level of pain intensity.

Examples for J0600B. Verbal Descriptor Scale

1. The nurse asks Resident R to rate their pain using the verbal descriptor scale. They look at the response options presented using a cue card and say their pain is "severe" sometimes, but most of the time it is "mild."

   Coding: J0600B would be **coded 3, severe.**
   Rationale: The resident said their worst pain was "Severe."

2. The nurse asks Resident U to rate their pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. Resident U says, "I'm not sure whether it's mild or moderate." The nurse reminds Resident U to think about their worst pain over the last 5 days. Resident U says, "At its worst, it was moderate."

   Coding: Item J0600B would be **coded 2, moderate.**
   Rationale: The resident indicated that their worst pain was "Moderate."

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J0700: Should the Staff Assessment for Pain be Conducted?

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Item Rationale

Item J0700 closes the pain interview and determines if the resident interview was complete or incomplete and based on this determination, whether a staff assessment should be completed.

Health-related Quality of Life

- Resident interview for pain is preferred because it improves the detection of pain. However, a small percentage of residents are unable or unwilling to complete the pain interview.
- Persons unable to complete the pain interview may still have pain.

Planning for Care

- Resident self-report is the most reliable means of assessing pain. However, when a resident is unable to provide the information, staff assessment is necessary.
- Even though the resident was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors and observing the resident's affect during the interview.

DEFINITION

COMPLETED PAIN ASSESSMENT INTERVIEW

The Pain Assessment Interview is successfully completed if the resident reported no pain (J0300 = 0. No), or if the resident reported pain (J0300 = 1. Yes) and the follow-up question J0410 is answered.

Steps for Assessment

1. The **Staff Assessment for Pain** should only be completed if the **Pain Assessment Interview** (J0300–J0600) was not completed.

Coding Instructions for J0700. Should the Staff Assessment for Pain be Conducted?

- **Code 0, no:** if the resident completed the **Pain Assessment Interview** item (J0410 = 1, 2, 3, or 4). Skip to **Shortness of Breath (dyspnea)** item (J1100).
- **Code 1, yes:** if the resident was unable to complete the **Pain Assessment Interview** (J0410 = 9). Continue to **Indicators of Pain or Possible Pain** item (J0800).

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J0800: Indicators of Pain

Staff Assessment for Pain.

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓	Check all that apply
☐	A. **Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
☐	B. **Vocal complaints of pain** (e.g., that hurts, ouch, stop)
☐	C. **Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	D. **Protective body movements or postures** (e.g., 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)

Item Rationale

Health-related Quality of Life

- Residents who cannot verbally communicate about their pain are at particularly high risk for under-detection and undertreatment of pain.
- Severe cognitive impairment may affect the ability of residents to verbally communicate, thus limiting the availability of self-reported information about pain. In this population, fewer complaints may not mean less pain.
- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.
- Even in this population some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for residents who are unable to verbally communicate their pain.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking and potentially during eating).
- Staff must carefully monitor, track, and document any possible signs and symptoms of pain.
- Identification of these pain indicators can:
  - provide a basis for more comprehensive pain assessment,
  - provide a basis for determining appropriate treatment, and
  - provide a basis for ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.

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J0800: Indicators of Pain (cont.)

Steps for Assessment

1. **Review the medical record** for documentation of each indicator of pain listed in J0800 that occurred in the last 5 days. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with the direct care staff on all shifts who work most closely with the resident during activities of daily living (ADL).
2. **Interview staff** because the medical record may fail to note all observable pain behaviors. For any indicators that were not noted as present in medical record review, interview direct care staff on all shifts who work with the resident during ADL. Ask directly about the presence of each indicator that was not noted as being present in the record.
3. **Observe resident** during care activities. If you observe additional indicators of pain in the last 5 days code the corresponding items.
    - Observations for pain indicators may be more sensitive if the resident is observed during ADL, or wound care.

DEFINITIONS

NON VERBAL SOUNDS
e.g., crying, whining, gasping, moaning, groaning or other audible indications associated with pain.

VOCAL COMPLAINTS OF PAIN
e.g., "That hurts," "ouch," "stop," etc.

FACIAL EXPRESSIONS THAT MAY BE INDICATORS OF PAIN
e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.

PROTECTIVE BODY MOVEMENTS OR POSTURES
e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.

Coding Instructions

Check all that apply in the last 5 days based on staff observation of pain indicators.

- If the medical record review and the interview with direct care providers and observation on all shifts provide no evidence of pain indicators, Check J0800Z, None of these **signs observed or documented**, and proceed to the **Shortness of Breath** item (J1100).
- **Check J0800A, nonverbal sounds:** included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported in the last 5 days.
- **Check J0800B, vocal complaints of pain:** included but not limited to if the resident was observed to or reported to have made vocal complaints of pain (e.g. "that hurts," "ouch," or "stop") in the last 5 days.
- **Check J0800C, facial expressions:** included but not limited to if grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported in the last 5 days.
- **Check J0800D, protective body movements or postures:** included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported in the last 5 days.

Draft

J0800: Indicators of Pain (cont.)

- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported in the last 5 days.

Coding Tips

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors.

Examples

1. Resident P has advanced dementia and is unable to verbally communicate. A note in their medical record documents that they have been awake during the last night crying and rubbing their elbow. When you go to their room to interview the certified nurse aide (CNA) caring for them, you observe Resident P grimacing and clenching their teeth. The CNA reports that they have been moaning and said "ouch" when the CNA tried to move their arm.

   Coding: Nonverbal Sounds item (J0800A); Vocal Complaints of Pain item (J0800B); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be **checked**.

   Rationale: Resident P has demonstrated vocal complaints of pain (ouch), nonverbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing their elbow).

2. Resident M has end-stage Parkinson's disease and is unable to verbally communicate. There is no documentation of pain in their medical record in the last 5 days. The CNAs caring for them report that on some mornings they moan and wince when their arms and legs are moved during morning care. During direct observation, you note that Resident M cries and attempts to pull their hand away when the CNA tries to open the contracted hand to wash it.

   Coding: Nonverbal Sounds items (J0800A); **Facial Expressions** item (J0800C); and **Protective Body Movements or Postures** item (J0800D), would be **checked**.

   Rationale: Resident M has demonstrated nonverbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).

3. Resident E has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer. There is no documentation of pain in their medical record. The CNA who cares for them reports that they do not seem to have any pain. You observe the resident during their pressure ulcer dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.

   Coding: Nonverbal Sounds item (J0800A), and **Facial Expressions** item (J0800C), would be **checked**.

   Rationale: The resident has demonstrated nonverbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).

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J0800: Indicators of Pain (cont.)

Examples (cont.)

4. Resident S is in a persistent vegetative state following a traumatic brain injury. They are unable to verbally communicate. There is no documentation of pain in their medical record in the last 5 days. The CNA reports that they appear comfortable whenever the CNA cares for them. You observe the CNA providing morning care and transferring them from bed to chair. No pain indicators are observed at any time.

   Coding: None of These Signs Observed or Documented item (J0800Z), would be **checked**.
   Rationale: All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.

J0850: Frequency of Indicator of Pain or Possible Pain

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**

Item Rationale

Health-related Quality of Life

- Unrelieved pain adversely affects function and mobility contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired residents.

Planning for Care

- Assessment of pain frequency provides:
  - A basis for evaluating treatment need and response to treatment.
  - Information to aide in identifying optimum timing of treatment.

Steps for Assessment

1. Review medical record and interview staff and direct caregivers to determine the number of days the resident either complained of pain or showed evidence of pain as described in J0800 in the last 5 days.

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J0850: Frequency of Indicator of Pain or Possible Pain (cont.)

Coding Instructions

Code for pain frequency in the last 5 days.

- **Code 1:** if based on staff observation, the resident complained or showed evidence of pain 1 to 2 days.
- **Code 2:** if based on staff observation, the resident complained or showed evidence of pain 3 to 4 days.
- **Code 3:** if based on staff observation, the resident complained or showed evidence of pain on a daily basis.

Examples

1. Resident M is an 80-year-old individual with advanced dementia. During the last 5 days, Resident M was noted to be grimacing and verbalizing "ouch" over the past 2 days when their right shoulder was moved.

   Coding: Item J0850 would be **coded 1, indicators of pain observed 1 to 2 days.**
   Rationale: They have demonstrated vocal complaints of pain ("ouch"), facial expression of pain (grimacing) on 2 of the last 5 days.

2. Resident C is a 78-year-old individual with a history of CVA with expressive aphasia and dementia. In the last 5 days, the resident was noted on a daily basis to be rubbing their right knee and grimacing.

   Coding: Item J0850 would be **coded 3, indicators of pain observed daily.**
   Rationale: The resident was observed with a facial expression of pain (grimacing) and protective body movements (rubbing their knee) every day in the last 5 days.

J1100: Shortness of Breath (dyspnea)

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**

Item Rationale

Health-related Quality of Life

- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.
- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.

Draft

J1100: Shortness of Breath (dyspnea) (cont.)

Planning for Care

- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Steps for Assessment

Interview the resident about shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.

1. If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when they engage in certain activities.
2. Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing. Interview staff on all shifts, and family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
3. Observe the resident for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.
4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

Coding Instructions

Check all that apply during the 7-day look-back period.

Any evidence of the presence of a symptom of shortness of breath should be captured in this item. A resident may have any combination of these symptoms.

- **Check J1100A:** if shortness of breath or trouble breathing is present when the resident is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- **Check J1100B:** if shortness of breath or trouble breathing is present when the resident is sitting at rest.
- **Check J1100C:** if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath.
- **Check J1100Z:** if the resident reports no shortness of breath or trouble breathing and the medical record and staff interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

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J1100: Shortness of Breath (dyspnea) (cont.)

Examples

1. Resident W has diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure. They are on 2 liters of oxygen and daily respiratory treatments. With oxygen they are able to ambulate and participate in most group activities. They report feeling "winded" when going on outings that require walking one or more blocks and have been observed having to stop to rest several times under such circumstances. Recently, they describe feeling "out of breath" when they try to lie down.

   Coding: J1100A and J1100C would be **checked.**

   Rationale: Resident W reported being short of breath when lying down as well as during outings that required ambulating longer distances.

2. Resident T has used an inhaler for years. They are not typically noted to be short of breath. Three days ago, during a respiratory illness, they had mild trouble with their breathing, even when sitting in bed. Their shortness of breath also caused them to limit group activities.

   Coding: J1100A and J1100B would be **checked.**

   Rationale: Resident T was short of breath at rest and was noted to avoid activities because of shortness of breath.

J1300: Current Tobacco Use

J1300. Current Tobacco Use

Enter Code ☐

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

Item Rationale

Health-related Quality of Life

- The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life.

Planning for Care

- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.
- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.

Steps for Assessment

1. Ask the resident if they used tobacco in any form during the 7-day look-back period.
2. If the resident states that they used tobacco in some form during the 7-day look-back period, **code 1, yes**.

DEFINITION

TOBACCO USE
Includes tobacco used in any form.

Draft

J1300: Current Tobacco Use (cont.)

3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.

Coding Instructions

- **Code 0, no:** if there are no indications that the resident used any form of tobacco.
- **Code 1, yes:** if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

J1400: Prognosis

J1400. Prognosis

Enter Code ☐ 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**

Item Rationale

Health-related Quality of Life

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services in the nursing home.

Planning for Care

- If life expectancy is less than 6 months, interdisciplinary team care planning should be based on the resident's preferences for goals and interventions of care whenever possible.

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 they 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.

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.

Draft

J1400: Prognosis (cont.)

Coding Instructions

- **Code 0, no:** if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
- **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.

Examples

1. Resident T has a diagnosis of heart failure. During the past few months, they have had three hospital admissions for acute heart failure. Their heart has become significantly weaker despite maximum treatment with medications and oxygen. Their physician has discussed their deteriorating condition with them and their family and has documented that their prognosis for survival beyond the next couple of months is poor.

   Coding: J1400 would be **coded 1, yes**.
   Rationale: The physician documented that their life expectancy is likely to be less than 6 months.

2. Resident J was diagnosed with non-small cell lung cancer that is metastatic to their bone. They are not a candidate for surgical or curative treatment. With their consent, Resident J has been referred to hospice by their physician, who documented that their life expectancy was less than 6 months.

   Coding: J1400 would be **coded 1, yes**.
   Rationale: The physician referred the resident to hospice and documented that their life expectancy is likely to be less than 6 months.

DEFINITIONS

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.

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

J1550: Problem Conditions

J1550. Problem Conditions	
↓	Check all that apply
☐	A. Fever
☐	B. Vomiting
☐	C. Dehydrated
☐	D. Internal bleeding
☐	Z. None of the above

Draft

J1550: Problem Conditions (cont.)

Intent: This item provides an opportunity for screening in the areas of fever, vomiting, fluid deficits, and internal bleeding. Clinical screenings provide indications for further evaluation, diagnosis and clinical care planning.

Item Rationale

Health-related Quality of Life

- Timely assessment is needed to identify underlying causes and risk for complications.

Planning for Care

- Implementation of care plans to treat underlying causes and avoid complications is critical.

Steps for Assessment

1. Review the medical record, interview staff on all shifts and observe the resident for any indication that the resident had vomiting, fever, potential signs of dehydration, or internal bleeding during the 7-day look-back period.

Coding Instructions

Check all that apply (blue box)

- **J1550A**, fever
- **J1550B**, vomiting
- **J1550C**, dehydrated
- **J1550D**, internal bleeding
- **J1550Z**, none of the above

Coding Tips

- **Fever:** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date.
- **Fever assessment prior to establishing base line temperature:** A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.
- **Vomiting:** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).

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J1550: Problem Conditions (cont.)

- **Dehydrated:** Check this item if the resident presents with two or more of the following potential indicators for dehydration:
  1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
  2. Resident has one or more potential clinical signs (indicators) of dehydration, **including but not limited to** dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
  3. Resident's fluid loss exceeds the amount of fluids they take in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
- **Internal Bleeding:** Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, 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.

J1700: Fall History on Admission/Entry or Reentry

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

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** prior to admission/entry or reentry?
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 or reentry?
0. **No**
1. **Yes**
9. **Unable to determine**

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

Draft

J1700: Fall History on Admission/Entry or Reentry (cont.)

Planning for Care

- Determine the potential need for further assessment and intervention, including evaluation of the resident's need for rehabilitation or assistive devices.
- Evaluate the physical environment as well as staffing needs for residents who are at risk for falls.

Steps for Assessment

The period of review is 180 days (6 months) prior to admission, looking back from the resident's entry date (A1600).

1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred.
2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls.
3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred.

DEFINITION

FALL

Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person – this is still considered a fall.

CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

J1700: Fall History on Admission/Entry or Reentry (cont.)

Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the resident's entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

DEFINITION

FRACTURE RELATED TO A FALL

Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

Examples

1. On admission interview, Resident J is asked about falls and says they have "not really fallen." However, they go on to say that when they went shopping with their child about 2 weeks ago, their walker got tangled with the shopping cart and they slipped down to the floor.

   Coding: J1700A would be **coded 1, yes**.

   Rationale: Falls caused by slipping meet the definition of falls.

J1700: Fall History on Admission/Entry or Reentry (cont.)

2. On admission interview a resident denies a history of falling. However, their child says that they found their parent on the floor near their toilet twice about 3–4 months ago.

   Coding: J1700B would be **coded 1, yes**.

   Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On admission interview, Resident M and their family deny any history of falling. However, nursing notes in the transferring hospital record document that Resident M repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at their bedside to prevent injury the week prior to nursing home transfer.

   Coding: J1700A would be **coded 1, yes**.

   Rationale: Medical records from an outside facility document that Resident M was found on a mat on the floor. This is defined as a fall.

4. Medical records note that Resident K had hip surgery 5 months prior to admission to the nursing home. Resident K's child says the surgery was needed to fix a broken hip due to a fall.

   Coding: Both J1700B and J1700C would be **coded 1, yes**.

   Rationale: Resident K had a fall related fracture 1–6 months prior to nursing home entry.

5. Resident O's hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Resident O denies any history of falling.

   Coding: J1700C would be **coded 0, no**.

   Rationale: The fractures were not related to a fall.

6. Resident P has a history of a "Colles' fracture" of their left wrist about 3 weeks before nursing home admission. Their child recalls that the fracture occurred when Resident P tripped on a rug and fell forward on their outstretched hands.

   Coding: Both J1700A and J1700C would be **coded 1, yes.**

   Rationale: Resident P had a fall-related fracture less than 1 month prior to entry.

Draft

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

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 J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Fear of falling can limit an individual's activity and negatively impact quality of life.

DEFINITION

PRIOR ASSESSMENT
Most recent MDS assessment that reported on falls.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment

1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the 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 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.
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.

Draft

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

Coding Instructions

- **Code 0, no:** if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to **Prior Surgery** item (J2000).
- **Code 1, yes:** if the resident has fallen since the last assessment. Continue to **Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)** item (J1900), whichever is more recent.

Example

1. An incident report describes an event in which Resident S was walking down the hall and appeared to slip on a wet spot on the floor. They lost their balance and bumped into the wall, but were able to grab onto the hand rail and steady themself.

   Coding: J1800 would be **coded 1, yes**.
   Rationale: An intercepted fall is considered a fall.

Draft

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

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

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.
- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.

DEFINITION

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.

DEFINITIONS

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.

Draft

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

Steps for Assessment

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last 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. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.
4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.
5. Ask the resident, staff, 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 Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. **If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.**

Coding Instructions for J1900A, No Injury

- **Code 0, none:** if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none:** if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one injurious fall (except major) 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 (cont.)

- **Code 2, two or more:** if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

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 the Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.

Examples

1. A nursing note states that Resident K slipped out of their wheelchair onto the floor while at the dining room table. Before being assisted back into their chair, a range of motion assessment was completed that indicated no injury. A skin assessment conducted shortly after the fall also revealed no injury.

   Coding: J1900A would be **coded 1, one**.
   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Nurse's notes describe a situation in which Resident Z went out with their family for dinner. When they returned, their child stated that while at the restaurant, Resident Z fell in the bathroom. No injury was noted when they returned from dinner.

   Coding: J1900A would be **coded 1, one**.
   Rationale: Falls during the nursing home stay, even if on outings, are captured here.

3. A nurse's note describes a resident who, while being treated for pneumonia, climbed over their bedrails and fell to the floor. They had a cut over their left eye and some swelling on their arm. They were sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   Coding: J1900B would be **coded 1, one**.
   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

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

4. A resident fell, lacerated their head, and head CT scan indicated a subdural hematoma.

   Coding: J1900C would be **coded 1, one**.

   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

5. Resident R fell on their right hip in the facility on the ARD of their Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Resident R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to iQIES. Three days later, Resident R complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.

   Original Coding: J1900B, Injury (except major) is **coded 1, one** and J1900C, Major Injury is **coded 0, none**.

   Rationale: Resident R had a fall-related injury that caused them to complain of pain.

   Modification of Quarterly assessment: J1900B, Injury (except major) is **coded 0, none** and J1900C, Major Injury, is **coded 1, one**.

   Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to iQIES and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

J2000: Prior Surgery

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐

Did the resident have major surgery during the **100 days prior to admission?**

0. **No**
1. **Yes**
8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the 100 days prior to admission can affect a resident's recovery.

J2000: Prior Surgery (cont.)

Planning for Care

- This item identifies whether the resident has had major surgery during the 100 days prior to the start of the Medicare Part A stay. A recent history of major surgery can affect a resident's recovery.

Steps for Assessment

1. Ask the resident and their family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days prior to admission.

   Medical record sources include medical records received from facilities where the resident received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

DEFINITION

MAJOR SURGERY
Refers to a procedure that meets the following criteria:

1. The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the skilled nursing facility (SNF), **and**
2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the 100 days prior to admission.
- **Code 1, Yes:** if the resident had major surgery during the 100 days prior to admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission.

Examples

1. Resident T reports that they required surgical removal of a skin tag from their neck a month and a half ago. They had the procedure as an outpatient. Resident T report no other surgeries in the last 100 days.

   Coding: J2000 would be coded **0, No.**

   Rationale: Resident T's skin tag removal surgery did not require an acute care inpatient stay; therefore, the skin tag removal does not meet the required criteria to be coded as major surgery. Resident T did not have any other surgeries in the last 100 days.

Draft

J2000: Prior Surgery (cont.)

2. Resident A's spouse informs their nurse that six months ago Resident A was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Resident A's spouse reports Resident A has had no other surgeries since the time of their bowel resection.

   Coding: J2000 would be coded **0, No.**

   Rationale: Bowel resection is a major surgery that has some degree of risk for death or severe disability, and Resident A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Resident A has not undergone any surgery since that time.

3. Resident G was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in their medical record. They were transferred to the facility immediately following a four-day acute care hospital stay.

   Coding: J2000 would be coded **1, Yes.**

   Rationale: In the last 100 days, Resident G underwent a complicated cholecystectomy, which required a four-day hospitalization. They additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability.

J2100: Recent Surgery Requiring Active SNF Care

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code ☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. **No**
1. **Yes**
8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.

Planning for Care

- This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Draft

J2100: Recent Surgery Requiring Active SNF Care (cont.)

Steps for Assessment

1. Ask the resident and their family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident's Part A admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

   Medical record sources include medical records received from facilities where the resident received health care during the inpatient hospital stay that immediately preceded the resident's Part A admission, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 1, Yes:** if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

Coding Tips

- Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
  1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), **and**
  2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care

Surgical Procedures - Complete only if J2100 = 1

↓ **Check all that apply**

Major Joint Replacement

- ☐ **J2300. Knee Replacement** - partial or total
- ☐ **J2310. Hip Replacement** - partial or total
- ☐ **J2320. Ankle Replacement** - partial or total
- ☐ **J2330. Shoulder Replacement** - partial or total

Spinal Surgery

- ☐ **J2400. Involving the spinal cord or major spinal nerves**
- ☐ **J2410. Involving fusion of spinal bones**
- ☐ **J2420. Involving lamina, discs, or facets**
- ☐ **J2499. Other major spinal surgery**

Other Orthopedic Surgery

- ☐ **J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
- ☐ **J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
- ☐ **J2520. Repair but not replace joints**
- ☐ **J2530. Repair other bones** (such as hand, foot, jaw)
- ☐ **J2599. Other major orthopedic surgery**

Neurological Surgery

- ☐ **J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
- ☐ **J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
- ☐ **J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
- ☐ **J2699. Other major neurological surgery**

Cardiopulmonary Surgery

- ☐ **J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
- ☐ **J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
- ☐ **J2799. Other major cardiopulmonary surgery**

Genitourinary Surgery

- ☐ **J2800. Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
- ☐ **J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
- ☐ **J2899. Other major genitourinary surgery**

Other Major Surgery

- ☐ **J2900. Involving tendons, ligaments, or muscles**
- ☐ **J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
- ☐ **J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
- ☐ **J2930. Involving the breast**
- ☐ **J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
- ☐ **J5000. Other major surgery not listed above**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.

Planning for Care

- This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Steps for Assessment

1. **Identify recent surgeries:** The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.
   - Medical record sources for recent surgeries include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.
   - Although open communication regarding resident information between the physician and other members of the interdisciplinary team is important, it is also essential that resident information communicated verbally be documented in the medical record by the physician to ensure follow-up.
   - Surgery 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.
2. **Determine whether the surgeries require active care during the SNF stay:** Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay**.** Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B.
   - 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 surgeries that do not require active care during the SNF stay.
   - Check the following information sources in the medical record for the last 30 days to identify "active" surgeries: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

Code surgeries that are documented to have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission, that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.

- Check off each surgery requiring active SNF care as defined above, as follows:
  - — Surgeries are listed by major surgical category: Major Joint Replacement, Spinal Surgery, Orthopedic Surgery, Neurologic Surgery, Cardiopulmonary Surgery, Genitourinary Surgery, Other Major Surgery.

DRAFT

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

  - — Examples of surgeries are included for each surgical category. For example, **J2810, Genitourinary surgery - the kidneys, ureter, adrenals, and bladder—open, laparoscopic,** includes open or laparoscopic surgeries on the kidneys, ureter, adrenals, and bladder, but not other components of the genitourinary system.

- Check all that apply.

Major Joint Replacement

- **J2300,** Knee Replacement - partial or total
- **J2310,** Hip Replacement - partial or total
- **J2320,** Ankle Replacement - partial or total
- **J2330,** Shoulder Replacement - partial or total

Spinal Surgery

- **J2400,** Spinal surgery - spinal cord or major spinal nerves
- **J2410,** Spinal surgery - fusion of spinal bones
- **J2420,** Spinal surgery - lamina, discs, or facets
- **J2499,** Spinal surgery - other

Orthopedic Surgery

- **J2500,** Ortho surgery - repair fractures of shoulder or arm
- **J2510,** Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle
- **J2520,** Ortho surgery - repair but not replace joints
- **J2530,** Ortho surgery - repair other bones
- **J2599,** Ortho surgery - other

Neurologic Surgery

- **J2600,** Neuro surgery - brain, surrounding tissue or blood vessels
- **J2610,** Neuro surgery - peripheral and autonomic nervous system - open and percutaneous
- **J2620,** Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices
- **J2699,** Neuro surgery - other

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Cardiopulmonary Surgery

- **J2700,** Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures
- **J2710,** Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic
- **J2799,** Cardiopulmonary surgery - other

Genitourinary Surgery

- **J2800,** Genitourinary surgery - male or female organs
- **J2810,** Genitourinary surgery - the kidneys, ureter, adrenals, and bladder - open, laparoscopic
- **J2899,** Genitourinary surgery - other

Other Major Surgery

- **J2900,** Major surgery - tendons, ligament, or muscles
- **J2910,** Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen - open or laparoscopic
- **J2920,** Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open
- **J2930,** Major surgery - the breast
- **J2940,** Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant
- **J5000,** Major surgery - not listed above

Coding Tips

The following information may assist assessors in determining whether a surgery should be coded as requiring active care during the SNF stay.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.**
  - The physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) may specifically indicate that the SNF stay is for treatment related to the surgical intervention. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.

Draft

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

- **In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:**

  The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:

  — The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).

  — Daily skilled therapy to restore functional loss after surgical procedures.

  — Administration of medication and monitoring that requires skilled nursing.

Examples of surgeries requiring active SNF care and related to the primary SNF diagnosis

1. Resident V was hospitalized for gram-negative pneumonia. Since this was their second episode of pneumonia in the past six months, a diagnostic bronchoscopy was performed while in the hospital. They also have Parkinson's disease and rheumatoid arthritis. They were discharged to a SNF for continued antibiotic treatment for their pneumonia and require daily skilled care.

   Coding: I0020 is coded as 13, Medically Complex Conditions, and the **I0020B** SNF ICD-10 code is J15.6, Pneumonia due to other aerobic Gram-negative bacteria. There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: Resident V did not receive any major surgery during the prior inpatient stay, and they were admitted to the SNF for continued care due to pneumonia.

2. Resident O, a diabetic, was hospitalized for sepsis from an infection due to Methicillin susceptible Staphylococcus aureus that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. They were discharged to a SNF for continued antibiotic treatment and monitoring.

   Coding: I0020 is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is A41.01 (Sepsis due to Methicillin susceptible Staphylococcus aureus). There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: Neither the placement of a central line nor the outpatient bunion surgery is considered to be a major surgery, but the resident was admitted to the SNF for continued antibiotic treatment and monitoring.

DRAFT

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

3. Resident H was hospitalized for severe back pain from a compression fracture of a lumbar vertebral body, which was caused by their age-related osteoporosis. They were treated with a kyphoplasty that relieved their pain. They were transferred to a SNF after discharge because of their mild dementia and need to regulate their anticoagulant treatment for atrial fibrillation.

   Coding: I0020 is coded 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is M80.08XD (Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter for fracture with routine healing). There was no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.

   Rationale: Resident H was treated with a kyphoplasty during the inpatient stay prior to SNF admission. Although kyphoplasty is a minor surgery and does not require SNF care in and of itself, the resident has other conditions requiring skilled care that are unrelated to the kyphoplasty surgery.

4. Resident J had a craniotomy to drain a subdural hematoma after suffering a fall at home. They have COPD and use oxygen at night. In addition, they have moderate congestive heart failure, are moderately overweight, and have hypothyroidism. After a six-day hospital stay, they were discharged to a SNF for continuing care. The hospital discharge summary indicated that the patient had a loss of consciousness of 45 minutes.

   Coding: I0020 is coded 07, Other Neurological Conditions. The **I0020B** SNF ICD-10 code is S06.5X2D (Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter). **J2100** would be coded 1, Yes. **J2600**, Neuro surgery - brain, surrounding tissue or blood vessels, would be checked.

   Rationale: The craniotomy surgery during the inpatient stay immediately preceding the SNF stay requires continued skilled care and skilled monitoring for wound care, as well as therapies to address any deficits that led to their fall or any functional deficits resulting from their fall.

5. Resident D was admitted to an acute care hospital for cytoreductive surgery for metastatic renal cell carcinoma. They were admitted to the SNF for further treatment of the metastatic renal cell carcinoma and post-surgical care.

   Coding: I0020 is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is C79.01 (Secondary malignant neoplasm of the right kidney and renal pelvis). **J2100** would be coded 1, Yes. **J2810**, Genitourinary surgery – the kidneys, ureter, adrenals, and bladder – open, laparoscopic, would be checked.

   Rationale: Resident D was treated with a surgical procedure, genitourinary surgery of the kidney, and admitted to the SNF for further treatment of the metastatic kidney cancer and post-surgical care.

DRAFT

J2300–J5000: Recent Surgeries Requiring Active SNF Care (cont.)

6. Resident G was admitted to an acute care hospital for severe abdominal pain. They were found to have diverticulitis of the small intestine with perforation and abscess without bleeding. They had surgery to repair the perforation. They were admitted to the SNF for continued antibiotics and post-surgical care.

   Coding: I0020 is coded 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is K57.00 (Diverticulitis of small intestine with perforation and abscess without bleeding), and **J2100** would be coded 1, Yes. **J2910**, Major surgery – the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen – open or laparoscopic, would be checked.

   Rationale: Resident G was treated with a surgical procedure, repair of the small intestine perforation, which is a major surgical procedure. They were admitted to the SNF for continued antibiotics and post-surgical care.

7. Resident W underwent surgical repair for a left fractured hip (i.e., subtrochanteric fracture) during an inpatient hospitalization. They were admitted to the SNF for post-surgical care.

   Coding: I0020 is coded as Code 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is S72.22XD (Displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing) and **J2100** is coded as 1, Yes. **J2510**, Ortho surgery – repair fractures of pelvis, hip, leg, knee, or ankle, would be checked.

   Rationale: This is major surgery requiring skilled nursing care to provide wound care and to monitor for early signs of infection or blood clots, for which Resident W was admitted to the SNF.

Draft

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the resident's risk for malnutrition, dehydration, and aspiration pneumonia.

Planning for Care

- Care planning should include provisions for monitoring the resident during mealtimes and during functions/activities that include the consumption of food and liquids.
- When necessary, the resident should be evaluated by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.
- Care plan should be developed to assist resident to maintain safe and effective swallow using compensatory techniques, alteration in diet consistency, and positioning during and following meals.

Steps for Assessment

1. Ask the resident if they have had any difficulty swallowing during the 7-day look-back period. Ask about each of the symptoms in K0100A through K0100D.

   Observe the resident during meals or at other times when they are eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.

Draft

K0100: Swallowing/Nutritional Status (cont.)

2. Interview staff members on all shifts who work with the resident and ask if any of the four listed symptoms were evident during the 7-day look-back period.
3. Review the medical record, including nursing, physician, dietician, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

Coding Instructions

Check all that apply.

- **K0100A, loss of liquids/solids from mouth when eating or drinking.** When the resident has food or liquid in their mouth, the food or liquid dribbles down chin or falls out of the mouth.
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.
- **K0100C, coughing or choking during meals or when swallowing medications.** The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."
- **K0100D, complaints of difficulty or pain with swallowing.** Resident may refuse food because it is painful or difficult to swallow.
- **K0100Z, none of the above:** if none of the K0100A through K0100D signs or symptoms were present during the look-back period.

Coding Tips

- Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.

K0200: Height and Weight

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

Inches ☐☐

A. **Height** (in inches). Record most recent height measure since the most recent admission/entry or reentry

Pounds ☐☐☐

B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0200: Height and Weight (cont.)

Item Rationale

Health-related Quality of Life

- Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as quality of life.

Planning for Care

- Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status.

Steps for Assessment for K0200A, Height

1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again.

Coding Instructions for K0200A, Height

- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0200B, Weight

1. Base weight on the most recent measure in the last 30 days.
2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment.
4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again.
5. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding Instructions for K0200B, Weight

- Use mathematical rounding (i.e., If weight is X.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound). For example, a weight of 152.5 lbs would be rounded to 153 lbs and a weight of 152.4 lbs would be rounded to 152 lbs.

DRAFT

K0200: Height and Weight (cont.)

- If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

K0300: Weight Loss

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

Item Rationale

Health-related Quality of Life

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

Planning for Care

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with their weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT LOSS IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.

10% WEIGHT LOSS IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.

Draft

K0300: Weight Loss (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is less than the previous weight, calculate the percentage of weight loss.
4. Complete the same process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 30 days ago.
2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss.
3. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 180 days ago.
4. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss.

DEFINITIONS

PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN
A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.

BODY MASS INDEX (BMI)
Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- **Code 0, no or unknown:** if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight-loss regimen:** if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as **1**.

Draft

K0300: Weight Loss (cont.)

- **Code 2, yes, not on physician-prescribed weight-loss regimen:** if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.
- If the resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0300 as **1, yes**, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.
- On occasion, a resident with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is not to induce weight loss, and it would not be considered a physician-ordered weight-loss regimen.

Examples

1. Resident J has been on a physician ordered calorie-restricted diet for the past year. They and their physician agreed to a plan of weight reduction. Their current weight is 169 lbs. Their weight 30 days ago was 172 lbs. Their weight 180 days ago was 192 lbs.

   Coding: K0300 would be **coded 1, yes, on physician-prescribed weight-loss regimen**.

   Rationale:

   - 30-day calculation: 172 x 0.95 = 163.4. Since the resident's current weight of 169 lbs is more than 163.4 lbs, which is the 5% point, they **have not** lost 5% body weight in the last 30 days.
   - 180-day calculation: 192 x .90 = 172.8. Since the resident's current weight of 169 lbs **is** less than 172.8 lbs, which is the 10% point, they **have** lost 10% or more of body weight in the last 180 days.

Draft

K0300: Weight Loss (cont.)

2. Resident S has had increasing need for assistance with eating over the past 6 months. Their current weight is 195 lbs. Their weight 30 days ago was 197 lbs. Their weight 180 days ago was 185 lbs.

   Coding: K0300 would be **coded 0, No.**

   Rationale:

   - 30-day calculation: 197 x 0.95 = 187.15. Because the resident's current weight of 195 lbs is more than 187.15 lbs, which is the 5% point, they **have not** lost 5% body weight in the last 30 days.
   - 180-day calculation: Resident S's current weight of 195 lbs is greater than their weight 180 days ago, so there is no need to calculate their weight loss. They have gained weight over this time period.

3. Resident K underwent a BKA (below the knee amputation). Their preoperative weight 30 days ago was 130 lbs. Their most recent postoperative weight is 102 lbs. The amputated leg weighed 8 lbs. Their weight 180 days ago was 125 lbs.

   Was the change in weight significant? Calculation of change in weight must take into account the weight of the amputated limb (which in this case is 6% of 130 lbs = 7.8 lbs).

   - 30-day calculation:
     Step 1: Add the weight of the amputated limb to the current weight to obtain the weight if no amputation occurred:
     102 lbs (current weight) + 8 lbs (weight of leg) = 110 lbs (current body weight taking the amputated leg into account)
     Step 2: Calculate the difference between the most recent weight (including weight of the limb) and the previous weight (at 30 days)
     130 lbs (preoperative weight) - 110 lbs (present weight if had two legs) = 20 lbs (weight lost)
     Step 3: Calculate the percent weight change relative to the initial weight:
     20 lbs (weight change) /130 lbs (preoperative weight) = 15% weight loss
     Step 4: The percent weight change is significant if >5% at 30 days
     Therefore, the most recent postoperative weight of 102 lbs (110 lbs, taking the amputated limb into account) is >5% weight loss (significant at 30 days).

   - 180-day calculation:
     Step 1: Add the weight of the amputated limb to the current weight to obtain the weight if no amputation occurred:
     102 lbs (current weight) + 8 lbs (weight of leg) = 110 lbs (current body weight taking the amputated leg into account)
     Step 2: Calculate the difference between the most recent weight (including weight of the limb) and the previous weight (at 180 days):
     125 lbs (preoperative weight 180 days ago) - 110 lbs (present weight if had two legs) = 15 lbs (weight lost)
     Step 3: Calculate the percent weight change relative to the initial weight:
     15 lbs (weight change) / 130 lbs (preoperative weight) = 12% weight loss
     Step 4: The percent weight change is significant if >10% at 180 days

K0300: Weight Loss (cont.)

The most recent postoperative weight of 110 lbs (110 lbs, taking the amputated limb into account) is >10% weight loss (significant at 180 days).

Present weight of 110 lbs >10% weight loss (significant at 180 days).

Coding: K0300 would be **coded 2, yes, weight change is significant; not on physician-prescribed weight-loss regimen.**

Rationale: The resident had a significant weight loss of >5% in 30 days and did have a weight loss of >10% in 180 days, the item would be coded as 2, yes weight change is significant; not on physician-prescribed weight–loss regime, with one of the items being triggered. This item is coded for either a 5% 30-day weight loss or a 10% 180-day weight loss. In this example both items, the criteria are met but the coding does not change as long as one of them are met.

K0310: Weight Gain

K0310. Weight Gain

Enter Code ☐

Gain of 5% or more in the last month or gain of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-gain regimen
2. **Yes, not on** physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the resident's health status or environment.
- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroidals), or changed fluid volume status.
- Weight should be monitored on a continuing basis; weight gain should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with their weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

10% WEIGHT GAIN IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

Draft

K0310: Weight Gain (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight gain assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.
4. Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 30 days ago.
2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain.
3. From the medical record, compare the resident's weight in the current observation period to their weight in the observation period 180 days ago.
4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- **Code 0, no or unknown:** if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- **Code 1, yes on physician-prescribed weight-gain regimen:** if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as **1**.
- **Code 2, yes, not on physician-prescribed weight-gain regimen:** if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

Draft

K0310: Weight Gain (cont.)

- If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0520: Nutritional Approaches

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

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

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

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

DEFINITIONS

PARENTERAL/IV FEEDING
Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

FEEDING TUBE
Presence of any type of tube that can deliver food/ nutritional substances/ fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.

Draft

K0520: Nutritional Approaches (cont.)

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period.
- If none apply, check K0520Z. None of the above.

Coding Instructions

Check all that apply. If none apply, check K0520Z, None of the above

- **K0520A,** parenteral/IV feeding.
- **K0520B,** feeding tube – nasogastric or abdominal (PEG).
- **K0520C,** mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids).
- **K0520D,** therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **K0520Z,** none of the above.

Coding Instructions for Column 1

- Check all nutritional approaches performed during the first 3 days of the SNF PPS Stay.

Coding Instructions for Column 2

- Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 2 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.
- When completing the Interim Payment Assessment (IPA), the completion of items K0520A, K0520B, and K0520Z is required.

Coding Instructions for Column 3

- Check all nutritional approaches performed **after** admission/entry or reentry to the facility and within the 7-day look-back period.

DEFINITIONS

MECHANICALLY ALTERED DIET
A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET
A therapeutic diet is a diet intervention prescribed by a physician or other authorized nonphysician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition, to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet (Academy of Nutrition and Dietetics, 2020).

Draft

K0520: Nutritional Approaches (cont.)

Coding Instructions for Column 4

- Check all nutritional approaches performed within the last 3 days of the SNF PPS Stay.

Coding Tips for K0520A

K0520A includes any and all nutrition and hydration received by the nursing home resident during the observation period either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

- Parenteral/IV feeding—The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and Federal Regulations and/or internal facility policy:**
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy
  - IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and*/or* hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.
- **The following items are NOT to be coded in K0520A:**
  - IV Medications—**Code these when appropriate in O0110H, IV Medications.**
  - IV fluids used to reconstitute and/or dilute medications for IV administration.
  - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
  - IV fluids administered solely as flushes.
  - Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Enteral feeding formulas:
  - Should not be coded as a mechanically altered diet.
  - Should only be coded as **K0520D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to residents with diabetes.

Coding Tip for K0520B

- Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B.

K0520: Nutritional Approaches (cont.)

Coding Tips for K0520C

- Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0520C, mechanically altered diet.

Coding Tips for K0520D

- Therapeutic diets are not defined by the content of what is provided or when it is served, but ***why*** the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***part*** of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0520D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.

Examples

1. Resident H was diagnosed in the acute hospital with a soft tissue infection. A treatment regime was initiated in the acute hospital, including IV antibiotics received every 8 hours within the last 7 days. Because the resident was assessed in the acute hospital with inadequate oral fluid intake demonstrating signs and symptoms of dehydration, the acute care physician ordered that the antibiotic be reconstituted with 250 cc of normal saline rather than 100 cc, which is the minimum amount required for reconstitution. This IV antibiotic and fluid regimen continues for 7 additional days following admission to the SNF due to continued infection and decreased oral intake.

   Coding: K0520A1, K0520A2, and K0520A3 would **be checked.** The IV medication would be coded at **IV Medications** item (O0110H).

   Rationale: The resident's physician in the acute care hospital ordered additional volume of dilutant for the IV medication reconstitution to address Resident H's inadequate oral fluid intake. The treatment regime continues upon admission to the SNF to address hydration needs. There is supporting documentation that reflected an identified need for additional fluid intake for hydration.

2. Resident J is receiving an antibiotic in 100 cc of normal saline via IV. They have a UTI, no fever, and documented adequate fluid intake. They are placed on the nursing home's hydration plan to ensure adequate hydration.

   Coding: K0520A1 would **NOT be checked.** The IV medication would be coded at **IV Medications** item (O0110H).

   Rationale: Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

K0520: Nutritional Approaches (cont.)

3. Resident Q will be discharged today following a 16-day stay in the nursing home. They were receiving rehabilitation services for a stroke. They have longstanding celiac disease and therefore were placed on a gluten-free diet. Because of their recent stroke, they also have documented dysphagia requiring a mechanical soft diet and honey-thick liquids to prevent aspiration and will be discharged on this same diet.

   Coding: K0520C3 and K0520C4, as well as K0520D3 and K0520D4, would **be checked**.

   Rationale: Resident Q required both a mechanically altered diet (i.e., mechanical soft diet and honey-thick liquids) and a therapeutic diet (i.e., gluten free) for their celiac disease in the last 7 days as well as at discharge.

4. Resident B will be discharged today after rehabilitation services for multiple fractures sustained in a car accident. Resident B has been on a regular diet during their entire stay and has not required any parenteral or enteral nutrition. During the acute hospital stay Resident B required a mechanical soft diet following the accident. The resident upgraded to a regular texture diet prior to discharge from the hospital.

   Coding: K0520Z3and K0520Z4 would **be checked**.

   Rationale: Resident B had a regular diet their entire stay and did not require any nutritional modifications.

K0710: Percent Intake by Artificial Route

Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B.

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	☐	☐

DRAFT

K0710: Percent Intake by Artificial Route (cont.)

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

Planning for Care

- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake as indicated by the resident's condition.

K0710A, Proportion of Total Calories the Resident Received through Parental or Tube Feeding

Steps for Assessment

1. Review intake records within the last 7 days to determine actual intake through parenteral or tube feeding routes.
2. Calculate proportion of total calories received through these routes.
   - If the resident took no food or fluids by mouth or took just sips of fluid, stop here and **code 3, 51% or more.**
   - If the resident had more substantial oral intake than sips of fluid, consult with the dietician.

Coding Instructions

- Select the best response:
  1. 25% or less
  2. 26% to 50%
  3. 51% or more

Draft

K0710: Percent Intake by Artificial Route (cont.)

Example

1. **Calculation for Proportion of Total Calories from IV or Tube Feeding**

   Resident H has had a feeding tube since their surgery two weeks ago. They are currently more alert and feeling much better. They have been taking soft solids by mouth, but only in small to medium amounts. Within the last 7 days, they have been receiving tube feedings for nutritional supplementation. The dietitian has totaled their calories per day as follows:

Oral and Tube Feeding Intake		
	Oral	**Tube**
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

Coding: K0710A columns 2 and 3 would be coded **3, 51% or more.**

Rationale: Total Oral intake is 2,450 calories
Total Tube intake is 15,000 calories
Total calories is 2,450 + 15,000 = 17,450
Calculation of the percentage of total calories by tube feeding:
15,000/17,450 = .859 X 100 = 85.9%
Resident H received 85.9% of their calories by tube feeding, therefore K0710A **code 3**, **51% or more** is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding

Steps for Assessment

1. Review intake records from the last 7 days.
2. Add up the total amount of fluid received each day by IV and/or tube feedings only.
3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days.

Coding Instructions

Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.

- **Code 1:** 500 cc/day or less
- **Code 2:** 501 cc/day or more

DRAFT

K0710: Percent Intake by Artificial Route (cont.)

Examples

1. **Calculation for Average Daily Fluid Intake**

Resident A, a long term care resident, has swallowing difficulties secondary to Huntington's disease. They are able to take oral fluids by mouth with supervision, but not enough to maintain hydration. They received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) within the last 7 days.

IV Fluid Intake	
Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	500 cc
Sat.	450 cc
Total	6,300 cc

Coding: K0710B columns 2 and 3 would be coded **2, 501cc/day or more**.

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc
6,300 cc divided by 7 days = 900 cc/day
900 cc is greater than 500 cc, therefore **code 2**, **501 cc/day or more** is correct.

Draft

K0710: Percent Intake by Artificial Route (cont.)

2. Resident K has been able to take some fluids orally; however, due to their progressing multiple sclerosis, their dysphagia is not allowing them to remain hydrated enough. Therefore, they received the following fluid amounts within the last 7 days via supplemental tube feedings while in the hospital and after they were admitted to the nursing home.

While in the Hospital		While in the Nursing Home	
Mon.	400 cc	Fri.	510 cc
Tues.	520 cc	Sat.	520 cc
Wed.	500 cc	Sun.	490 cc
Thurs.	480 cc		
Total	1,900 cc	Total	1,520 cc

Coding: K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Resident K was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more is correct for K0710B2, While a Resident**.

The total fluid intake during the entire 7 days (includes fluid intake while Resident K was in the hospital AND while Resident K was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days**.

Draft

SECTION L: ORAL/DENTAL STATUS

Intent: This item is intended to record any dental **problems** present in the 7-day look-back period.

L0200: Dental

L0200. Dental	
↓	Check all that apply
☐	A. **Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	B. **No natural teeth or tooth fragment(s)** (edentulous)
☐	C. **Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	D. **Obvious or likely cavity or broken natural teeth**
☐	E. **Inflamed or bleeding gums or loose natural teeth**
☐	F. **Mouth or facial pain, discomfort or difficulty with chewing**
☐	G. **Unable to examine**
☐	Z. **None of the above were present**

Item Rationale

Health-related Quality of Life

- Poor oral health has a negative impact on:
  - — quality of life
  - — overall health
  - — nutritional status
- Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Planning for Care

- Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

DEFINITIONS

CAVITY
A tooth with a discolored hole or area of decay that may have debris in it.

BROKEN NATURAL TEETH OR TOOTH FRAGMENT
Very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).

ORAL LESIONS
A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.

EDENTULOUS
Having no natural permanent teeth in the mouth. Complete tooth loss.

Draft

L0200: Dental (cont.)

Steps for Assessment

1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials, examine for loose fit. Ask them to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use their gloved fingers to adequately feel for masses or loose teeth.
5. If the resident is unable to self-report, then observe them while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.

DEFINITIONS

ORAL MASS
A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.

ULCER
Mouth sore, blister or eroded area of tissue on any oral surface.

Coding Instructions

- **Check L0200A, broken or loosely fitting full or partial denture:** if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens their mouth, or the denture moves when the resident tries to talk.
- **Check L0200B, no natural teeth or tooth fragment(s) (edentulous):** if the resident is edentulous/lacks all natural teeth or parts of teeth.
- **Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions):** select if any ulcer, mass, or oral lesion is noted on any oral surface.
- **Check L0200D, obvious or likely cavity or broken natural teeth:** if any cavity or broken tooth is seen.
- **Check L0200E, inflamed or bleeding gums or loose natural teeth:** if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- **Check L0200F, mouth or facial pain or discomfort with chewing:** if the resident reports any pain in the mouth or face, or discomfort with chewing.
- **Check L0200G, unable to examine:** if the resident's mouth cannot be examined.
- **Check L0200Z, none of the above:** if none of conditions A through F is present.

L0200: Dental (cont.)

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.
- The dental status for a resident who has some, but not all, of their natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above.
- Many residents have dentures or partials that fit well and work properly. However, for individualized care planning purposes, consideration should be taken for these residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication pass, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

Draft

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

M0100: Determination of Pressure Ulcer/Injury Risk

M0100. Determination of Pressure Ulcer/Injury Risk	
↓	Check all that apply
☐	A. Resident has a pressure ulcer/injury, 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

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development.
- The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individualized needs of the resident.

Draft

M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- Throughout this section, terminology referring to "healed" versus "unhealed" ulcers refers to whether or not the ulcer is "closed" versus "open." When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although "closed" (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered "healed."
- Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.

DEFINITION

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.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- **Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device.** Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.

DEFINITIONS

PRESSURE ULCER/ INJURY RISK FACTOR
Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, malnutrition, and hydration deficits; and a healed ulcer.

PRESSURE ULCER/ INJURY RISK TOOLS
Screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©.

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M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*©. Other tools may be used.
- **Check C if the resident's risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability
  - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
  - drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
  - resident refusal of some aspects of care and treatment;
  - cognitive impairment;
  - urinary and fecal incontinence;
  - malnutrition and hydration deficits; and
  - healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.
- **Check Z if none of the above apply.**

M0150: Risk of Pressure Ulcers/Injuries

M0150. Risk of Pressure Ulcers/Injuries

Enter Code ☐ **Is this resident at risk of developing pressure ulcers/injuries?**

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

Item Rationale

Health-related Quality of Life

- It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.

Planning for Care

- The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Steps for Assessment

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

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M0150: Risk of Pressure Ulcers/Injuries (cont.)

2. If the medical record reveals that the resident currently has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries.
3. Review formal risk assessment tools to determine the resident's "risk score."
4. Review the components of the clinical assessment conducted for evidence of pressure ulcer/injury risk.

Coding Instructions

- **Code 0, no:** if the resident is not at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.
- **Code 1, yes:** if the resident is at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcers/Injuries

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcers/injuries?**

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.
- An existing pressure ulcer/injury identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. 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 must code the MDS according to the instructions in this manual.

DEFINITION

PRESSURE ULCER/INJURY

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.

M0210: Unhealed Pressure Ulcers/Injuries (cont.)

- 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.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any skin ulcers/injuries are present.
   - Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.
   - Without a full body skin assessment, a pressure ulcer/injury can be missed.
   - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers/injuries.

Coding Instructions

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

- **Code 0, no:** if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers.
- **Code 1, yes:** if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Coding Tips

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.
- Mucosal ulcers caused by pressure should not be coded in Section M. Oral mucosal ulcers are captured in item L0200C, Abnormal mouth tissue.
- 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.

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M0210: Unhealed Pressure Ulcers/Injuries (cont.)

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, code 1 and proceed to code items in M0300 as appropriate for the pressure ulcer/injury.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. 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 characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- 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.
- Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

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

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

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 (see Step 2 below).
3. Review the history of each pressure ulcer in the medical record. If the stageable 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 until healed unless it becomes unstageable. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.
4. 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.
5. Clinical standards do not support reverse staging or back-staging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or back-staging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed unless it becomes unstageable. 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.

DEFINITIONS

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.

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

6. A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

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 are 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, as illustrated at https://npiap.com/page/PressureInjuryStages.
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, as illustrated at https://npiap.com/page/PressureInjuryStages.
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"

*For **each** pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.*

DEFINITION

ON ADMISSION
As close to the actual time of admission as possible.

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 the pressure ulcer/injury was present on admission/entry or reentry 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/entry or reentry 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."**

M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, 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 a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury **is coded as "present on admission."**
11. 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."

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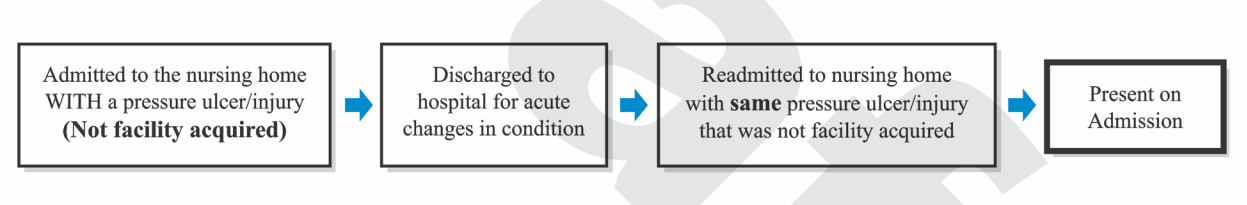
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

Examples

1. Resident K is admitted to the facility without a pressure ulcer/injury. During the stay, they develop a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Resident K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when they return from the hospital.



2. Resident J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Resident J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed.



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M0300A: Number of Stage 1 Pressure Injuries

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

A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number ☐

1. **Number of Stage 1 pressure injuries**

Item Rationale

Health-related Quality of Care

- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure injury should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code here.
3. Reliance on only one descriptor is inadequate to determine the staging of a pressure injury between Stage 1 and deep tissue injury (see definition of "deep tissue injury" on page M-24). The descriptors are similar for these two types of injuries (e.g., temperature [warmth or coolness]; tissue consistency [firm or boggy]).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes as well as surrounding tissue that may be painful, firm, or soft.

DEFINITIONS

STAGE 1 PRESSURE INJURY
An observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.

NON-BLANCHABLE
Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

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M0300A: Number of Stage 1 Pressure Injuries (cont.)

Coding Instructions for M0300A

- **Enter the number** of Stage 1 pressure injuries that are currently present.
- **Enter 0** if no Stage 1 pressure injuries are currently present.

M0300B: Stage 2 Pressure Ulcers

B. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐

2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers may worsen without proper interventions.
- These residents are at risk for further complications or skin injury.

Planning for Care

- Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

DEFINITION

STAGE 2 PRESSURE ULCER

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.

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M0300B: Stage 2 Pressure Ulcers (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. **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.**
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.
5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-8).

Coding Instructions for M0300B

M0300B1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- **Enter 0** if no Stage 2 pressure ulcers are present and skip to M0300C, Stage 3.

M0300B2

- **Enter the number** of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- 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.
- Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.

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M0300C: Stage 3 Pressure Ulcers

Enter Number ☐

Enter Number ☐

C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.
- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

DEFINITION

STAGE 3 PRESSURE ULCER
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 (see definition of undermining and tunneling on page M-19).

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 3 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

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M0300C: Stage 3 Pressure Ulcers (cont.)

Coding Instructions for M0300C

M0300C1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- **Enter 0** if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4.

M0300C2

- **Enter the number** of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

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. Do **not** code moisture-associated skin damage or excoriation here.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

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M0300C: Stage 3 Pressure Ulcers (cont.)

Examples

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer in the same location.

   Coding: The admission coding would be **M0300B1 as 1, and M0300B2 as 1, present upon admission/entry or reentry.** On the current assessment, the coding for the Stage 2 data elements would be **M0300B1 as 0, and M0300B2 is skipped, since there is no longer a Stage 2 pressure ulcer.** The Stage 3 pressure ulcer currently assessed would be coded at **M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.**
   Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location **and** not have increased in numerical stage or become unstageable due to slough or eschar. This pressure ulcer worsened from Stage 2 to Stage 3 after admission. **M0300C1 is coded as 1 and M0300C2 is coded as 0 on the current assessment** because the ulcer was not a Stage 3 pressure ulcer on admission.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is discharged to an acute-care hospital and was hospitalized. The resident returns to the nursing facility with a Stage 3 pressure ulcer in the same location.

   Coding: The Stage 3 pressure ulcer, assessed on reentry, would be coded at **M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.**
   Rationale: The resident developed a Stage 2 pressure ulcer while at the nursing facility. This is a "facility acquired" pressure ulcer and was not "present on admission." The resident is hospitalized and returns with a pressure ulcer in the same location, which has now worsened to a Stage 3. Although the pressure ulcer was originally acquired in the nursing facility, it is coded as "present on admission/entry or reentry," because it increased in numerical stage while the resident was in the hospital.

DRAFT

M0300C: Stage 3 Pressure Ulcers (cont.)

3. On admission, the resident has three small Stage 2 pressure ulcers on their coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer.

   Coding: The admission coding would be **M0300B1 as 3, and M0300B2 as 1, present on admission/entry or reentry.** On the subsequent assessment, the two merged pressure ulcers would be coded at **M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry**. The Stage 3 pressure ulcer would be **coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.**

   Rationale: On the subsequent assessment, two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, **M0300B1 and M0300B2 would be coded as 1**; the pressure ulcer that increased in numerical stage to a **Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0**, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.

4. A resident was admitted with no pressure ulcers/injuries and developed two Stage 2 pressure ulcers during their stay; one on the coccyx and the other on the left lateral malleolus. At some point they are hospitalized and return with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.

   Coding: On admission, the resident had no pressure ulcers/injuries. The two Stage 2 pressure ulcers developed during the stay and are coded at **M0300B1 as 2, and M0300B2 as 0,** when the resident is discharged to the hospital. On return from the hospital, the Stage 2 pressure ulcer on the coccyx, which was present prior to the resident's discharge, would be coded at **M0300B1 as 1, and at M0300B2 as 0, not present on admission/entry or reentry; the Stage 3** pressure ulcer, which was identified upon reentry, is new and would be coded **at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.**

   Rationale: The Stage 2 pressure ulcers that were facility acquired are coded as not present on admission when the resident is discharged to the hospital. When the resident returns to the facility, the Stage 2 pressure ulcer on the coccyx was present prior to hospitalization and therefore would be not be considered as present on reentry. The Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded on the assessment.

DRAFT

M0300C: Stage 3 Pressure Ulcers (cont.)

5. A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. They have no visible wounds on admission but arrives with documentation that a pressure ulcer/injury exists under the cast. Two weeks after admission to the nursing facility, the cast is removed by the physician. Following removal of the cast, a Stage 3 pressure ulcer is observed on the right heel, which remains until the subsequent assessment.

   Coding: On admission, code **M0300E1 and M0300E2 as 1, present on admission, entry or reentry.** On subsequent assessment, code **M0300C1 as 1**, and **M0300C2 as 1, present on admission/entry or reentry**.
   Rationale: Because the resident was admitted to the nursing facility with documentation that a pressure ulcer/injury was present under the cast, and the cast could not be removed for the first two weeks, the pressure ulcer is coded on the Admission assessment as an unstageable pressure ulcer/injury due to non-removable dressing/device. On the subsequent assessment the pressure ulcer is coded as present on admission/entry or reentry as a Stage 3, the stage at which it was first able to be assessed after the removal of the cast.

6. Resident P was admitted to the nursing facility with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains at Stage 3.

   Coding: Code **M0300C1 as 1**, and **M0300C2 as 1**, present on admission/entry or reentry.
   Rationale: This resident was admitted with an unstageable DTI that subsequently was debrided and could be numerically staged. The first numerical stage was 3, and it remained a Stage 3 for the subsequent assessment; therefore, it is coded as present on admission/entry or reentry.

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M0300C: Stage 3 Pressure Ulcers (cont.)

7. Resident H was admitted with a known pressure ulcer/injury under a non-removable dressing/device. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point assessed as a Stage 3. It remained a Stage 3 at the time of the next assessment.

   Coding: On admission, code **M0300E1 as 1, unstageable pressure ulcer/injury due to non-removable dressing/device, and M0300E2 as 1, present on admission/entry or reentry.** On the subsequent assessment, code **M0300C1 as 1, Stage 3 pressure ulcer, and M0300C2 as 0, not present on admission/entry reentry**.

   Rationale: Resident H was admitted with a documented pressure ulcer/injury that was unstageable due to a non-removable dressing/device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage documented in the medical record. Subsequent to this first documented stage, the ulcer worsened to Stage 3 and remained a Stage 3 until the next assessment. On the next assessment, because this pressure ulcer was previously staged as Stage 2 upon initial removal of the dressing, and it increased in numerical stage to a Stage 3, it is not considered as present on admission/entry or reentry.

M0300D: Stage 4 Pressure Ulcers

Enter Number ☐

Enter Number ☐

D. **Stage 4:** 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

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device
2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

DEFINITION

STAGE 4 PRESSURE ULCER

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.

DRAFT

M0300D: Stage 4 Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

DEFINITIONS

TUNNELING
A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

UNDERMINING
The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

Coding Instructions for M0300D

M0300D1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers are present and skip to M0300E, Unstageable – Non-removable dressing.

M0300D2

- **Enter the number** of these Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 4 pressure ulcers were first noted at the time of admission/entry or reentry.

Draft

M0300D: Stage 4 Pressure Ulcers (cont.)

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS, but should be assessed, monitored, and treated as part of the comprehensive care plan.

M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device

Enter Number ☐

Enter Number ☐

E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device

1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for residents because it may limit activity and may be painful.

DEFINITION

NON-REMOVABLE DRESSING/ DEVICE
Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Planning for Care

- Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

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M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device (cont.)

Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer/injury covered by a non-removable dressing/device.
2. Determine the number of documented pressure ulcers/injuries covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or an orthopedic device that is not to be removed per physician's order, or a cast.
3. Identify the number of these pressure ulcers/injuries that were present on admission/entry or reentry (see page M-8 for assessment process).

Coding Instructions for M0300E

M0300E1

- **Enter the number** of pressure ulcers/injuries that are unstageable related to non-removable dressing/device.
- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar.

M0300E2

- **Enter the number** of these unstageable pressure ulcers/injuries related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer/injury related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

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M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

Enter Number ☐ **F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury
2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.
- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

DEFINITIONS

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 tissue 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.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar.
2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-8 for assessment process).

Draft

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Coding Instructions for M0300F

M0300F1

- **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to M0300G, Unstageable – Deep tissue injury.

M0300F2

- **Enter the number** of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry.

Coding Tips

DEFINITION

FLUCTUANCE
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

- Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

DRAFT

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Examples

1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.

   Coding: The pressure ulcer would be coded at **M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.**
   Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission.

2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.

   Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at **M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.**
   Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D.

3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.

   Coding: Code **M0300F1 as 1, and M0300F2 as 0, not present on admission/entry or reentry.**
   Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

Draft

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

4. Resident M was admitted to the nursing facility with pressure ulcers that were unstageable due to eschar on both heels, as well as a Stage 2 pressure ulcer on the coccyx. Resident M's pressure ulcers were reassessed before the subsequent assessment, and it was noted in the medical record that the Stage 2 coccyx pressure ulcer had healed. The left-heel eschar became fluctuant, showed signs of infection, and had to be debrided at the bedside. The left heel was subsequently numerically staged as a Stage 4 pressure ulcer. The right-heel eschar remained stable and dry (i.e., remained unstageable).

   Coding: On admission, code **M0300B1, Stage 2 as 1, M0300B2, present on admission/entry or reentry as 1;** and **M0300F1 Unstageable due to slough/eschar as 2** and **M0300F2 as 2, present on admission, entry or reentry.** On the subsequent assessment, code **M0300D1 as 1,** and **M0300D2 as 1, present on admission/entry or reentry;** and **M0300F1 as 1,** and **M0300F2 as 1, present on admission/entry or reentry**.

   Rationale: Since both of Resident M's heels cannot be numerically staged, because the level of tissue damage cannot be determined as a result of the eschar present, they are coded on admission as unstageable pressure ulcers due to slough/eschar. The left heel eschar was subsequently debrided and is coded as a Stage 4 on the subsequent assessment—since the left heel eschar was debrided, and the first time an unstageable ulcer/injury is staged, it is considered as present on admission/entry or reentry at the stage at which it is initially assessed. The other heel eschar remained unstageable and is coded as present on admission/entry or reentry, and the Stage 2 pressure ulcer on the coccyx healed, so it is not coded on the subsequent assessment.

Draft

M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury

Enter Number ☐

Enter Number ☐

G. Unstageable - Deep tissue injury:

1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds/injuries. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative.

DEFINITION

DEEP TISSUE INJURY
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Planning for Care

- Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Draft

M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not** code as a deep tissue injury.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure injuries that are unstageable related to deep tissue injury.
6. Identify the number of **these** pressure injuries that were present on admission/entry or reentry (see page M-8 for instructions).
7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

Coding Instructions for M0300G

M0300G1

- **Enter the number** of unstageable pressure injuries related to deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of deep tissue injury.
- **Enter 0** if no unstageable pressure injuries related to deep tissue injury are present and skip to M1030, Number of Venous and Arterial Ulcers.

M0300G2

- **Enter the number** of these unstageable pressure injuries related to deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure injury related to deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure injuries related to deep tissue injury were first noted at the time of admission/entry or reentry.

DRAFT

M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury (cont.)

Coding Tips

- Once deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- 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 (see definition of Stage 2 pressure ulcer on page M-12).

Example

1. A resident is admitted with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Four days after admission, the right heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is assessed and staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains a Stage 3.

   Coding: On admission, the pressure injury to the right heel would be coded at **M0300G1 as 1, and at M0300G2 as 1, present on admission/entry or reentry.** On the subsequent assessment, the pressure ulcer is coded at **M0300C1, Stage 3 pressure ulcer** and at **M0300C2 as 1, present on admission/entry or reentry.**

   Rationale: After a thorough clinical and skin examination, an assessment of the right heel and surrounding tissues revealed skin injury consistent with a DTI, which was observed at the time of admission. The heel DTI blister is drained, tissue is debrided, and the ulcer is subsequently numerically staged as a Stage 3. Because this was the first time the ulcer was able to be assessed and numerically staged, and it remained at that same stage at the time of the current assessment, it is considered to have been present on admission.

Draft

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ Enter the total number of venous and arterial ulcers present

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheet or other skin tracking form.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any venous or arterial ulcers are present.
   - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
   - Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
   - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
   - Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

DEFINITIONS

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.

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.

DEFINITION

HEMOSIDERIN
An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment.

Draft

M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Instructions

*Pressure ulcers coded in M0210 through M0300 should **not** be coded here.*

- **Enter the number** of venous and arterial ulcers present.
- **Enter 0:** if there were no venous or arterial ulcers present.

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Example

1. A resident has three toes on their right foot that have black tips. They do not have diabetes, but have been diagnosed with peripheral vascular disease.

   Coding: Code **M1030 as 3.**

   Rationale: Ischemic changes point to the ulcer being vascular.

Draft

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓	Check all that apply
	Foot Problems
☐	A. **Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	B. **Diabetic foot ulcer(s)**
☐	C. **Other open lesion(s) on the foot**
	Other Problems
☐	D. **Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	E. **Surgical wound(s)**
☐	F. **Burn(s)** (second or third degree)
☐	G. **Skin tear(s)**
☐	H. **Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	Z. **None of the above** were present

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Draft

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
    - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

***Check all that apply** in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.*

*Pressure ulcers/injuries coded in items M0200 through M0300 should **not** be coded here.*

- **M1040A,** Infection of the foot (e.g., cellulitis, purulent drainage)
- **M1040B,** Diabetic foot ulcer(s)
- **M1040C,** Other open lesion(s) on the foot (e.g., cuts, fissures)
- **M1040D,** Open lesion(s) other than ulcers, rashes, cuts (e.g., bullous pemphigoid)
- **M1040E,** Surgical wound(s)
- **M1040F,** Burn(s)(second or third degree)
- **M1040G,** Skin tear(s)
- **M1040H,** Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
- **M1040Z,** None of the above were present

DEFINITIONS

DIABETIC FOOT ULCERS
Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

SURGICAL WOUNDS
Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

OPEN LESION(S) OTHER THAN ULCERS, RASHES, CUTS
Most typically skin lesions that develop as a result of diseases and conditions such as syphilis and cancer.

BURNS (SECOND OR THIRD DEGREE)
Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

Draft

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on their other foot.
- Do **not** include pressure ulcers/injuries that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do **not** code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.
- Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

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.
- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound.

DRAFT

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

M1040F Burns (Second or Third Degree)

- Do **not** include first degree burns (changes in skin color only).

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.
- Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.

M1040H Moisture Associated Skin Damage (MASD)

- MASD is also referred to as maceration and includes incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.
- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

DEFINITION

MOISTURE ASSOCIATED SKIN DAMAGE

Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

DRAFT

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Examples

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.

   Coding: This ulcer is **not checked at M1040B. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210–M0300).**
   Rationale: Persons with diabetes can still develop pressure ulcers.

2. A resident is readmitted from the hospital after myocutaneous flap surgery to excise and close their sacral pressure ulcer.

   Coding: Check **M1040E**, Surgical Wound.
   Rationale: A surgical flap procedure was used to close the resident's pressure ulcer. The pressure ulcer is now considered a surgical wound.

3. Resident J was reaching over to get a magazine off of their bedside table and sustained a skin tear on their wrist from the edge of the table when they pulled the magazine back towards them.

   Coding: Check **M1040G**, Skin Tear(s).
   Rationale: The resident sustained a skin tear while reaching for a magazine.

4. Resident S who is incontinent, is noted to have a large, red and excoriated area on their buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

   Coding: Check **M1040H**, Moisture Associated Skin Damage (MASD).
   Rationale: Resident S skin assessment reveals characteristics of incontinence-associated dermatitis.

5. Resident F complained of discomfort of their right great toe and when their stocking and shoe was removed, it was noted that their toe was red, inflamed and had pus draining from the edge of their nail bed. The podiatrist determined that Resident F has an infected ingrown toenail.

   Coding: Check **M1040A**, Infection of the foot.
   Rationale: Resident F has an infected right great toe due to an ingrown toenail.

6. Resident G has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.

   Coding: Check **M1040D**, Open lesion other than ulcers, rashes, cuts.
   Rationale: Resident G has open bullous pemphigoid blisters.

7. Resident A was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. They are here for continued treatment of their burns and for rehabilitative therapy.

   Coding: Check **M1040F**, Burns (second or third degree).
   Rationale: Resident A has second and third degree burns, therefore, burns (second or third degree) should be checked.

Draft

M1200: Skin and Ulcer/Injury Treatments

M1200. Skin and Ulcer/Injury Treatments	
↓	Check all that apply
☐	A. **Pressure reducing device for chair**
☐	B. **Pressure reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention** to manage skin problems
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	H. **Applications of ointments/medications** other than to feet
☐	I. **Application of dressings to feet** (with or without topical medications)
☐	Z. **None of the above** were provided

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

Planning for Care

- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

DEFINITION

PRESSURE REDUCING DEVICE(S)
Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.

Steps for Assessment

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility's policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

Draft

M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A,** Pressure reducing device for chair
- **M1200B,** Pressure reducing device for bed
- **M1200C,** Turning/repositioning program
- **M1200D,** Nutrition or hydration intervention to manage skin problems
- **M1200E,** Pressure ulcer/injury care
- **M1200F,** Surgical wound care
- **M1200G,** Application of non-surgical dressings (with or without topical medications) other than to feet. Non- surgical dressings do not include Band-Aids.
- **M1200H,** Application of ointments/medications other than to feet
- **M1200I,** Application of dressings to feet (with or without topical medications)
- **M1200Z,** None of the above were provided

Draft

M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Tips

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is 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 (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

DEFINITIONS

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.

Draft

M1200: Skin and Ulcer/Injury Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment. If it is determined that nutritional supplementation, that is, adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.
- It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries 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.
- 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.

M1200: Skin and Ulcer/Injury Treatments (cont.)

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 ulcers/injuries other than to feet in this item; use M1200E, Pressure ulcer/injury 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, wound closure strips).

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/injury 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/injury**.
- Do **not** code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Draft

M1200: Skin and Ulcer/Injury Treatments (cont.)

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing pad on the resident's wheelchair. The medical record documents delivery of care and notes that the resident is on a two-hour turning/repositioning program that is organized, planned, documented, monitored, and evaluated based on an individualized assessment of their needs. The physician documents, after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, dietician's nutritional assessment, and laboratory results, that the resident has protein-calorie malnutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients, and micronutrients. All mattresses in the nursing home are pressure reducing mattresses.

   Coding: Check items **M1200A, M1200B, M1200C, M1200D, and M1200E.**
   Rationale: Interventions include pressure reducing pad on the wheelchair (M1200A) and pressure reducing mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the last 7 days the resident has had a three-layer compression-bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure reducing mattress and pad for the wheelchair.

   Coding: Check items **M1200A, M1200B, and M1200G.**
   Rationale: Treatments include pressure reducing mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression-bandaging system (M1200G).

3. Resident S has a diagnosis of right-sided hemiplegia from a previous stroke. As part of their assessment, it was noted that while in bed Resident S is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on their skin. Staff assist them to turn every 3 hours while in bed. When they are in their wheelchair, it is difficult for them to offload the pressure to their buttocks. Their assessment indicates that their skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when they are sitting, and therefore, Resident S is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions.

   Coding: Check **M1200C.**
   Rationale: Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident's unique needs.

DRAFT

M1200: Skin and Ulcer/Injury Treatments (cont.)

4. Resident J has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of their care. Their care plan states that they are to be turned and repositioned, per facility policy, every 2 hours.

   Coding: Do **not** check item **M1200C.**

   Rationale: Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident's response to turning and repositioning. There are not any skin or ulcer treatments being provided.

Scenarios for Pressure Ulcer Coding

Example M0100-M1200

1. Resident P was admitted to the nursing home on 10/23/2019 for a Medicare stay. In completing the PPS 5-day assessment (ARD of 10/28/2019), it was noted that the resident had a head-to-toe skin assessment and their skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. The resident was noted to have a Stage 2 pressure ulcer that was identified on their coccyx on 11/1/2019. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Resident P does not have any arterial or venous ulcers, wounds, or skin problems. They are receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Resident P also has pressure reducing devices on both their bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to their family, Resident P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and their OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated.

   5-Day PPS:

   Coding:

   - **M0100B** (Formal assessment instrument), Check box.
   - **M0100C** (Clinical assessment), Check box.
   - **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
   - **M0210** (One or more unhealed pressure ulcers/injuries), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).
   - **M1030** (Number of Venous and Arterial Ulcers), Code 0.
   - **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
   - **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).

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Scenarios for Pressure Ulcer Coding (cont.)

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident's skin was noted to be intact, therefore, **M0210** was coded 0. **M1030** was coded 0 due to the resident not having any of these conditions. **M1040Z** was checked since none of these problems were noted. **M1200Z** was checked because none of these treatments were provided.

Discharge Assessment:

Coding:

- **M0100A** (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box.
- **M0210** (Unhealed Pressure Ulcers/Injuries), Code 1.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).
- **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device).
- **M0300E1** (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar).
- **M0300F1** (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury).
- **M0300G1** (Unstageable – Deep tissue injury), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).

Rationale: The resident has a pressure ulcer. On the 5-day PPS assessment, the resident's skin was noted to be intact; however, on the Discharge assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day PPS and Discharge assessment completed, the Discharge assessment would be coded 0 at A0310E. This is because the Discharge assessment is **not** the first assessment since the most recent admission/entry or reentry.

Draft

SECTION N: MEDICATIONS

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.

In addition, two medication sections have been added. The first is an Antipsychotic Medication Review. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications. The second is a series of data elements addressing Drug Regimen Review. These data elements document whether a drug regimen review was conducted upon the start of a SNF PPS stay through the end of the SNF PPS stay and whether any clinically significant medication issues identified were addressed in a timely manner.

N0300: Injections

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0415, High-Risk Drug Classes: Use and Indication

Item Rationale

Health-related Quality of Life

- Frequency of administration of medication via injection can be an indication of stability of a resident's health status and/or complexity of care needs.

Planning for Care

- Monitor for adverse effects of injected medications.
- Although antigens and vaccines are not considered to be medications per se, it is important to track when they are given to monitor for localized or systemic reactions.

Steps for Assessment

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care locations where the resident may have received injections while a resident of the nursing home (e.g., flu vaccine in a physician's office, in the emergency room – as long as the resident was not admitted).
3. Determine if any medications were received by the resident via injection. If received, determine the number of days during the look-back period they were received.

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N0300: Injections (cont.)

Coding Instructions

Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by injection.

*Insulin injections **are** counted in this item as well as in Item N0350.*

- Count the number of days that **the resident received any type of injection while a resident of the nursing home.**
- Record the number of days that any type of injection (e.g., subcutaneous, intramuscular, or intradermal) was received in Item N0300.

Coding Tips and Special Populations

- For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on one day, and another vaccine is provided on the next day, the number of days the resident received injections would be **coded as 2 days.**
- If two injections were administered on the same day, the number of days the resident received injections would be **coded as 1 day.**

Examples

1. During the **7**-day look-back period, Resident T received an influenza shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B_{12} injection on Wednesday.

   Coding: N0300 would be **coded 3.**
   Rationale: The resident received injections on 3 separate days during the **7**-day look-back period.

2. During the **7**-day look-back period, Resident C received both an influenza shot and their vitamin B_{12} injection on Thursday.

   Coding: N0300 would be **coded 1.**
   Rationale: The resident received injections on one day during the **7**-day look-back period.

Draft

N0350: Insulin

N0350. Insulin

Enter Days ☐ A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days

Enter Days ☐ B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

Item Rationale

Health-related Quality of Life

- Insulin is a medication used to treat diabetes mellitus (DM).
- Individualized meal plans should be created with the resident's input to ensure appropriate meal intake. Residents are more likely to be compliant with their DM diet if they have input related to food choices.

Planning for Care

- Orders for insulin may have to change depending on the resident's condition (e.g., fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections take into account meals, activity, etc., based on individualized resident assessment.
- Monitor for adverse effects of insulin injections (e.g., hypoglycemia).
- Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.

Steps for Assessment

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or insulin orders changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist **if allowable under state licensure laws**) changed the resident's insulin orders.

Draft

N0350: Insulin (cont.)

Coding Tips and Special Populations

- For sliding scale orders:
  - A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
  - If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.
- For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

N0415: High-Risk Drug Classes: Use and Indication

N0415. High-Risk Drug Classes: Use and Indication

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

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

Draft

N0415: High-Risk Drug Classes: Use and Indication (cont.)

Item Rationale

Health-related Quality of Life

- Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.
- As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

DEFINITIONS

ADVERSE CONSEQUENCE
An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (e.g., medication-medication, medication-food, and medication-disease).

NON-PHARMACOLOGICAL INTERVENTION
Approaches that do not involve the use of medication to address a medical condition.

Draft

N0415: High-Risk Drug Classes: Use and Indication (cont.)

Planning for Care

- The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication.
- Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.
- Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects.
- Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

Steps for Assessment

1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).

Coding Instructions

- Code all high-risk drug class medications according to their pharmacological classification, not how they are being used.
    - **Column 1:** Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
    - **Column 2:** If Column 1 is checked, check if there is an indication noted for all medications in the drug class.

DEFINITIONS

INDICATION

The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.

DOSE

The total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

MONITORING

The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or the treatments and support decisions about adding, modifying, continuing, or discontinuing any interventions.

N0415: High-Risk Drug Classes: Use and Indication (cont.)

- **N0415A1. Antipsychotic:** Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415A2. Antipsychotic:** Check if there is an indication noted for all antipsychotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415B1. Antianxiety:** Check if an anxiolytic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415B2. Antianxiety:** Check if there is an indication noted for all anxiolytic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415C1. Antidepressant:** Check if an antidepressant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415C2. Antidepressant:** Check if there is an indication noted for all antidepressant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415D1. Hypnotic:** Check if a hypnotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415D2. Hypnotic:** Check if there is an indication noted for all hypnotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415E1. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin):** Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415E2. Anticoagulant:** Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415F1. Antibiotic:** Check if an antibiotic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415F2. Antibiotic:** Check if there is an indication noted for all antibiotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415G1. Diuretic:** Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

DRAFT

N0415: High-Risk Drug Classes: Use and Indication (cont.)

- **N0415G2. Diuretic:** Check if there is an indication noted for all diuretic medications received by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415H1. Opioid:** Check if an opioid medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **N0415H2. Opioid:** Check if there is an indication noted for all opioid medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415I1. Antiplatelet:** Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
- **N0415I2. Antiplatelet:** Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- **N0415J1. Hypoglycemic (including insulin):** Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
- **N0415J2. Hypoglycemic (including insulin):** Check if there is an indication noted for all hypoglycemic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
- ***N0415K1. Anticonvulsant:*** *Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).*
- ***N0415K2. Anticonvulsant:*** *Check if there is an indication noted for all anticonvulsant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).*
- **N0415Z1. None of the above:** Check if none of the medications above were taken by the resident at any time during the observation period (or since admission/entry or reentry if less than 7 days).

Coding Tips and Special Populations

- Code medications in Item N0415 according to the medication's 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 medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.

DRAFT

N0415: High-Risk Drug Classes: Use and Indication (cont.)

- 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 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 of these medications given to the resident by any route in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- Do not code flushes to keep an IV access patent.
- Code a medication even if it was given only once during the look-back period.
- 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).
- Transdermal patches are generally worn for and release medication over a period of several days. To code N0415, only capture the medication if the transdermal patch was applied to the resident's skin during the observation period. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0415H Opioid would be checked, because the application occurred 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.
- 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. If necessary, request input from the consulting pharmacist.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.

N0415: High-Risk Drug Classes: Use and Indication (cont.)

- Opioid medications can be an effective intervention in a resident's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.
- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- When residents are having difficulty sleeping, nursing home staff should explore non-pharmacological interventions (e.g., sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and prior customary routine) to try to improve sleep prior to initiating pharmacologic interventions. If residents are currently on sleep-enhancing medications, nursing home staff can try non-pharmacologic interventions to help reduce the need for these medications or eliminate them.

DEFINITION

SLEEP HYGIENE
Practices, habits and environmental factors that promote and/or improve sleep patterns.

- Many psychoactive medications increase confusion, sedation, and falls. For those residents who are already at risk for these conditions, nursing home staff should develop plans of care that address these risks.
- Doses of psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.

DRAFT

N0415: High-Risk Drug Classes: Use and Indication (cont.)

- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances and duration of use. Certain anticoagulants require monitoring via laboratory results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
  - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html]), which may
    - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
    - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.

DEFINITION

MEDICATION INTERACTION
The impact of medication or other substance (such as nutritional supplements including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Example

1. The Medication Administration Record for Resident P reflects the following during the 7-day observation period:
   - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday for bipolar disorder.
   - Lorazepam 1 mg PO QAM: Received every day for bipolar disorder.
   - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

   Coding: Medications in N0415, would be coded as follows: **N0415A1 and N0415A2. Antipsychotic = checked;** risperidone is an antipsychotic medication and indication of use for bipolar disorder noted. **N0415B1 and N0415B2. Antianxiety = checked;** lorazepam is an antianxiety medication and indication of use for bipolar disorder noted. **N0415D1. Hypnotic = checked;** temazepam is a hypnotic medication. **N0415D2. Hypnotic = not checked;** indication for use of temazepam was not noted.

   Please note: if a resident is receiving medications in all three of these high-risk drug classes simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

Draft

N0415: High-Risk Drug Classes: Use and Indication (cont.)

Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition** (**DSM-5**) (or subsequent editions) (https://www.psychiatry.org/psychiatrists/practice/dsm), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html)].

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- 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

The above resource list is not all-inclusive, and use of these resources is not required for MDS completion. The resources are being provided as a convenience, for informational purposes only, and CMS is not responsible for their accessibility, content, or accuracy. Providers are 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.

NOTE: References to non-CMS sources do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services and were current as of the date of this publication.

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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 N0450B, N0450C, N0450D, and N0450E
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 N0450E, Date physician documented GDR as clinically contraindicated
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

Draft

N0450: Antipsychotic Medication Review (cont.)

Item Rationale

Health-related Quality of Life

- The use of unnecessary medications in long term care settings can have a profound effect on the resident's quality of life.
- Antipsychotic medications are associated with increased risks for adverse outcomes that can affect health, safety, and quality of life.
- In addition to assuring that antipsychotic medications are being utilized to treat the resident's condition, it is also important to assess the need to reduce these medications whenever possible.

Planning for Care

- Identify residents receiving antipsychotic medications to ensure that each resident is receiving the lowest possible dose to achieve the desired therapeutic effects.
- Monitor for appropriate clinical indications for continued use.
- Implement a system to ensure gradual dose reductions (GDR) are attempted at recommended intervals unless clinically contraindicated.

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.

Coding Instructions for N0450A

- **Code 0, no:** if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E.
- **Code 1, yes:** if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 2, yes:** if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 3, yes:** if antipsychotics were received on a routine and PRN basis**:** Continue to N0450B, Has a GDR been attempted?

Draft

N0450: Antipsychotic Medication Review (cont.)

Coding Tips and Special Populations

- Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used.

Coding Instructions for N0450B

- **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.

Coding Instructions for N0450C

- **Enter the date of the last attempted Gradual Dose Reduction.**

Coding Tips and Special Populations (N0450B and N0450C)

- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the 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. Information on GDR and tapering of medications can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** (see F758). The **State Operations Manual** can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.
- 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.
- Do not include gradual dose reductions 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 the resident was admitted to the 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.

DRAFT

N0450: Antipsychotic Medication Review (cont.)

- Prior to discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).
- Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication.

DEFINITION

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.

- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication 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 medication.
- In 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.
- Federal requirements regarding GDRs are found at 42 CFR 483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

Draft

N0450: Antipsychotic Medication Review (cont.)

Coding Instructions for N0450D

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

Coding Instructions for N0450E

- Enter date the physician documented GDR attempts as clinically contraindicated.

Coding Tips and Special Populations (N0450D and N0450E)

- In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.
- In N0450D and N0450E, include physician documentation that a 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.

Draft

N2001: Drug Regimen Review

Complete only if A0310B = 01.

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

Item Rationale

Health-related Quality of Life

- Potential and actual resident medication adverse consequences and errors are prevalent in health care settings and often occur during transitions in care.
- Adverse consequences related to medications may result in serious harm or death, emergency department visits, and rehospitalizations and affect the resident's health, safety, and quality of life.
- Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident's admission (start of SNF PPS stay) and throughout the resident's stay (through Part A PPS discharge).

Planning for Care

- Drug regimen review is an important component of the overall management and monitoring of a resident's medication regimen.
- Prevention and timely identification of potential and actual medication-related adverse consequences reduces the resident's risk for harm and improves quality of life.
- Educate staff in proper medication administration techniques and adverse effects of medications, as well as to be observant for these adverse effects.
- Implement a system to ensure that each resident's medication usage is evaluated upon admission and on an ongoing basis and that risks and problems are identified and acted upon.

DEFINITION

DRUG REGIMEN REVIEW

A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.

The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

DRAFT

N2001: Drug Regimen Review (cont.)

Steps for Assessment

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.
2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.

   Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
3. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.
4. Clinically significant medication issues may include, but are not limited to:
   - Medication prescribed despite documented medication allergy or prior adverse reaction.
   - Excessive or inadequate dose.
   - Adverse reactions to medication.
   - Ineffective drug therapy.
   - Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
   - Duplicate therapy (for example, generic-name and brand-name equivalent drugs are both prescribed).
   - Wrong resident, drug, dose, route, and time errors.
   - Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice.
   - Use of a medication without evidence of adequate indication for use.
   - Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed).
   - Omissions (medications missing from a prescribed regimen).
   - Nonadherence (purposeful or accidental).

Draft

N2001: Drug Regimen Review (cont.)

Coding Instructions

- **Code 0, No:** if no clinically significant medication issues were identified during the drug regimen review.
- **Code 1, Yes:** if one or more clinically significant medication issues were identified during the drug regimen review.
- **Code 9, NA:** if the resident was not taking any medications at the time of the drug regimen review.

Coding Tips

- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
- The drug regimen review includes all medications, prescribed and over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.
- Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

DEFINITIONS

POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE

A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.

"Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

DRAFT

N2001: Drug Regimen Review (cont.)

Examples

1. The admitting nurse reviewed and compared the acute care hospital discharge medication orders and the physician's admission medication orders for Resident D. The nurse interviewed Resident D, who confirmed the medications they were taking for their current medical conditions. The nurse found no discrepancies between the acute care hospital discharge medications and the admitting physician's medication orders. After the nurse contacted the pharmacy to request the medication, the pharmacist reviewed and confirmed the medication orders as appropriate for Resident D. As a result of this collected and communicated information, the nurse determined that there were no potential or actual clinically significant medication issues.

   Coding: N2001 would be coded **0, No**—No issues found during review.

   Rationale: The admitting nurse reviewed and compared Resident D's discharge medication records from the acute care hospital with the physician's admission medication orders, collaborated with the pharmacist, and interviewed the resident. The nurse determined there were no potential or actual clinically significant medication issues.

2. Resident H was admitted to the nursing facility after undergoing cardiac surgery for mitral valve replacement. The acute care hospital discharge information indicated that Resident H had a mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of Resident H's discharge records from the hospital with the physician's admission medication orders and admission note, the nurse noted that the admitting physician had ordered Resident H's anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0, however, the physician's admission note indicated that the desired therapeutic INR parameters for Resident H was 2.5–3.5. The nurse questioned the INR level listed on the admitting physician's order, based on the therapeutic parameters of 2.5–3.5 documented in the physician's admission note, which prompted the nurse to call the physician immediately to address the issue.

   Coding: N2001 would be coded **1, Yes**—Issues found during review.

   Rationale: The admitting nurse reviewed and compared Resident H's discharge health care records from the acute care hospital with the nursing facility physician's admission medication orders and admission note. The nurse identified a discrepancy between the physician's documented therapeutic INR level (2.5–3.5) for Resident H in the admission note and the physician's order to hold anticoagulation medication for an INR level of 1.0. The nurse considered this discrepancy to be a potential clinically significant medication issue that could lead to potential clotting issues for Resident H.

DRAFT

N2003: Medication Follow-up

N2003. Medication Follow-up - Complete only if N2001 = 1

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

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

Item Rationale

Health-related Quality of Life

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

Planning for Care

- When a potential or actual clinically significant medication issue is identified, prompt communication with the physician and implementation of prescribed actions is necessary to protect the health and safety of the resident.

DEFINITION

MEDICATION FOLLOW-UP

The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest.

Steps for Assessment

This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).

1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:
   - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
   - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

   Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

   Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.

Draft

N2003: Medication Follow-up (cont.)

Coding Instructions

- **Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions in response to **each** identified potential or actual clinically significant medication issue by midnight of the next calendar day.
- **Code 1, Yes:** if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.

DEFINITION

CONTACT WITH PHYSICIAN

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, and a response from the physician to convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident's status.

Coding Tips

- If the physician prescribes/recommends an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes,** should still be entered, if by midnight of the next calendar day the facility has taken the appropriate steps to comply with the prescribed/recommended action.
  - Example of a **physician-recommended action that would take longer than midnight of the next calendar day to complete**:
    - The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of **by midnight of the next calendar day**:
    - A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

DRAFT

N2003: Medication Follow-up (cont.)

Examples

1. Resident P was admitted to the nursing facility with active diagnoses of pneumonia and atrial fibrillation. The acute care facility medication record indicated that Resident P was on a seven-day course of antibiotics and had three remaining days of this treatment plan. The nurse reviewing the discharge records from the acute care facility and the nursing facility admission medication orders noted that Resident P had an order for an anticoagulant medication that required INR monitoring, as well as the antibiotic. On the date of admission, the nurse contacted the physician responsible for Resident P and communicated a concern about a potential increase in Resident P's INR with this combination of medications that could place them at greater risk for bleeding. The physician provided orders for laboratory testing so that Resident P's INR levels would be monitored over the next three days, starting that day. However, the nurse did not request the first INR laboratory test until after midnight of the next calendar day.

   Coding: N2003 would be coded **0, No.**

   Rationale: A potential clinically significant medication issue was identified during the drug regimen review; the staff did contact the physician before midnight of the next calendar day, but did not complete, to the extent possible, the physician-prescribed actions related to the INR laboratory test until after midnight of the next calendar day.

2. Resident S was admitted to the facility from an acute care hospital. During the admitting nurse's review of Resident S's hospital discharge records, it was noted that Resident S had been prescribed metformin. However, laboratory tests at admission indicated that Resident S had a serum creatinine of 2.4, consistent with renal insufficiency. The admitting nurse contacted the physician to ask whether this medication would be contraindicated with Resident S's current serum creatinine level. Three hours after Resident S's admission to the facility, the physician provided orders to discontinue the metformin and start Resident S on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour.

   Coding: N2003 would be coded **1, Yes.**

   Rationale: A potential clinically significant medication issue was identified during the drug regimen review; the physician communication occurred, and the nurse completed the physician-prescribed actions, by midnight of the next calendar day.

DRAFT

N2005: Medication Intervention

Complete only if A0310H = 1.

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Item Rationale

Health-related Quality of Life

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.
- Potential or actual clinically significant medication issues can occur throughout the resident's stay.

Planning for Care

- Every time a potential or actual clinically significant medication issue is identified throughout the resident's stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

Steps for Assessment

The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

1. Review the resident's medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident's stay:
   - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
   - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

- Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
- Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.

Draft

N2005: Medication Intervention (cont.)

Coding Instructions

- **Code 0, No:** if the facility did not contact the physician **and** complete prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- **Code 1, Yes:** if the facility contacted the physician **and** completed prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- **Code 9, NA:** if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident's stay or the resident was not taking any medications at admission or at any time throughout the stay.

Coding Tips

- If the physician prescribes an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes,** should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.
  - Example of a **physician-recommended action that would take longer than midnight of the next calendar day to complete**:
    - The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of by **midnight of the next calendar day**:
    - A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

DRAFT

N2005: Medication Intervention (cont.)

Examples

1. At the end of the resident's Part A PPS stay, the discharging nurse reviewed Resident T's medical records, from the time of admission (start of SNF PPS stay) through their entire Part A PPS stay (Part A PPS discharge) and noted that a clinically significant medication issue was documented during the admission assessment. Resident T's medical records indicated that a nurse had attempted to contact the assigned physician several times about the clinically significant medication issue. After midnight of the second calendar day, the physician communicated to the nurse, via telephone, orders for changes to Resident T's medications to address the clinically significant medication issue. The nurse implemented the physician's orders. Upon further review of Resident T's medical records, the discharging nurse determined that no additional issues had been recorded throughout the remainder of Resident T's stay.

   Coding: N2005 would be coded **0, No**—the facility did not contact the physician **and** complete prescribed/recommended actions by midnight of the next calendar day **each** time a potential or actual clinically significant medication issue was identified since the resident's admission (start of SNF PPS stay).

   Rationale: Coding of this item includes all potential or actual clinically significant medication issues identified at any time during the resident's stay. When reviewing Resident T's medical record at discharge, the nurse found that a clinically significant medication issue was identified during the admission (start of SNF PPS stay) drug regimen review, but the facility did not communicate with the physician **and** complete prescribed actions by midnight of the next calendar day. Although no other potential or actual clinically significant medication issues were identified during the remainder of the resident's stay, the facility did not communicate with the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified during the resident's SNF PPS stay.

Draft

N2005: Medication Intervention (cont.)

2. At discharge, the nurse completing a review of Resident K's medical records found that two clinically significant medication issues had been identified during the resident's stay. During the admission drug regimen review, the admitting nurse had identified a clinically significant medication issue, contacted the physician, and implemented new orders provided by the physician on the same day. Another potentially significant medication issue was identified on day 12 of Resident K's stay; the nurse communicated with the physician and carried out the orders within one hour of identifying the potential issue. Both medication issues identified during Resident K's stay were communicated to the physician and resolved by midnight of the next calendar day after identification. There were no other clinically significant medication issues identified during Resident K's stay.

   Coding: N2005 would be coded as **1, Yes—all** potential or actual clinically significant medication issues identified at any time during the resident's stay (admission through discharge) were communicated to the physician and prescribed/recommended actions were completed by midnight of the next calendar day after each issue was identified.

   Rationale: While a medication issue was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. During Resident K's stay, an additional clinically significant medication issue was identified; it too was resolved by midnight of the following day. Each time a clinically significant medication issue was identified (at admission and during the stay), it was communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day after identification.

Draft

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods.

O0110: Special Treatments, Procedures, and Programs

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0110. Special Treatments, Procedures, and Programs

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

a. **On Admission**
Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B

b. **While a Resident**
Performed ***while a resident*** of this facility and within the ***last 14 days***

c. **At Discharge**
Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

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

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐	[redacted]	☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐	[redacted]	☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care	[redacted]	☐	[redacted]
M1. **Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐	[redacted]	☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

Item Rationale

Health-related Quality of Life

- The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period defined for each column.

Coding Instructions for Column a. On Admission

Check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1–3 of the SNF PPS Stay starting with A2400B. If no treatments, procedures, or programs were received or performed in the 3-day assessment period, **check Z, None of the above**.

Coding Instructions for Column b. While a Resident

Check all treatments, procedures, and programs that the resident received or performed **after** admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, **check Z, None of the above**.

Coding Instructions for Column c. At Discharge

Check all treatments, procedures, and programs received by, performed on, or participated in by the resident in the last 3 days of the SNF PPS Stay ending with A2400C. If no treatments, procedures or programs were received by, performed on, or participated in by the resident in the 3-day assessment period, **check Z, None of the above**.

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **O0110A1, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. 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. IVs, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0520A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

Example: Resident J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After their cancer treatment, Resident J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **O0110A2, IV**

  Check if chemotherapy was administered intravenously.

- **O0110A3, Oral**

  Check if chemotherapy was administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered through a feeding tube/PEG (i.e., enterally).

- **O0110A10, Other**

  Check if chemotherapy was given in a way other than intravenously or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).

- **O0110B1, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

- **O0110C1, Oxygen therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes their own oxygen mask, cannula.

- **O0110C2, Continuous**

  Check if oxygen therapy was continuously delivered for 14 hours or greater per day.

- **O0110C3, Intermittent**

  Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).

- **O0110C4, High-concentration**

  Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).

  A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks).

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%.

Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 of greater than 40%.

- **O0110D1, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs their own tracheal and/or nasopharyngeal suctioning.

  - **O0110D2, Scheduled**

    Check if suctioning was scheduled. Scheduled suctioning is performed when the resident is assessed as clinically benefiting from regular interventions, such as every hour or once per shift. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, and guidelines.

  - **O0110D3, As needed**

    Check if suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted or a sudden desaturation occurs from a mucus plug.

- **O0110E1, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care. This item includes laryngectomy tube care.

- **O0110F1, 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 their own respiration** in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

Example: Resident J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day while a resident, because of an irreversible neurological injury and inability to breathe on their own. O0110F1b should be checked, as Resident J is using an invasive mechanical ventilator because they are unable to initiate spontaneous breathing on their own and the ventilator is controlling their breathing.

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110G1, Non-invasive Mechanical Ventilator**

Code any 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 their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their 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 their own BiPAP/CPAP mask/device.

  - **O0110G2, BiPAP**

    Check if the non-invasive mechanical ventilator support was BiPAP.

  - **O0110G3, CPAP**

    Check if the non-invasive mechanical ventilator support was CPAP.

- **O0110H1, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Lactated Ringers given IV is not considered a medication and should not be coded here. Resources and tools providing information on medications are available in Section N of this manual (see the end of item N0415 following the Example).

  - **O0110H2, Vasoactive medications**

    Check when at least one of the IV medications was an IV vasoactive medication.

  - **O0110H3, Antibiotics**

    Check when at least one of the IV medications was an IV antibiotic.

  - **O0110H4, Anticoagulation**

    Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

  - **O0110H10, Other**

    Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110I1, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0110J1, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions). This item may be coded if the resident performs their own dialysis.

  – **O0110J2, Hemodialysis**

    Check when the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.

  – **O0110J3, Peritoneal dialysis**

    Check when the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.

- **O0110K1, Hospice care**

Code residents identified as being in a hospice 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.

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110M1, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)**

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. 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 their room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

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 O0110M for single room isolation since it is still being maintained while the resident is in the facility.

DRAFT

O0110: Special Treatments, Procedures, and Programs (cont.)

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, Section 2.6, 03. Significant Change in Status Assessment (SCSA) (A0310A = 04). 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.

- **O0110O1, IV Access**

Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measurement of central venous pressure. *An arteriovenous (AV) fistula does not meet the definition of IV Access for O0110O1.*

  - **O0110O2, Peripheral**

    Check when IV access was peripheral access (catheter is placed in a peripheral vein) and remains peripheral.

  - **O0110O3, Midline**

    Check when IV access was midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.

  - **O0110O4, Central (e.g., PICC, tunneled, port)**

    Check when IV access was centrally located (e.g., PICC, tunneled, port).

- **O0110Z1, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

Draft

O0110: Special Treatments, Procedures, and Programs (cont.)

Examples

1. Resident R, who was admitted five days ago, has advanced prostate cancer and is receiving radiation and docetaxel (IV) via a port in their right upper chest to treat their prostate cancer. They were admitted to the SNF following an inpatient stay for an acute pulmonary embolism.

   Coding: Check boxes O0110A1a (Chemotherapy, On Admission), O0110A1b (Chemotherapy, While a Resident), and O0110A2a (IV, On Admission); O0110B1a (Radiation, On Admission) and O0110B1b (Radiation, While a Resident); and O0110O1a (IV Access, On Admission), O0110O1b (IV Access, While a Resident), and O0110O4a (Central, On Admission).

   Rationale: The resident received intravenous therapy via a port (i.e., a central line in their right upper chest) and radiation during their first three days of their SNF PPS stay and while a resident.

2. Resident M was admitted to the SNF for rehabilitation following cardiac surgery three weeks ago. They have sleep apnea and require a CPAP device nightly. While in the SNF, the staff set up the humidifier element of the CPAP, and Resident M put on the CPAP mask prior to falling asleep each night through their discharge to home.

   Coding: Check boxes O0110G1b (Non-invasive Mechanical Ventilator, While a Resident), O0110G1c (Non-invasive Mechanical Ventilator, At Discharge), and O0110G3c (CPAP, On Discharge).

   Rationale: Resident M can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day discharge assessment period.

3. Resident D was admitted 10 days ago to the SNF for rehabilitation following spinal surgery. They have sleep apnea and require a CPAP device while sleeping. The staff set-up the water receptacle and humidifier element of the machine. Each night since admission, Resident D puts on the CPAP mask and starts the machine prior to falling asleep.

   Coding: Check O0110G1a (Non-invasive Mechanical Ventilator, On Admission), O0110G1b (Non-invasive Mechanical Ventilator, While a Resident) and O0110G3a (CPAP, On Admission).

   Rationale: Resident D can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day admission assessment period.

DRAFT

O0250: Influenza Vaccine

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?

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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**

Item Rationale

Health-related Quality of Life

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

Planning for Care

- Influenza vaccines have been proven effective in preventing hospitalizations.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.
  - — **Mild problems:** soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days.
  - — **Severe problems:**
    - Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.

DRAFT

O0250: Influenza Vaccine (cont.)

- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine.
- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.
- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC: http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html

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 they 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.

Draft

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?

- **Code 0, no:** if the resident **did NOT receive the influenza vaccine *in this facility*** during this year's influenza vaccination season. Proceed to **If influenza vaccine not received, state reason** (O0250C).
- **Code 1, yes:** if the resident **did receive the influenza vaccine *in this facility*** during this year's influenza season. Continue to **Date influenza vaccine received** (O0250B).

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
  - If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
  - If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
  - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

Coding Instructions for O0250C, If influenza vaccine not received, state reason

If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

- **Code 1, Resident not in this facility during this year's influenza vaccination season:** resident was not in this facility during this year's influenza vaccination season.
- **Code 2, Received outside of this facility:** includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.
- **Code 3, Not eligible—medical contraindication:** if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.
- **Code 4, Offered and declined:** resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.

Draft

O0250: Influenza Vaccine (cont.)

- **Code 5, Not offered:** resident or responsible party/legal guardian not offered the influenza vaccine.
- **Code 6, Inability to obtain influenza vaccine due to a declared shortage:** vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
- **Code 9, None of the above:** if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

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. More information about when facilities must offer residents the influenza vaccine is available in 42 CFR 483.80(d), Influenza and pneumococcal immunizations, which can be found in Appendix PP of the State Operations Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf#page=708.
- 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.
- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.
- A "high dose" inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident's primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.

Draft

O0250: Influenza Vaccine (cont.)

Examples

1. Resident J received the influenza vaccine in the facility during this year's influenza vaccination season, on January 7, 2014.

   Coding: O0250A would be **coded 1, yes;** O0250B would be **coded 01-07-2014,** and O0250C would be skipped.
   Rationale: Resident J received the vaccine in the facility on January 7, 2014, during this year's influenza vaccination season.

2. Resident R did not receive the influenza vaccine in the facility during this year's influenza vaccination season due to their known allergy to egg protein.

   Coding: O0250A would be **coded 0, no;** O0250B is skipped, and O0250C would be **coded 3, not eligible-medical contraindication.**
   Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Resident R did not receive the vaccine.

3. Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season. Their doctor provided documentation of receipt of the vaccine to the facility to place in Resident T's medical record. They also provided documentation that Resident T was explained the benefits and risks of the influenza vaccine prior to administration.

   Coding: O0250A would be **coded 0, no;** and O0250C would be **coded 2, received outside of this facility.**
   Rationale: Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season.

4. Resident K wanted to receive the influenza vaccine if it arrived prior to their scheduled discharge on October 5th. Resident K was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Resident K did not receive the influenza vaccine in the facility.

   Resident K was encouraged to receive the influenza vaccine at their next scheduled physician visit.

   Coding: O0250A would be **coded 0, no;** O0250B is skipped, and O0250C would be **coded 9, none of the above.**
   Rationale: Resident K was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after their discharge. None of the codes in O0250C, **Influenza vaccine not received, state reason**, are applicable.

DRAFT

O0300: Pneumococcal Vaccine

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0350, Resident's COVID-19 vaccination is up to date

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:

1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Item Rationale

Health-related Quality of Life

- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates.
- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive pneumococcal disease or its complications, i.e., those 65 years of age and older with certain medical conditions, should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include decreased immune function; damaged or no spleen; sickle cell and other hemoglobinopathies; cerebrospinal fluid (CSF) leak; cochlear implants; and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking.

Steps for Assessment

1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if they received any pneumococcal vaccines 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.

DRAFT

O0300: Pneumococcal Vaccine (cont.)

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.

Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?

- **Code 0, no:** if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, **If Pneumococcal vaccine not received, state reason**.
- **Code 1, yes:** if the resident's pneumococcal vaccination status is up to date. Skip to O0400, **Therapies**.

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason

If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- **Code 1, Not eligible:** if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.
- **Code 2, Offered and declined:** resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- **Code 3, Not offered:** resident or responsible party/legal guardian not offered the pneumococcal vaccine.

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

Draft

O0300: Pneumococcal Vaccine (cont.)

- If a resident has received one or more pneumococcal vaccinations 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.

Examples

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

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

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

2. Resident B, who is 95 years old, has never received a pneumococcal vaccine. Their physician has an order stating that they are NOT to be immunized.

   Coding: O0300A would be **coded 0, no**; and O0300B would be **coded 1, not eligible.**

   Rationale: Resident B has never received the pneumococcal vaccine; therefore, their vaccine is not up to date. Their physician has written an order for them not to receive a pneumococcal vaccine, thus they are not eligible for the vaccine.

3. Resident A, who has congestive heart failure, received PPSV23 vaccine at age 62 when they were hospitalized for a broken hip. They are now 78 years old and were admitted to the nursing home one week ago for rehabilitation. They were offered and given PCV13 on admission.

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

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

4. Resident T, who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when they were living in a congregate care community. They are now 64 years old and are being admitted to the nursing home for chemotherapy and respite care. They have not been offered any additional pneumococcal vaccines.

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

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

DRAFT

O0350: Resident's COVID-19 vaccination is up to date

O0350. Resident's COVID-19 vaccination is up to date

Enter Code ☐

0. **No,** resident is not up to date
1. **Yes,** resident is up to date

Item Rationale

Health-related Quality of Life

- *The intent of this item is to report if a person is up to date with their COVID-19 vaccine status.*
- *Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81 percent of U.S. COVID-19-related deaths.*
- *Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, or ventilator support for breathing, or may even die.*

Planning for Care

- *A strong infection prevention and control program is vital to protect both patients and healthcare personnel.*
- *Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and patients from Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection.*
- *COVID-19 vaccines currently approved or authorized by the U.S. Food & Drug Administration are effective in reducing the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death.*
- *Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain an important strategy for preventing illnesses, hospitalizations, and deaths from COVID-19.*
- *A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems from the COVID-19 vaccine are very rare. More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the CDC webpage "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States" at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications.*

DRAFT

O0350: Resident's COVID-19 vaccination is up to date (cont.)

Steps for Assessment

- *Vaccination status may be determined based on information from any available source.*
  - *Review the patient's medical record or documentation of COVID-19 vaccination and/or interview the patient, family or other caregivers or healthcare providers to determine whether the patient is up to date with their COVID-19 vaccine.*
- *If the patient is **not up to date**, and the facility has the vaccine available, ask the patient if they would like to receive the COVID-19 vaccine.*

Coding Instructions

- *Code 0, No, patient is not up to date if the patient does not meet the CDC's definition of up to date.*
  - *This includes patients who have not received one or more recommended COVID-19 vaccine doses **for any reason** including medical, religious, or other qualified exemptions.*
  - *This includes patients for whom vaccination status cannot be determined.*
- *Code 1, Yes, patient is up to date if the patient meets the CDC's definition of up to date.*
- *A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.*

DEFINITION

UP TO DATE for COVID-19 Vaccine

For the definition of "up to date," providers should refer to the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.

Coding Tip

- *Current COVID-19 vaccine recommendations are available on the Centers for Disease Control and Prevention's (CDC's) webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.*

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O0400: Therapies

Section O - Special Treatments, Procedures, and Programs

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

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

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B. Occupational Therapy

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 O0400B5, 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

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

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Month Day Year

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O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

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 O0400C5, 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

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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

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Month Day Year

D. Respiratory Therapy

Enter Number of Minutes ☐☐☐☐

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

Enter Number of Days ☐

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 ☐☐☐☐

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

Enter Number of Days ☐

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 ☐☐☐☐

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 O0420, Distinct Calendar Days of Therapy

Enter Number of Days ☐

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

Draft

O0400: Therapies (cont.)

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

Draft

O0400: Therapies (cont.)

Steps for Assessment

1. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Skip the item if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.

DRAFT

O0400: Therapies (cont.)

- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption, in cases where the resident discontinued and then resumed therapy.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

Coding Tips and Special Populations

- **Therapy Start Date:**
  1. Look at the date at A1600.
  2. Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.
  3. If so, enter the date that the therapy regimen started; if there was more than one therapy regimen since the A1600 date, enter the start date of the most recent therapy regimen.
- 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.

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O0400: Therapies (cont.)

Minutes of Therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.
- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted, except in the case of an interrupted stay.
- In the case of an interrupted stay, the therapy start date entered in O0400A5, O0400B5, and/or O0400C5 must reflect a date on or after the date in A2400B. Although the therapy start date occurred prior to the interrupted stay, the data specifications only accept a therapy start date that is on or after the date entered in A2400B.
- The therapist's time spent on documentation or on initial evaluation is not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- Family education when the resident is present is counted and must be documented in the resident's record.
- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- 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.

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O0400: Therapies (cont.)

- Set-up time shall be recorded under the mode for which the resident receives initial treatment when they receive more than one mode of therapy per visit.
  - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
  - Code as concurrent minutes when the resident receives only concurrent therapy or concurrent therapy followed by another mode(s); and
  - Code as group minutes when the resident receives only group therapy or group therapy followed by another mode(s).
- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services **must** meet **all** of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):
  - for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
  - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
  - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
  - the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
  - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
  - the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable, and they must be furnished by qualified personnel.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if they are under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.

O0400: Therapies (cont.)

- Record the actual minutes of therapy. **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute**. The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
- When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.
- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
  - the physician orders the therapy;
  - the physician's order includes a statement of frequency, duration, and scope of treatment;
  - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - the services must be reasonable and necessary for treatment of the resident's condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 **Therapies**, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident's medical record.

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O0400: Therapies (cont.)

- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies**. The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

Co-treatment

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. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of two to six participants who were doing the same or similar activities in each discipline. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

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.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for their services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.

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O0400: Therapies (cont.)

Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

Therapy Students

Medicare Part A—Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (**Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed.

Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

- Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
  - The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
  - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
  - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
  - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.

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O0400: Therapies (cont.)

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look-back period for an MDS assessment).

Individual Therapy

The treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the resident individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals **and** they are able to immediately intervene/assist the student as needed.

Example:

- A speech therapy graduate student treats Resident A for 30 minutes. Resident A's therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Resident A. Resident A's therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy

Medicare Part A

The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

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O0400: Therapies (cont.)

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

Medicare Part B

- The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment

Examples:

- A physical therapist provides therapies that are not the same or similar, to Resident Q and Resident R at the same time, for 30 minutes. Resident Q's stay is covered under the Medicare SNF PPS Part A benefit. Resident R is paying privately for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident Q received concurrent therapy for 30 minutes.
  - Resident R received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar to Resident S and Resident T at the same time, for 30 minutes. Resident S's stay is covered under the Medicare SNF PPS Part A benefit. Resident T's therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident S received concurrent therapy for 30 minutes.
  - Resident T received group therapy (Medicare Part B definition) for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)

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O0400: Therapies (cont.)

- An Occupational Therapist provides therapy to Resident K for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Resident R at the same time for the same 60 minutes but Resident K and Resident R are not doing the same or similar activities. Both Resident K and Resident R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident K received concurrent therapy for 60 minutes.
  - Resident R received concurrent therapy for 60 minutes.

Group Therapy

Medicare Part A

The treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B

The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

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O0400: Therapies (cont.)

Examples:

- A Physical Therapist provides similar therapies to Resident W, Resident X, Resident Y and Resident Z at the same time, for 30 minutes. Resident W and Resident X's stays are covered under the Medicare SNF PPS Part A benefit. Resident Y's therapy is covered under Medicare Part B, and Resident Z has private insurance paying for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident W received group therapy for 30 minutes.
  - Resident X received group therapy for 30 minutes.
  - Resident Y received group therapy for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
  - Resident Z received group therapy for 30 minutes.
- Resident V, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with Resident S, whose therapy is covered by Medicare Part B, while Resident V continues with their skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to Resident V and Resident S for 24 minutes who are not performing the same or similar activities, at which time Resident V's therapy session ends. The therapist continues to treat Resident S individually for 10 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident V received individual therapy for 13 minutes and concurrent therapy for 24.
  - Resident S received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- Resident A and Resident B, whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Resident A and Resident B are joined by Resident T and Resident E, whose stays are also covered by Medicare Part A, and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Resident A becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Resident A received concurrent therapy for 30 minutes and group therapy for 15 minutes.
  - Resident B received concurrent therapy for 30 minutes and group therapy for 30 minutes.
  - Resident T received group therapy for 30 minutes.
  - Resident E received group therapy for 30 minutes.

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O0400: Therapies (cont.)

Therapy Modalities

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the resident's plan of care.

Dates of Therapy

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident's episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. 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.

For example, Resident N was admitted to the nursing home following a fall that resulted in a hip fracture in November 2019. Occupational and Physical therapy started December 3, 2019. Their physical therapy ended January 27, 2020 and occupational therapy ended January 29, 2020. Later on during their stay at the nursing home, due to the progressive nature of their Parkinson's disease, they were referred to SLP and OT February 10, 2020 (they remained in the facility the entire time). The speech-language pathologist evaluated them on that day and the occupational therapist evaluated them the next day. The ARD for Resident N's MDS assessment is February 28, 2020. Coding values for their MDS are:

- O0400A5 (SLP start date) is 02102020,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112020,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032019, and
- O0400C6 (PT end date) is 01272020.

O0400: Therapies (cont.)

General Coding Example:

Following a stroke, Resident F was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/19 under Part A skilled nursing facility coverage. They had slurred speech, difficulty swallowing, severe weakness in both their right upper and lower extremities, and a Stage 3 pressure ulcer on their left lateral malleolus. They were referred to SLP, OT, and PT with the long-term goal of returning home with their child and child's spouse. Their initial SLP evaluation was performed on 10/06/19, the PT initial evaluation on 10/07/19, and the OT initial evaluation on 10/09/19. They were also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/13/19 was an appropriate ARD for their 5-Day assessment. During the look-back period they received the following:

Speech-language pathology services that were provided over the 7-day look-back period:

- Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

  Coding:

  O0400A1 would be **coded 190;** O0400A2 would be **coded 70;** O0400A3 would be **coded 75;** O0400A4 would be **coded 5;** O0400A5 would be **coded 10062019;** and O0400A6 would be **coded with dashes**.

  Rationale:

  Individual minutes totaled 190 over the 7-day look-back period [(30 × 5) + (20 × 2) = 190]; concurrent minutes totaled 70 over the 7-day look-back period (35 × 2 = 70); and group minutes totaled 75 over the 7-day look-back period (25 × 3 = 75). Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2019, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.

  Coding:

  O0400B1 would be **coded 113,** O0400B2 would be **coded 0,** O0400B3 would be **coded 80**, O0400B3A would be **coded 60**, O0400B4 would be **coded 5**, O0400B5 would be **coded 10092019**, and O0400B6 would be **coded with dashes**.

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O0400: Therapies (cont.)

Rationale:
Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 2) + 23 + 18 + 12 = 113]; concurrent minutes totaled 0 over the 7-day look-back period (0 × 0 = 0); and group minutes totaled 80 over the 7-day look-back period (20 × 4 = 80). Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2019 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

Coding:
O0400C1 would be **coded 287,** O0400C2 would be **coded 100,** O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 10072019**, and O0400C6 would be **coded with dashes**.

Rationale:
Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 0 = 0). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2019, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

- Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

Coding:
O0400D1 would be **coded 50,** O0400D2 would be **coded 0**.

Rationale:
Total minutes were 50 over the 7-day look-back period (10 × 5 = 50). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.

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O0400: Therapies (cont.)

Psychological therapy services that were provided over the 7-day look-back period:

- Psychological therapy services were not provided at all over the 7-day look-back period.
  Coding:
  O0400E1 would be **coded 0,** O0400E2 would be **left blank**.
  Rationale:
  There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

Recreational therapy services that were provided over the 7-day look-back period:

- Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.
  Coding:
  O0400F1 would be **coded 90,** O0400F2 would be **coded 3**.
  Rationale:
  Total minutes were 90 over the 7-day look-back period (30 × 3 = 90). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

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O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes: 190

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: 70

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: 75

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: 0

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: 5

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

10 - 06 - 2019
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

B. Occupational Therapy

Enter Number of Minutes: 113

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: 0

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: 80

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 O0400B5, Therapy start date

Enter Number of Minutes: 60

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: 5

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

10 - 09 - 2019
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

O0400 continued on next page

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O0400: Therapies (cont.)

Section O - Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes: 287

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: 100

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: 0

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 O0400C5, Therapy start date

Enter Number of Minutes: 60

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: 5

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

10 - 07 - 2019
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

D. Respiratory Therapy

Enter Number of Minutes: 50

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

Enter Number of Days: 0

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

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

Enter Number of Days:

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: 90

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 O0420, Distinct Calendar Days of Therapy

Enter Number of Days: 3

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

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O0420: Distinct Calendar Days of Therapy

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.

Item Rationale

To 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.

Coding Instructions

Enter 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. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Resident T received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Resident T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the last 7 days. Given the therapy services received by Resident T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).
- Example 2: Resident F received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Resident F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the last 7 days. Finally, Resident F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Resident F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0425: Part A Therapies

Section O - Special Treatments, Procedures, and Programs

O0425. Part A Therapies

Complete only if A0310H = 1

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

Enter Number of Minutes

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

B. Occupational Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy

Enter Number of Minutes

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

C. Physical Therapy

Enter Number of Minutes

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

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** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy

Enter Number of Minutes

4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days

5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

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O0425: Part A Therapies (cont.)

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

Planning for Care

- Except in the case of an interrupted stay, code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist as allowable under state licensure laws) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- In the case of an interrupted stay, code medically necessary therapies that occurred during the entire current Medicare Part A PPS stay that meet the above-noted criteria.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

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O0425: Part A Therapies (cont.)

Steps for Assessment

1. Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1, Yes.
2. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

   NOTE: The look-back period for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay. Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each resident as a percentage of all therapies provided to that resident, by discipline. If the combined amount of group and concurrent therapy provided, by discipline, exceeds 25 percent, then this would be deemed as non-compliance and a warning message would be received on the Final Validation Report.

   Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

   - Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)
   - Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2+O0425X3)
   - Step 3: Concurrent/Group Ratio (Step 2 result/Step 1 result)
   - Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.

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O0425: Part A Therapies (cont.)

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time. (For detailed definitions and examples of individual therapy, refer to O0400 above.)
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. (For detailed definitions and examples of concurrent therapy, refer to item O0400 above.)
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. (For detailed definitions and examples of group therapy, refer to item O0400 above.)
- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). Skip the item if none were provided. (For detailed definitions and examples of co-treatment, refer to item O0400 above.)
- **Speech-Language Pathology Days**—Enter the number of days speech-language pathology therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

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O0425: Part A Therapies (cont.)

- **Occupational Therapy Days—**Enter the number of days occupational therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.
- **Physical Therapy Days**—Enter the number of days physical therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

Coding Tips and Special Populations

- For detailed descriptions of how to code minutes of therapy and explanation of skilled versus nonskilled therapy services, co-treatment, therapy aides and students, please refer to these topic headings in the discussion of item O0400 above.

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. These modes are individual, concurrent and group therapy. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look-back period for an MDS assessment).

Individual Therapy

For a detailed definition and example of individual therapy, please refer to the discussion of item O0400 above.

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O0425: Part A Therapies (cont.)

Concurrent Therapy

For a detailed definition and example of concurrent therapy, please refer to the discussion of item O0400 above.

Group Therapy

For a detailed definition and example of group therapy, please refer to the discussion of item O0400 above.

Therapy Modalities

For a detailed definition and explanation of therapy modalities, please refer to the discussion of item O0400 above.

General Coding Example:

Following a bilateral knee replacement, Resident G was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on Sunday 10/06/19 under Part A skilled nursing facility coverage. While in the hospital, they exhibited some short-term memory difficulties specifically affecting orientation. They were non-weight bearing, had reduced range of motion, and had difficulty with ADLs. They were referred to SLP, OT, and PT with the long-term goal of returning home with their spouse. Their initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. They were also referred to recreational therapy. They were in the SNF for 14 days and were discharged home on 10/19/2019. Resident G received the following rehabilitation services during their stay in the SNF.

Speech-language pathology services that were provided over the SNF stay:

- Individual cognitive training; six sessions for 45 minutes each day.
- Discharged from SLP services on 10/14/2019.

  Coding:

  O0425A1 would be **coded 270;** O0425A2 would be **coded 0;** O0425A3 would be **coded 0;** O0425A4 would be **coded 0;** O0425A5 would be **coded 6**.

  Rationale:

  Individual minutes totaled 270 over the stay (45 minutes × 6 days); concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 0 over the stay (0 × 0 = 0). Therapy was provided 6 days of the stay.

Occupational therapy services that were provided over the SNF stay:

- Individual ADL activities daily for 30 minutes each starting 10/08/19.
- Co-treatment: seating and transferring with PT; three sessions for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities: 10 sessions for 20 minutes each session in a group.

O0425: Part A Therapies (cont.)

- Discharged from OT services on 10/19/19.
  Coding:
  O0425B1 would be **coded 413**, O0425B2 would be **coded 0**, O0425B3 would be **coded 200**, O0425B4 would be **coded 53**, O0425B5 would be **coded 12**.
  Rationale:
  Individual minutes (including 53 co-treatment minutes) totaled 413 over the stay [(30 × 12) + 53 = 413]; concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 200 over the stay (20 × 10 = 200). Therapy was provided 12 days of the stay.

Physical therapy services that were provided over the stay:

- Individual mobility training daily for 45 minutes per session starting 10/07/19.
- Group mobility training for 30 minutes Tuesdays, Wednesdays, and Fridays.
- Co-treatment seating and transferring for three sessions with OT for 7 minutes, 22 minutes, and 18 minutes.
- Concurrent therapeutic exercises Monday-Friday for 20 minutes each day.
- Discharged from PT services on 10/19/19.
  Coding:
  O0425C1 would be **coded 632,** O0425C2 would be **coded 200,** O0425C3 would be **coded 180**, O0425C4 would be **coded 47**, O0425C5 would be **coded 13**.
  Rationale:
  Individual minutes (including 47 co-treatment minutes) totaled 632 over stay [(45 × 13) + (7 + 22 + 18) = 632]; concurrent minutes totaled 200 over the stay (20 × 10 = 200); and group minutes totaled 180 over the stay (30 × 6 = 180). Therapy was provided 13 days of the stay.

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O0430: Distinct Calendar Days of Part A Therapy

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

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 since the start date of the resident's most recent Medicare Part A stay (A2400B)

Item Rationale

To 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 during the Part A SNF stay.

Coding Instructions

Enter 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 during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C). If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding item O0430. Consider the following example:

Example: Resident T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18. They received 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay. Resident T also received 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay. Given the therapy services received by Resident T during the stay, item **O0430 would be coded as 12** because therapy services were provided for at least 15 minutes on 12 distinct calendar days during the stay (i.e., every Monday, Tuesday, Wednesday, and Friday).

O0500: Restorative Nursing Programs

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

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.

Planning for Care

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- A resident may be started on a restorative nursing program when they are admitted to the facility with restorative needs, but are not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

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O0500: Restorative Nursing Programs (cont.)

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:
   - Measurable 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.
   - 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.
   - 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 or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies and O0425, Part A Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
   - This category does not include groups with more than four residents per supervising helper or caregiver.

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O0500: Restorative Nursing Programs (cont.)

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A or O0425A, **Occupational Therapy** item O0400B or O0425B, and **Physical Therapy** item O0400C or O0425C.
- 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

Activities provided by restorative nursing staff.

- **O0500A, Range of Motion (Passive)**

  Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- **O0500B, Range of Motion (Active)**

  Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.

- **O0500C, Splint or Brace Assistance**

  Code 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. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

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O0500: Restorative Nursing Programs (cont.)

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

- **O0500D, Bed Mobility**

  Code 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 themself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500E, Transfer**

  Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500F, Walking**

  Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500G, Dressing and/or Grooming**

  Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500H, Eating and/or Swallowing**

  Code 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. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500I, Amputation/ Prosthesis Care**

  Code 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. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

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O0500: Restorative Nursing Programs (cont.)

- **O0500J, Communication**

  Code 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. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Coding Tips and Special Populations

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), 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. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

DRAFT

O0500: Restorative Nursing Programs (cont.)

Examples

1. Resident V has lost range of motion in their right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. They have moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to their right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to their right arm, wrist, and hand three times per day. The nurse's aides and Resident V's spouse have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in Resident V's care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse's aides report that there is less resistance in Resident V's affected extremity when bathing and dressing them.

   Coding: Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be **coded 7.**
   Rationale: Because this was the number of days these restorative nursing techniques were provided.

2. Resident R's right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, their physician diagnosed them with right shoulder impingement syndrome. Resident R was given exercises to perform on a daily basis to help improve their right shoulder ROM. After initial training in these exercises by the physical therapist, Resident R and the nursing staff were provided with instructions on how to cue and sometimes actively assist Resident R when they cannot make the full ROM required by the exercises on their own. Their exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in Resident R's medical record. The nursing staff cued and sometimes actively assisted Resident R two times daily over the past 7 days.

   Coding: Range of motion (active) item (O0500B), would be **coded 7.**
   Rationale: Because this was the number of days restorative nursing training and skill practice for active ROM were provided.

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O0500: Restorative Nursing Programs (cont.)

3. Resident K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, they had difficulty moving themself in bed and were dependent for transfers. To prevent further deterioration and increase their independence, the nursing staff implemented a plan on the second day following admission to teach them how to move themself in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in Resident K's medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the 5 days Resident K has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, their endurance and strength have improved, and they require only substantial/maximal assistance for transferring. Each day the amount of time to provide this nursing restorative intervention has been decreasing, so that for the past 5 days, the average time is 45 minutes.

   Coding: Both **Bed Mobility** item (O0500D), **Transfer** item (O0500E)**,** would be **coded 5.**
   Rationale: Because this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.

4. Resident D is receiving training and skill practice in walking using a quad cane. Together, Resident D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Resident D with the instruction and guidance they need to achieve the goals. They have three scheduled times each day where they learn how to walk with their quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

   Coding: Walking item (O0500F), would be **coded 7.**
   Rationale: Because this was the number of days that restorative nursing skill and practice training for walking was provided.

5. Resident J had a CVA less than a year ago resulting in left-sided hemiplegia. Resident J has a strong desire to participate in their own care. Although they cannot dress themself independently, they are capable of participating in this activity of daily living. Resident J's overall care plan goal is to maximize their independence in ADLs. A plan, documented on the care plan, has been developed to assist Resident J in how to maintain the ability to put on and take off their shirt with no physical assistance from the staff. All of their shirts have been adapted for front closure with hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide Resident J as they put on and takes off their shirt to enhance their efficiency and maintain their level of function. It takes approximately 20 minutes per day for Resident J to complete this task (dressing and undressing).

   Coding: Dressing or Grooming item (O0500G), would be **coded 7.**
   Rationale: Because this was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.

O0500: Restorative Nursing Programs (cont.)

6. Resident W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration attempts to promote their independence in feeding themself, they will not eat unless they are fed.

   Coding: Eating and/or Swallowing item (O0500H), would be **coded 0.**
   Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

7. Resident E has Amyotrophic Lateral Sclerosis. They no longer have the ability to speak or even to nod their head "yes" or "no." Their cognitive skills remain intact, they can spell, and they can move their eyes in all directions. The speech-language pathologist taught both Resident E and the nursing staff to use a communication board so that Resident E could communicate with staff. The communication board has been in use over the past 2 weeks and has proven very successful. The nursing staff, volunteers, and family members are reminded by a sign over Resident E's bed that they are to provide them with the board to enable Resident E to communicate with them. This is also documented in Resident E's care plan. Because the teaching and practice using the communication board had been completed 2 weeks ago and Resident E is able to use the board to communicate successfully, they no longer receive skill and practice training in communication.

   Coding: Communication item (O0500J), would be **coded 0**.
   Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

Draft

SECTION P: RESTRAINTS AND ALARMS

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.

Are Restraints Prohibited by CMS?

CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirements for restraint use. These requirements, as well as those related to alarms and their relevant definitions, are available in Appendix PP of the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.10(e)(1) and 483.12). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use.

DEFINITION

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).

Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom(s), the nursing home is responsible for assessing the appropriateness of that restraint. When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use.

While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule.

P0100: Physical Restraints

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

Item Rationale

Health-related Quality of Life

- Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers.
- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. In many cases, the risk of using the physical restraint may be greater than the risk of it not being used.
- The risk of restraint-related injury and death is significant when physical restraints are used.

Planning for Care

- When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues.

DRAFT

P0100: Physical Restraints (cont.)

- When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected.
- Care planning must focus on preventing the adverse effects of physical restraint use.

Steps for Assessment

1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) 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 their 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 their own body.
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.
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,
   - a physician's order for the type of restraint and parameters of use, and
   - a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

DRAFT

P0100: Physical Restraints (cont.)

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 their 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.
- **"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.**
- The identification of medical symptoms should assist the nursing home in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The nursing home should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a physical restraint is employed to treat the medical symptom, protect the resident's safety, help the resident attain or maintain their highest level of physical or psychological well-being and support the resident's goals, wishes, independence, and self-direction.
- **Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom**.
- Physical restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring themself or others and/or to prevent the resident from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist.

P0100: Physical Restraints (cont.)

- Therefore, a clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom. If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint must be documented in the resident's medical record, ongoing assessments, and care plans. There also must be a physician's order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint. CMS will hold the nursing home ultimately accountable for the appropriateness of that determination.

Coding Instructions

Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:

- **Code 0, not used:** if the item was not used during the 7-day look-back period **or** it was used but did not meet the definition.
- **Code 1, used less than daily:** if the item met the definition and was used less than daily during the observation period.
- **Code 2, used daily:** if the item met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other. These devices, although not coded on the MDS, must be assessed, care-planned, monitored, and evaluated.
- In classifying any manual method or physical or mechanical device, material or equipment as 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 them.
- 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.

Draft

P0100: Physical Restraints (cont.)

- **Bed rails** include 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 (quarter-, half- or three-quarter, one or both, etc.) 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.

    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 their 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 their 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.

DRAFT

P0100: Physical Restraints (cont.)

- **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.
- **Restraints used in emergency situations.** If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR 483.10(c)(6) and 483.21(b)(ii)(A)–(F) respectively. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.
  - A resident who is injuring themself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places them or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

Additional Information

- **Restraint reduction/elimination.** It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.

DRAFT

P0100: Physical Restraints (cont.)

- **Restraints as a fall prevention approach.** Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- **Request for restraints.** While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.

  According to 42 CFR 483.10(e)(1) and 483.12, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom(s) the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a resident, legal surrogate or representative's request or approval." The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

DRAFT

P0200: Alarms

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

Item Rationale

Health-related Quality of Life

- 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.
- 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.

Draft

P0200: Alarms (cont.)

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.

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 themself due to fear of setting off the alarm?

Coding Instructions

Identify all alarms that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:

- **Code 0, not used:** if the device was not used during the 7-day look-back period.
- **Code 1, used less than daily:** if the device was used less than daily.
- **Code 2, used daily:** if the device was used on a daily basis during the look-back period.

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.

DRAFT

P0200: Alarms (cont.)

- **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 by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the 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.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- 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.
- Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the resident appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.
- 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 by or attached to the resident and/or their 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 or alerts the staff.
- 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 available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

DRAFT

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: Interviewing the resident or designated individuals places the resident or their family at the center of decision-making. The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. This may not be a nursing home. This is also a civil right for all residents.

Q0110: Participation in Assessment and Goal Setting



Q0110. Participation in Assessment and Goal Setting

Identify all active participants in the assessment process

↓	Check all that apply
☐	A. Resident
☐	B. Family
☐	C. Significant other
☐	D. Legal guardian
☐	E. Other legally authorized representative
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process and in development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.24 Quality of Life).

DEFINITION

RESIDENT'S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspectives during assessment.

Draft

Q0110: Participation in Assessment and Goal Setting (cont.)



- During the care planning meetings, the resident should be made comfortable and verbal communication should be directly with them.
- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.
- If the individual resident is unable to understand the process, their family member, significant other, and/or guardian/legally authorized representative, who represents the individual, should be invited to attend the assessment process whenever possible.
- When the resident is unable to participate in the assessment process, a family member or significant other, and/or guardian or legally authorized representatives can provide information about the resident's needs, goals, and priorities on the resident's behalf.

DEFINITIONS

FAMILY OR SIGNIFICANT OTHER
A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not include staff at the nursing home.

GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE
A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Steps for Assessment

1. Review the clinical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.
2. Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if they actively participated in the assessment process.
3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

Coding Instructions for Q0110, Participation in Assessment and Goal Setting

Record the participation of all those who participated in the assessment process. Check all that apply.

- **Code A, Resident:** if the resident actively participated in the assessment process.
- **Code B, Family:** if a member of the resident's family actively participated in the assessment process.
- **Code C, Significant other:** if a significant other of the resident actively participated in the assessment process.
- **Code D, Legal guardian:** if a legal guardian actively participated in the assessment process.

DRAFT

Q0110: Participation in Assessment and Goal Setting (cont.)

- **Code E, Other legally authorized representative:** if a legally authorized representative actively participated in the assessment process.
- **Code Z, None of the above:** if none of the above actively participated in the assessment process.

Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if they are able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.
- Significant other does not include nursing home staff.

Q0310: Resident's Overall Goal

Q0310. Resident's Overall Goal

Complete only if A0310E = 1

A. Resident's overall goal for discharge established during the assessment process

Enter Code ☐

1. Discharge to the community
2. Remain in this facility
3. Discharge to another facility/institution
9. Unknown or uncertain

B. Indicate information source for Q0310A

Enter Code ☐

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Item Rationale

This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about their own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet their individual long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

Some residents have very clear and directed expectations that will change little prior to discharge. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

Draft

Q0310: Resident's Overall Goal (cont.)

Health-related Quality of Life

- Unless the residents' goals for care are understood, their needs, goals, and priorities are not likely to be met.

Planning for Care

- The resident's goals should be the basis for care planning.
- Great progress has been made in this area. This progress allows individuals more choices when it comes to care options and available support options to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U.S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.

DEFINITION

DISCHARGE
To release from nursing home care. Can be to home, another community setting, or a healthcare setting.

Steps for Assessment

1. Ask the resident about their overall expectations and goals to be sure that they have participated in the assessment process and have an understanding of their current situation and the implications of choices such as returning home or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting.
2. Ask the resident to consider their current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services and supports in the community.
3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what their expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative, may also be recorded in the clinical record.
5. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response. If the resident is unable to communicate their preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.
6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about their goals, the response selected must reflect the resident's perspective if they are able to express it.
7. In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

Draft

Q0310: Resident's Overall Goal (cont.)

Coding Instructions for Q0310A, Resident's overall goal for discharge established during the assessment process

Record the resident's expectations as expressed by them. It is important to document their expectations.

- **Code 1, Discharge to the community:** if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- **Code 2, Remain in this facility:** if the resident indicates that they expect to remain in the nursing home.
- **Code 3, Discharge to another facility/institution:** if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- **Code 9, Unknown or uncertain:** if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.

Coding Tips

- The response to this item should be individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations, not whether or not the staff considers them to be realistic. Coding other than the resident's stated expectation is a violation of the resident's civil rights.
- Q0310A, Code 1 "Discharge to the community" may include newly admitted residents with a facility-arranged discharge plan or those residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1, Yes).
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive, e.g., "do not resuscitate" (DNR).
- The resident should be provided options, as well as access to information that allows them to make the decision and to be supported in directing their care planning.

DEFINITION

DESIGNATED LOCAL CONTACT AGENCY (LCA)

Each state has community contact agencies that can provide individuals with information about community living options and available community-based supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

Draft

Q0310: Resident's Overall Goal (cont.)



- If the resident is unable to communicate their preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. Families, significant others or legal guardians should be consulted as part of the assessment.

Coding Instructions for Q0310B, Indicate information source for Q0310A

- **Code 1, Resident:** if the resident is the source for completing this item.
- **Code 2, Family:** if a family member is the source for completing this item because the resident is unable to respond.
- **Code 3, Significant other:** if a significant other of the resident is the source for completing this item because the resident is unable to respond.
- **Code 4, Legal guardian:** if a legal guardian of the resident is the source for completing this item because the resident is unable to respond.
- **Code 5, Other legally authorized representative:** if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond.
- **Code 9, None of the above:** if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0310A = 9).

Examples

1. Resident F is a 55-year-old married individual who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. They were admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait, and wheelchair mobility training. Resident F is extremely motivated to return home. Their spouse is supportive and has been busy adapting their home to promote their independence. Resident F's goal is to return home once they have completed rehabilitation.

   Coding: Q0310A would be **coded 1, Discharge to the community**.
   Q0310B would be **coded 1, Resident**.

   Rationale: Resident F has clear expectations and a goal to return home.

2. Resident W is a 73-year-old individual who has severe heart failure and renal dysfunction. They also have a new diagnosis of metastatic colorectal cancer and were readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. They rely on nursing staff for all activities of daily living (ADLs). They indicate that they are "strongly optimistic" about their future and only want to think "positive thoughts" about what is going to happen and need to believe that they will return home.

   Coding: Q0310A would be **coded 1, Discharge to the community**.
   Q0310B would be **coded 1, Resident**.

DRAFT

Q0310: Resident's Overall Goal (cont.)



Rationale: Resident W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident's expressed goals.

3. Resident T is a 93-year-old individual with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about their care preferences, they are unable to voice consistent preferences for their own care, simply stating that "It's such a nice day." When their adult child is asked about goals for their parent's care, they state that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the adult child wants care oriented toward making their parent comfortable in their final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs.

   Coding: Q0310A would be **coded 2, Remain in this facility**.
   Q0310B would be **coded 2, Family**.

   Rationale: Resident T does not respond appropriately to the question of their care preferences, but their adult child has clear expectations that their parent will remain in the nursing home where they will be made comfortable for their remaining days.

4. Resident G, an 84-year-old individual with severe dementia, is admitted by their adult child for a 7-day period. Their adult child stated that they "just need to have a break." Their parent has been wandering at times and has little interactive capacity. The adult child is planning to take their parent back home at the end of the week.

   Coding: Q0310A would be **coded 1, Discharge to the community**.
   Q0310B would be **coded 2, Family**.

   Rationale: Resident G is not able to respond but their adult child has clear expectations that their parent will return home at the end of the 7-day respite visit.

5. Resident C is a 72-year-old individual who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, they were diagnosed with moderate dementia and were unable to voice consistent preferences for their own care. They have no living relatives and no significant other who is willing to participate in their care decisions. The court appointed a legal guardian to oversee their care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Resident C's best interest that they be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

   Coding: Q0310A would be **coded 3, Discharge to another facility/institution**.
   Q0310B would be **coded 4, Legal guardian**.

Q0310: Resident's Overall Goal (cont.)



Rationale: Resident C is not able to respond and has no family or significant other available to participate in their care decisions. A court-appointed legal guardian determined that it is in Resident C's best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Resident K is a 40-year-old with cerebral palsy and a learning disability. They lived in a group home 5 years ago, but after a hospitalization for pneumonia they were admitted to the nursing home for respiratory therapy. Although their group home bed is no longer available, they are now medically stable and there is no medical reason why they could not transition back to the community. Resident K states they want to return to the group home. Their legal guardian agrees that they should return to the community to a small group home.

   Coding: Q0310A would be **coded 1, Discharge to the community**
   Q0310B would be **coded 1, Resident**

   Rationale: Resident K understands and is able to respond and says they would like to go back to the group home. Their expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that Resident K is medically stable and would like to go back to the community, the legal guardian confirmed that it is in Resident K's best interest to be transferred to a group home. Small group homes are considered community settings. This information should also be recorded in the individual's clinical record.

Q0400: Discharge Plan

Q0400. Discharge Plan

Enter Code ☐

A. Is active discharge planning already occurring for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0610, Referral

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with LCA experts about returning to the community. Community resources and supports exist that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident's decline and increase the chances for re-hospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

Draft

Q0400: Discharge Plan (cont.)

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.
- The care plan should include the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative, arrangements for durable medical equipment (if needed), formal and informal supports that will be available, the person(s) and provider(s) in the community who will meet the resident's needs, and the place the resident is going to be living.
- Each situation is unique to the resident, their family, and/or guardian/legally authorized representative. A referral to the LCA may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.
- Discharge instructions should include at a minimum:
  - the individuals preferences and needs for care and supports;
    - personal identification and contact information, including Advance Directives;
    - contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - brief medical history;
    - current medications, treatments, therapies, and allergies;
    - arrangements for durable medical equipment;
    - arrangements for housing;
    - arrangements for transportation to follow-up appointments; and
    - contact information at the nursing home if a problem arises during discharge
  - A follow-up appointment with the designated primary care provider in the community and other specialists (as appropriate).
  - Medication education.
  - Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor.
  - Who to call in case of an emergency or if symptoms of decline occur.
  - Nursing home (NH) procedures and discharge planning for sub-acute and rehabilitation community discharges are most often well-defined and efficient.

Draft

Q0400: Discharge Plan (cont.)

— Section Q has broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.

- Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects their wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
- The NH is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with providing information regarding community-based services and, when appropriate, transition services planning. The nursing facility interdisciplinary team and the LCA should work closely together. The LCA is the entity that does the community support planning, (e.g., housing, home modification, setting up a household, transportation, community inclusion planning, etc.). A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line/website or by other state-approved processes. Each state has a process for referral to an LCA, and it is vital to know the process in your state and for your facility. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.
- Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, guardian or significant others concerning a potential return to the community. A thorough review of medical, psychological, functional, and financial information is necessary in order to assess what each individual resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
- Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are more readily available than in the recent past. Resource availability and eligibility coverage varies across States and local communities.
- Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions. However, a referral should not be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.

DRAFT

Q0400: Discharge Plan (cont.)

- Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help them to readjust to community living.
- Use teach-back methods to ensure that the resident understands all of the factors associated with their discharge.
- For additional guidance, see CMS' **Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting**. Available at https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf.

Steps for Assessment

1. A review should be conducted of the care plan, the clinical record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy to consider the resident's discharge planning needs.
2. If the resident is unable to communicate their preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual.
3. Record the resident's expectations as expressed/communicated, whether NH staff believe that they are realistic or not realistic.
4. The resident, their interdisciplinary team, and LCA (when a referral has been made) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).
5. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes).
6. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.

DEFINITION

ACTIVE DISCHARGE PLANNING

An **active** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future.

If there is not an **active** discharge plan, residents should be asked if they want to talk to someone about community living (Q0500B) and then referred to the LCA accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is active discharge planning already occurring for the resident to return to the community?

- **Code 0, No:** if there is not active discharge planning already occurring for the resident to return to the community.
- **Code 1, Yes:** if there is active discharge planning already occurring for the resident to return to the community.

Q0490: Resident's Documented Preference to Avoid Being Asked Question Q0500B

For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, or 99)

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment?

0. **No**
1. **Yes** → Skip to Q0610, Referral

Item Rationale

This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0490 allows them to opt-out of being asked question Q0500B on Quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a Quarterly assessment, then skip to item Q0610, **Referral**. Q0500B is, however, mandatory on all comprehensive assessments.

Note: Let the resident know that they can change their mind about requesting information regarding possible return to the community at *any* time and should be referred to the LCA if they voice this request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0610, continue to item Q0500B.

Q0490: Resident's Documented Preference to Avoid Being Asked Question Q0500B (cont.)

Coding Instructions for Q0490, Does the resident's clinical record document a request that this question (Q0500B) be asked only on comprehensive assessments?

- **Code 0, No:** if there is no notation in the resident's clinical record that they do not want to be asked Question Q0500B.
- **Code 1, Yes:** if there is a notation in the resident's clinical record to not ask Question Q0500B except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0610, **Referral**. If this is a comprehensive assessment, proceed to the next item, Q0500B.

Coding Tips

- Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded "No" to item Q0550A.

If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

Draft

Q0490: Resident's Documented Preference to Avoid Being Asked Question Q0500B (cont.)

Examples

1. Resident G is a 45-year-old individual weighing 300 pounds who is cognitively intact. They have congestive heart failure and shortness of breath requiring oxygen at all times. Resident G also requires 2 person assistance with bathing and transfers to the commode. They were admitted to the NH 3 years ago after their adult child who was caring for them passed away. During their Quarterly assessment, the NH social worker discussed options in which they could be cared for in the community but Resident G refused to consider leaving the NH. During the review of their clinical record, the assessor found that on their last MDS assessment, Resident G stated that they did not want to be asked again about returning to community living, that they have friends in the NH and really like the activities.

   Coding: Q0490 would be **coded 1, Yes, skip to Q0610; because this is a Quarterly assessment.**

   If this was a comprehensive assessment, then proceed to the next item Q0500B.

   Rationale: On their last MDS 3.0 assessment, Resident G indicated their preference to not want to be asked again about returning to community living (0. No on Q0550A).

2. Resident R is an 82-year-old widowed individual with advanced Alzheimer's disease. They have resided at the nursing home for 4½ years and their family requests that they not be interviewed because they become agitated and upset and cannot be cared for by family members or in the community.

   Coding: Q0490 would be **coded 1, Yes, skip to Q0610.**

   If this is a comprehensive assessment proceed to the next item, Q0500B.

   Rationale: Resident R's family requests that they opt out of the return to the community question because they become agitated when asked about return to community. They are only asked with comprehensive assessments.

Draft

Q0500: Return to Community

For Admission, Quarterly, and Annual Assessments.

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

0. **No**
1. **Yes**
9. **Unknown or uncertain**

Enter Code ☐

C. Indicate information source for Q0500B

1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the NH and the LCA to support the resident's expressed interest in talking to someone about the possibility of leaving the facility and returning to live and receive services in the community. The underlying intention of the return to the community item is to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting appropriate for their needs. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. LCAs are experts in available home and community-based service (HCBS) and can provide both the resident and the facility with valuable information.

Health-related Quality of Life

- Returning home or to a non-institutional setting can be beneficial to the residents' health and quality of life.
- This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a civil right to receive services in the least restrictive and most integrated setting.
- Item Q0500B requires that the resident be asked the question directly and formalizes the opportunity for the resident to be informed of and consider their options to return to community living. This ensures that the resident's desire to learn about the possibility of returning to the community will be honored and appropriate follow-up measures will be taken.
- The goal is to obtain the informed choice and preferences expressed by the resident and to provide information about available community supports and services.

Q0500: Return to Community (cont.)

Planning for Care

- Many NH residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.

Steps for Assessment: Interview Instructions

1. At the initial Admission assessment and in subsequent follow-up assessments (as applicable), make the resident comfortable by assuring them that this is a routine question that is asked of all residents.
2. Ask the resident if they would like to speak with someone about the possibility of returning to live and receive services in the community. Inform the resident that answering yes to this item signals the resident's request for more information and will initiate a contact by someone with more information about supports available for living in the community. A successful transition will depend on the resident's preferences and choices and the services, settings, and sometimes family supports that are available. In many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Answering yes ***does not*** commit the resident to leaving the NH at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that they can change their decision (i.e., whether or not they want to speak with someone) at ***any*** time.
3. Explain that this item is meant to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care. This step will help the resident clarify their discharge goals and identify important information for the LCA or, in some instances may indicate that the resident does not want to be referred to the LCA at this time. Also explain that the resident can change their mind at ***any*** time.
4. If the resident is unable to communicate their preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others are not available, a guardian or legally authorized representative, if one exists, can provide the information.
5. Ask the resident if they want information about different kinds of supports that may be available to support community living. Responding **"yes"** will be a way for the individual—and their family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living. It is simply a request for information, not a request for discharge.

DRAFT

Q0500: Return to Community (cont.)



Coding Instructions for Q0500B, **Ask the resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"**

A response code of 1, Yes, for this item indicates a desire to learn about home and community based services, it is not a request for discharge.

- **Code 0, No:** if the resident (or family or significant other, or guardian or legally authorized representative) states that they **do not** want to talk to someone about the possibility of returning to live and receive services in the community.
- **Code 1, Yes:** if the resident (or family or significant other, or guardian or legally authorized representative) states that they **do** want to talk to someone about the possibility of returning to live and receive services in the community.
- **Code 9, Unknown or uncertain:** if the resident cannot understand or respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Coding Instructions for Q0500C, Indicate information source for Q0500B

- **Code 1, Resident:** if the resident is the source for completing this item.
- **Code 2, Family:** if a family member is the source for completing this item because the resident is unable to respond.
- **Code 3, Significant other:** if a significant other of the resident is the source for completing this item because the resident is unable to respond.
- **Code 4, Legal guardian:** if a legal guardian of the resident is the source for completing this item because the resident is unable to respond.
- **Code 5, Other legally authorized representative:** if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond.
- **Code 9, None of the above:** if the resident cannot respond and the family, significant other, guardian, or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0310A = 9).

Draft

Q0500: Return to Community (cont.)

Coding Tips

- A "yes" response to item Q0500B will trigger follow-up care planning and contact with the facility's designated LCA.
- Follow-up by the LCA is expected in a "reasonable" amount of time. Each state has its own policy for follow-up. It is important to know your state's policy. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face-to-face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.
- Some residents will have a very clear expectation and some may change their expectations over time. Residents may also be unsure or unaware of the opportunities available to them for community living with needed services and supports.
- The SNF/NH should not assume that the resident cannot transition out of the SNF/NH due to their level of care needs. The SNF/NH and the resident should talk with the LCA to see what options are available for living and receiving services in the community.
- Return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the resident's documented level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian and/or legally appointed decision-maker for that individual should be asked the question.
- When Q0500B is answered 1 or 9, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.

Draft

Q0500: Return to Community (cont.)

Examples

1. Resident B is an 82-year-old individual with COPD. They were referred to the NH by their physician for end-of-life palliative care. They responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Resident B is afraid and explain that obtaining more information may help overcome some of their fears. They should also be informed that someone from an LCA is available to provide them with more information about receiving services and supports in the community. At the close of this discussion, Resident B says that they would like more information on community supports.

   Coding: Q0500B would be **coded 1, Yes**.

   Rationale: Coding Q0500B as yes should trigger a visit by the NH social worker to assess fears and concerns, as well as the designated LCA within a specified time frame established according to state policy.

2. Resident C is a 45-year-old individual with cerebral palsy and a learning disability who has been living in the facility for the past 20 years. They once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Resident C was sent to the NH because they required regular chest physical therapy and were told that they could no longer live in their previous group home because their needs were more intensive. No one had asked them about returning to the community until now. When administered the MDS assessment, they responded yes to item Q0500B.

   Coding: Q0500B would be **coded 1, Yes**.

   Rationale: Resident C's discussions with staff in the NH should be noted in their care plan, and care planning should be initiated to assess their preferences and needs for possible transition to the community. NH staff should contact the designated LCA according to established state guidelines, for them to initiate discussions with Resident C about options for returning to community living.

3. Resident D is a 65-year-old individual with a severe heart condition and interstitial pulmonary fibrosis. At the last Quarterly assessment, Resident D had been asked about returning to the community and their response was no. They also responded no to item Q0500B. The assessor should ask why they responded no. Depending upon this response, follow-up questions could include, "Is it that you think you cannot get the care you need in the community? Do you have a home to return to? Do you have any family or friends to assist you in any way?" Resident D responds no to the follow-up questions and does not want to offer any more information or talk about it any further.

   Coding: Q0500B would be **coded 0, No**.

   Rationale: During this assessment, they were asked about returning to the community and they responded no.

DRAFT

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B

Enter Code ☐

A. Does resident (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone)

0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment
1. **Yes**
8. **Information not available**

Enter Code ☐

C. Indicate information source for Q0550A

1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, Does the resident (or family or significant other or guardian or legally authorized representative only if resident is unable to understand or respond) want to be asked about returning to the community on all assessments? (Rather than on comprehensive assessments alone)

- **Code 0, No:** if the resident (or family or significant other, or guardian or legally authorized representative) states that they do not want to be asked again on Quarterly assessments about returning to the community. In this case, document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- **Code 1, Yes:** if the resident (or family or significant other, or guardian or legally authorized representative) states that they do want to be asked the return to community question, Q0500B, on all assessments.
- **Code 8, Information not available:** if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

DRAFT

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B (cont.)

Coding Instructions for Q0550C, Indicate information source for Q0550A

- **Code 1, Resident:** if resident responded to Q0550A.
- **Code 2, Family.**
- **Code 3, Significant other.**
- **Code 4, Legal guardian.**
- **Code 5, Other legally authorized representative.**
- **Code 9, None of the above.**

Example

1. Resident W is an 81-year-old individual who was admitted after a fall that broke their hip, wrist and collar bone. Their recovery is slow and their family visits regularly. Their apartment is awaiting them and they hope within the next 4–6 months to be discharged home. When asked, resident W stated that they would like to be asked about discharging to the community on all assessments.

   Coding: Q0550A would be **coded 1, Yes.**
   Q0550C would be **coded 1, Resident.**

   Rationale: Resident W responded yes to item Q0550A, indicating they want to be asked about returning to the community on all assessments.

Draft

Q0610: Referral

Q0610. Referral

Enter Code ☐

A. Has a referral been made to the Local Contact Agency (LCA)?

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

Item Rationale

Health-related Quality of Life

- Returning home or transitioning to a non-institutional setting can be very important to the resident's health and quality of life.

Planning for Care

- Some NH residents may be able to return to the community if they are provided assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Coding Instructions for Q0610, Has a referral been made to the Local Contact Agency (LCA)?

- **Code 0, No:** if a referral has not been made.
- **Code 1, Yes:** if a referral has been made. If a referral has been made skip to V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment.

Draft

Q0610: Referral (cont.)

Coding Tips

- State Medicaid Agencies (SMAs) are required to have designated LCA and a State point of contact (POC). The SMA is responsible for coordinating implementation of Section Q and designating LCAs for their State's SNFs and NHs. These LCAs may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Centers for Independent Living, or other entities the State may designate. LCAs have a Data Use Agreement (DUA) with the SMA to allow them access to MDS data. It is important that each facility know who their LCA and POC are and how to contact them.
- Resource availability and eligibility varies across States and local communities and may present barriers to allowing some residents to return to their community. The NH and LCA staff members should guard against raising the expectations of residents and their family members of what can occur until more information is obtained.
- Close collaboration between the NH and the LCA is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NH on the available community living situations, and options for community based supports and services including the level and scope of what is possible.
- The LCA team will explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- Resident support and interventions by the NH staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, problems with securing appropriate caregiving supports, community resource gaps, etc., preventing discharge to the community.

Draft

Q0610: Referral (cont.)

Examples

1. Resident S is a 48-year-old individual who suffered a stroke, resulting in paralysis below the waist. They are responsible for their 8-year-old child, who now stays with their grandparent. At the last Quarterly assessment, Resident S had been asked about returning to the community and their response was "Yes" to item Q0500B and they report no contact from the LCA. Resident S is more hopeful they can return home as they become stronger in rehabilitation. They want a location to be able to remain active in their child's school and use accessible public transportation when they find employment. They are worried whether they can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops, appliances, doorways, etc. The social worker documented the resident's responses and made a referral to the LCA.

   Coding: Q0500B would be **coded 1, Yes**;
   Q0610A would be **coded 1, Yes**.

   Rationale: The social worker or discharge planner would make a referral to the designated LCA for their area and Q0610A would be coded as 1, Yes, because a referral to the designated LCA was made.

2. Resident V is an 82-year-old individual with right sided paralysis, mild dementia, and diabetes who was admitted by the family because of safety concerns due to falls and difficulties cooking and proper nutrition. Resident V said no to Q0500B, but that they may wish this information at a later date, expressing their feeling that they are not yet ready to plan for community transition. They need to continue their rehabilitation therapy and regain their strength and ability to transfer. The social worker plans to talk to the resident and their family during future Quarterly assessments to determine whether a referral to the LCA is needed for Resident V to return to the community.

   Coding: Q0610A would be **coded 0, No**.

   Rationale: Resident V indicated that they wanted to have an opportunity to talk to someone about return to community, but that they were not yet ready. The NH staff will focus on their therapies and talk to them and their family to obtain more information for discharge planning in future months. Q0610A would be coded as 0, No. The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated LCA.

DRAFT

Q0620: Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0.

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0

Enter Code ☐

Indicate reason why referral to LCA was not made

1. LCA unknown
2. Referral previously made
3. Referral not wanted
4. Discharge date 3 or fewer months away
5. Discharge date more than 3 months away

Item Rationale

Health-related Quality of Life

- Understanding the reason that referrals to the LCA were not made can help the care team support the resident to receive care that supports them to achieve their highest practicable level of functioning in the least restrictive setting.

Planning for Care

- Understanding the reason that referrals to the LCA were not made allows for comprehensive care planning by the facility team in conjunction with the resident and their family.

Steps for Assessment

1. If Q0610: Referral = 0, No, indicate the primary reason that the referral has not been made to the LCA.

Coding Instructions for Q0620, Reason Referral to Local Contact Agency (LCA) Not Made

- **Code 1, LCA unknown**
- **Code 2, Referral previously made:** if a referral has previously been made to the LCA, which is currently working with the resident and facility staff on an active discharge plan to return to the community.
- **Code 3, Referral not wanted:** if the resident (or family, significant other, legal guardian, or other legally authorized representative **only** if resident doesn't understand or is unable to respond) responded they do not want a referral (Q0500B = 0).
- **Code 4, Discharge date 3 or fewer months away:** if the resident has an expected discharge date of three (3) months or fewer, has an active discharge plan in progress, and the discharge plan could not be improved upon with a referral to the LCA.
- **Code 5, Discharge date more than 3 months away:** if the resident has an expected discharge date of more than three (3) months and discharge plan is actively in progress.

Draft

Q0620: Reason Referral to Local Contact Agency (LCA) Not Made (cont.)

Examples

1. Resident S has been in the nursing home for several months following an automobile accident. They plan to return home after their therapy regime ends, which is expected in three to four weeks. In conjunction with Resident S's Admission assessment, the facility team made a referral to the LCA but the agency is not currently working with the resident. The interdisciplinary team and the resident have developed a safe discharge plan for Resident S that could not be improved upon with a referral to the LCA.

   Coding: Q0620 would be **coded 4, Discharge date 3 or fewer months away.**
   Rationale: Resident S's discharge is expected within three to four weeks, and their discharge plan could not be improved upon with a referral to the LCA.

2. Resident J is unable to communicate verbally due to severe dementia. Their spouse met with the care team, and the spouse and care team agree that long-term nursing home placement on the secure dementia unit is appropriate for Resident J. The spouse declined a referral to the LCA.

   Coding: Q0620 would be **coded 3, Referral not wanted.**
   Rationale: Resident J is unable to communicate verbally due to severe dementia. Their spouse declined a referral to the LCA as they and the care team agree that long-term placement on the secure dementia unit is appropriate for Resident J.

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SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL MDS VERSION 3.0 ITEM SET. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.

Draft

SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.

There are 20 CAAs in Version 3.0 of the RAI, which includes the addition of "Pain" and "Return to the Community Referral." These CAAs cover the majority of care areas known to be problematic for nursing home residents. The Care Area Assessment (CAA) process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas.

The interdisciplinary team (IDT) then identifies relevant assessment information regarding the resident's status. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas. Chapter 4 of this manual provides detailed instructions on the CAA process and development of an individualized care plan.

Whereas the MDS identifies actual or potential problem areas, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors, with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible, or (2) maintenance and prevention of avoidable declines. Documentation should support your decision making regarding whether to proceed with a care plan for a triggered CAA and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record, e.g., progress notes, consults, flowsheets, etc.

Draft

V0100: Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01 - 06 or A0310B = 01

Enter Code ☐☐

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. None of the above

Enter Code ☐☐

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)

☐☐ - ☐☐ - ☐☐☐☐

Month Day Year

Enter Score ☐☐

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score ☐☐

E. Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 value from prior assessment)

Enter Score ☐☐

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assesment)

Item Rationale

The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status. The values of these items are derived from a prior OBRA or scheduled PPS assessment that was performed since the most recent admission of any kind (i.e., since the most recent entry or reentry), if one is available. Items V0100A, B, C, D, E and F are skipped on the first assessment (OBRA or PPS) following the most recent admission of any kind (i.e., when A0310E = 1, Yes). Complete these items only if a prior assessment has been completed since the most recent admission of any kind to the facility (i.e., when A0310E = 0, No) and if the prior assessment is an OBRA or a scheduled PPS assessment. If such an assessment is available, the values of V0100A, B, C, D, E, and F should be copied from the corresponding items on that prior assessment.

Coding Instructions for V0100A, Prior Assessment Federal OBRA Reason for Assessment (A0310A Value from Prior Assessment)

- Record in V0100A the value for A0310A (Federal OBRA Reason for Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 06 or 99) must be selected.

V0100: Items From the Most Recent Prior OBRA or Scheduled PPS Assessment (cont.)

Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)

- Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 or 08 or 99) must be selected.

  Note: The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 or 08, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Coding Instructions for V0100C, Prior Assessment Reference Date (A2300 Value from Prior Assessment)

- Record in V0100C the value of A2300 (Assessment Reference Date) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details).

Coding Instructions for V0100D, Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 Value from Prior Assessment)

- Record in V0100D, the value for C0500 Mental Status (BIMS) Summary Score from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

Coding Instructions for V0100E, Prior Assessment Resident Mood Interview (PHQ-2 to 9©) Total Severity Score (D0160 Value from Prior Assessment)

- Record in V0100E the value of D0160 (Resident Mood Interview [PHQ-2 to 9©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600 Value from Prior Assessment)

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood [PHQ-9-OV©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

V0200: CAAs and Care Planning

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

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	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

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

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

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

1. Signature

2. Date

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Draft

V0200: CAAs and Care Planning (cont.)

Item Rationale

- Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA Summary documents the interdisciplinary team's and the resident, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.

Coding Instructions for V0200A, CAAs

- Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources 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.
- For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. 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.

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.

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V0200: CAAs and Care Planning (cont.)

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.
- Following completion of the MDS, CAAs (V0200A, Columns A and B) and the care plan, the MDS 3.0 comprehensive assessment record must be transmitted to iQIES within 14 days of the V0200C2 date.

Clarifications

- The signatures at V0200B1 and V0200C1 can be provided by the same person, if the person actually completed both functions. However, it is not a requirement that the same person complete both functions.
- If a resident is discharged prior to the completion of Section V, a comprehensive assessment may be in progress when a resident is discharged. Although the resident has been discharged, the facility may complete and submit the assessment. **The following guidelines apply to completing a comprehensive assessment* when the resident has been discharged**:

  1. Complete all required MDS items from Section A through Section Z and indicate the date of completion in Z0500B. Encode and verify these items.
  2. Complete the care area triggering process by checking all triggered care areas in V0200A, Column A.
  3. Sign and enter the date the CAAs were completed at V0200B1 and V0200B2.
  4. Dash fill all of the "Care Planning Decision" items in V0200A, Column B, which indicates that the decisions are unknown.
  5. Sign and enter the date that care planning decisions were completed at V0200C1 and V0200C2. Use the same date used in V0200B2.
  6. Submit the record.

  *Please see Chapter 2 for additional detailed instructions regarding options for when residents are discharged prior to completion of the RAI.

SECTION X: CORRECTION REQUEST

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the Internet Quality Improvement and Evaluation System (iQIES).

A modification request is used to correct an iQIES record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

The modification request record contains correct values for all MDS items (not just the values previously in error), including the Section X items. The corrected record will replace the prior erroneous record in iQIES.

In some cases, an incorrect MDS record requires a completely new assessment of the resident in addition to a modification request for that incorrect record. Please refer to Chapter 5 of this manual, Submission and Correction of the MDS Assessments, to determine if a new assessment is required in addition to a modification request.

An inactivation request is used to move an existing record in iQIES from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Item A0050 and the Section X items. All other MDS sections are skipped.

The modification and inactivation processes are automated and neither completely removes the prior erroneous record from iQIES. The erroneous record is archived in a history file. In certain cases, it is necessary to delete a record and not retain any information about the record in iQIES. This requires a request from the facility to the facility's state agency to manually delete all traces of a record from iQIES. The policy and procedures for a Manual Correction/Deletion Request are provided in Chapter 5 of this Manual.

A Manual Deletion Request is required **only** in the following three cases:

1. **Item A0410 Submission Requirement is incorrect.** Submission of MDS assessment records to iQIES constitutes a release of private information and must conform to privacy laws. Only records required by the State and/or the Federal governments may be stored in the iQIES. If a record has been submitted with the incorrect Submission Requirement value in Item A0410, then that record must be manually deleted and, in some cases, a new record with a corrected A0410 value submitted. Item A0410 cannot be corrected by modification or inactivation. See Chapter 5 of this Manual for details.

2. **Inappropriate submission of a test record as a production record.** Removal of a test record from iQIES requires manual deletion. Otherwise information for a "bogus" resident will be retained in the database and this resident will appear on some reports to the facility.
3. **Record was submitted for the wrong facility.** If a record was submitted to iQIES for an incorrect facility, the record must be removed manually and then a new record for the correct facility must be submitted to **iQIES. Manual deletion of the record for the wrong facility** is necessary to ensure that the resident is not associated with that facility and does not appear on reports to that facility.

X0150: Type of Provider (A0200 on existing record to be modified/inactivated)

This item contains the type of provider identified from the prior erroneous record to be modified/inactivated.

X0150. Type of Provider (A0200 on existing record to be modified/inactivated)

Enter Code ☐

Type of provider
1. Nursing home (SNF/NF)
2. Swing Bed

Coding Instructions for X0150, Type of Provider

Enter the type of provider code 1 "Nursing Home (SNF/NF)" or code 2 "Swing Bed" exactly as submitted for item A0200 "Type of Provider" on the prior erroneous record to be modified/inactivated.

- **Code 1, Nursing home (SNF/NF):** if the facility is a Nursing home (SNF/NF).
- **Code 2, Swing Bed:** if the facility is a Swing Bed facility.

X0200: Name of Resident (A0500 on existing record to be modified/inactivated)

These items contain the resident's name from the prior erroneous record to be modified/inactivated.

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)

A. First name:

☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coding Instructions for X0200A, First Name

- Enter the first name of the resident exactly as submitted for item A0500A "Legal Name of Resident—First Name" on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box.
- Note that the first name in X0200A does not have to match the current value of A0500A on a modification request. The entries may be different if the modification is correcting the first name.

X0200: Name of Resident (A0500 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0200C, Last Name

- Enter the last name of the resident exactly as submitted for item A0500C "Legal Name of Resident— Last Name" on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box. The last name in X0200C cannot be blank.
- Note that the last name in X0200C does not have to match the current value of A0500C on a modification request. The entries may be different if the modification is correcting the last name.

X0300: Gender (A0800 on existing record to be modified/inactivated)

X0300. Gender (A0800 on existing record to be modified/inactivated)

Enter Code ☐

1. **Male**
2. **Female**

Coding Instructions for X0300, Gender

- Enter the gender code 1 "Male," 2 "Female," or – (dash value indicating unable to determine) exactly as submitted for item A0800 "Gender" on the prior erroneous record to be modified/inactivated.
- Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record.
- Note that the gender in X0300 does not have to match the current value of A0800 on a modification request. The entries may be different if the modification is correcting the gender.

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X0400: Birth Date (A0900 on existing record to be modified/inactivated)

X0400. Birth Date (A0900 on existing record to be modified/inactivated)

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Coding Instructions for X0400, Birth Date

- Fill in the boxes with the birth date exactly as submitted for item A0900 "Birth Date" on the prior erroneous record to be modified/inactivated. If the month or day contains only a single digit, fill in the first box with a 0 For example, January 2, 1918, should be entered as:

0	1		0	2		1	9	1	8

  If the birth date in MDS item A0900 on the prior record was a partial date, with day of the month unknown and the day of the month boxes were left blank, then the day of the month boxes must be blank in X0400. If the birth date in MDS item A0900 on the prior record was a partial date with both month and day of the month unknown and the month and day of the month boxes were left blank, then the month and day of the month boxes must be blank in X0400.

- Note that the birth date in X0400 does not have to match the current value of A0900 on a modification request. The entries may be different if the modification is correcting the birth date.

X0500: Social Security Number (A0600A on existing record to be modified/inactivated)

X0500. Social Security Number (A0600A on existing record to be modified/inactivated)

☐☐☐ - ☐☐ - ☐☐☐☐

Coding Instructions for X0500, Social Security Number

- Fill in the boxes with the Social Security number exactly as submitted for item A0600 "Social Security and Medicare numbers" on the prior erroneous record to be modified/inactivated. If the Social Security number was unknown or unavailable and left blank on the prior record, leave X0500 blank.
- Note that the Social Security number in X0500 does not have to match the current value of A0600 on a modification request. The entries may be different if the modification is correcting the Social Security number.

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X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated)

These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated.

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

Enter Code ☐☐ **A. Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code ☐☐ **B. PPS Assessment**
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code ☐☐ **F. Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

Coding Instructions for X0600A, Federal OBRA Reason for Assessment

- Fill in the boxes with the Federal OBRA reason for assessment/tracking code exactly as submitted for item A0310A "Federal OBRA Reason for Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the Federal OBRA reason for assessment/tracking code in X0600A must match the current value of A0310A on a modification request.
- If item A0310A was incorrect on an assessment that was previously submitted and accepted by iQIES, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600B, PPS Assessment

- Fill in the boxes with the PPS assessment type code exactly as submitted for item A0310B "PPS Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the PPS assessment code in X0600B must match the current value of A0310B on a modification request.
- If item A0310B was incorrect on an assessment that was previously submitted and accepted by iQIES, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

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

Coding Instructions for X0600F, Entry/Discharge Reporting

- Enter the number corresponding to the entry/discharge code exactly as submitted for item A0310F "Entry/discharge reporting" on the prior erroneous record to be modified/inactivated.

  01. Entry tracking record
  10. Discharge assessment-return not anticipated
  11. Discharge assessment-return anticipated
  12. Death in facility tracking record
  99. None of the above

- Note that the Entry/discharge code in X0600F must match the current value of A0310F on a modification request.
- If item A0310F was incorrect on an assessment that was previously submitted and accepted by iQIES, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

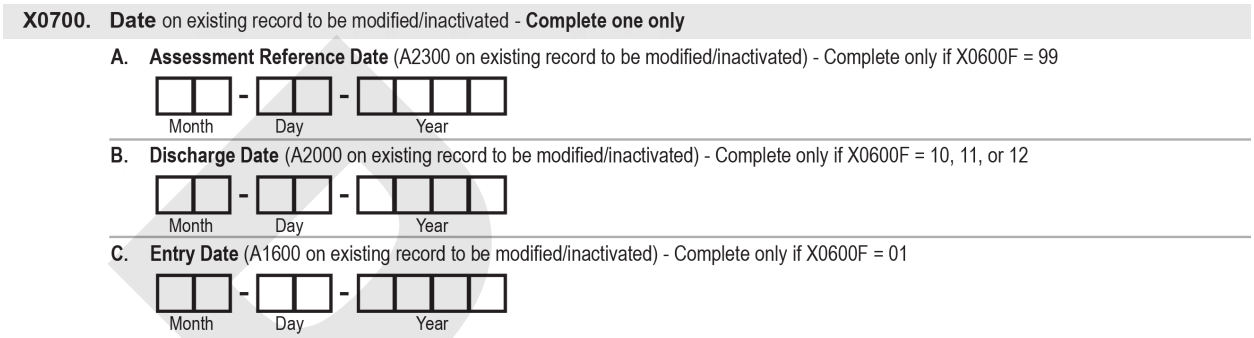
Coding Instructions for X0600H, Is this a Part A PPS Discharge Assessment?

- Enter the code exactly as submitted for item A0310H, "Is this a Part A PPS Discharge Assessment?" on the prior erroneous record to be modified/inactivated.
- **Code 0, no:** if this is not a Part A PPS Discharge assessment.
- **Code 1, yes:** if this is a Part A PPS Discharge assessment.
- Note that the code in X0600H must match the current value of A0310H on a modification request.
- If item A0310H was incorrect on an assessment that was previously submitted and accepted by iQIES, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

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X0700: Date on Existing Record to Be Modified/Inactivated – Complete one only

The item that is completed in this section is the event date for the prior erroneous record to be modified/inactivated. The event date is the assessment reference date for an assessment record, the discharge date for a discharge record, or the entry date for an entry record. In iQIES, this date is often referred to as the "target date." Enter only one (1) date in X0700.



Coding Instructions for X0700A, Assessment Reference Date—(A2300 on existing record to be modified/inactivated) – Complete Only if X0600F = 99

- If the prior erroneous record to be modified/inactivated is an OBRA assessment or a PPS assessment, where X0600F = 99, enter the assessment reference date here exactly as submitted in item A2300 "Assessment Reference Date" on the prior record.
- Note that the assessment reference date in X0700A must match the current value of A2300 on a modification request.

Coding Instructions for X0700B, Discharge Date—(A2000 on existing record to be modified/inactivated) – Complete Only If X0600F = 10, 11, or 12

- If the prior erroneous record to be modified/inactivated is a discharge record (indicated by X0600F = 10, 11, or 12), enter the discharge date here exactly as submitted for item A2000 "Discharge Date" on the prior record. If the prior erroneous record was a discharge combined with an OBRA or PPS assessment, then that prior record will contain both a completed assessment reference date (A2300) and discharge date (A2000) and these two dates will be identical. If such a record is being modified or inactivated, enter the prior discharge date in X0700B and leave the prior assessment reference date in X0700A blank.
- Note that the discharge date in X0700B must match the current value of A2000 on a modification request.

X0700: Date on Existing Record to Be Modified/Inactivated (cont.)

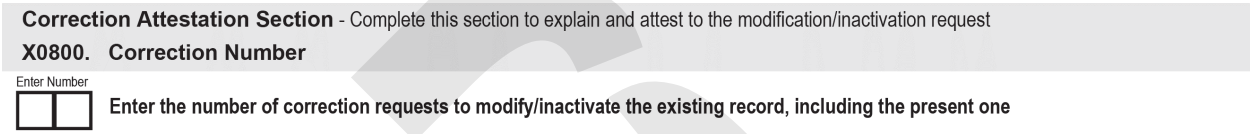
Coding Instructions for X0700C, Entry Date—(A1600 on existing record to be modified/inactivated) – Complete Only If X0600F = 01

- If the prior erroneous record to be modified/inactivated is an entry record (indicated by X0600F = 01), enter the entry date here exactly as submitted for item A1600 "Entry Date [date of admission/reentry into the facility]" on the prior record.
- Note that the entry date in X0700C must match the current value of A1600 on a modification request.

X0800: Correction Attestation Section

The items in this section indicate the number of times a record accepted into iQIES has been corrected, the reason for the current modification/inactivation request, the person attesting to the modification/inactivation request, and the date of the attestation.

This item may be populated automatically by the nursing home's data entry software; however, if it is not, the nursing home should enter this information.


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

X0800. Correction Number

Enter Number

Enter the number of correction requests to modify/inactivate the existing record, including the present one

Coding Instructions for X0800, Correction Number

- Enter the total number of correction requests to modify/inactivate the record in iQIES that is in error. Include the present modification/inactivation request in this number.
- For the first correction request (modification/inactivation) for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, X0800 is incremented by one. For values between one and nine, a leading zero should be used in the first box. For example, enter "01" into the two boxes for X0800.
- This item identifies the total number of correction requests following the original assessment or tracking record, including the present request. Note that Item X0800 is used to track successive correction requests in iQIES.

X0900: Reasons for Modification

The items in this section indicate the possible reasons for the modification request of the record in iQIES. Check all that apply. These items should only be completed when A0050 = 2, indicating a modification request. If A0050 = 3, indicating an inactivation request, these items should be skipped.

X0900.	**Reasons for Modification** - Complete only if Type of Record is to modify a record in error (A0050 = 2)
↓	**Check all that apply**
☐	**A. Transcription error**
☐	**B. Data entry error**
☐	**C. Software product error**
☐	**D. Item coding error**
☐	**Z. Other error requiring modification** If "Other" checked, please specify: _____

Coding Instructions for X0900A, Transcription Error

- Check the box if any errors in the prior record accepted into iQIES were caused by data transcription errors.
- A transcription error includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the resident's weight (e.g., recording "191" rather than the correct weight of "119" that appears in the medical record).

Coding Instructions for X0900B, Data Entry Error

- Check the box if any errors in the prior record accepted into iQIES were caused by data entry errors.
- A data entry error includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is an error where the response to the individual minutes of physical therapy O0400C1 is incorrectly encoded as "3000" minutes rather than the correct number of "0030" minutes.

Coding Instructions for X0900C, Software Product Error

- Check the box if any errors in the prior record accepted into iQIES were caused by software product errors.
- A software product error includes any error created by the encoding software, such as storing an item in the wrong format (e.g., storing weight as "020" instead of "200").

Coding Instructions for X0900D, Item Coding Error

- Check the box if any errors in the prior record accepted into iQIES were caused by item coding errors.

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X0900: Reasons for Modification (cont.)

- An item coding error includes any error made coding an MDS item (for exceptions when certain items may not be modified see Chapter 5), such as choosing an incorrect code for the Functional Abilities – Mobility item GG0170A, Roll left and right (e.g., choosing a code of "02" for a resident who requires supervision and should be coded as "04"). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

Coding Instructions for X0900Z, Other Error Requiring Modification

- Check the box if any errors in the prior record accepted into iQIES were caused by other types of errors not included in Items X0900A through X0900D.
- Such an error includes any other type of error that causes a record accepted into iQIES to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided with the item.

X1050: Reasons for Inactivation

The items in this section indicate the possible reasons for the inactivation request. Check all that apply. These items should only be completed when A0050 = 3, indicating an inactivation request. If A0050 = 2, indicating a modification request, these items should be skipped.

X1050.	**Reasons for Inactivation** - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)
↓	**Check all that apply**
☐	**A. Event did not occur**
☐	**Z. Other error requiring inactivation** If "Other" checked, please specify:

Coding Instructions for X1050A, Event Did Not Occur

- Check the box if the record accepted into iQIES does not represent an event that actually occurred.
- An example would be a Discharge assessment submitted for a resident, but there was no actual discharge. There was **no event**.

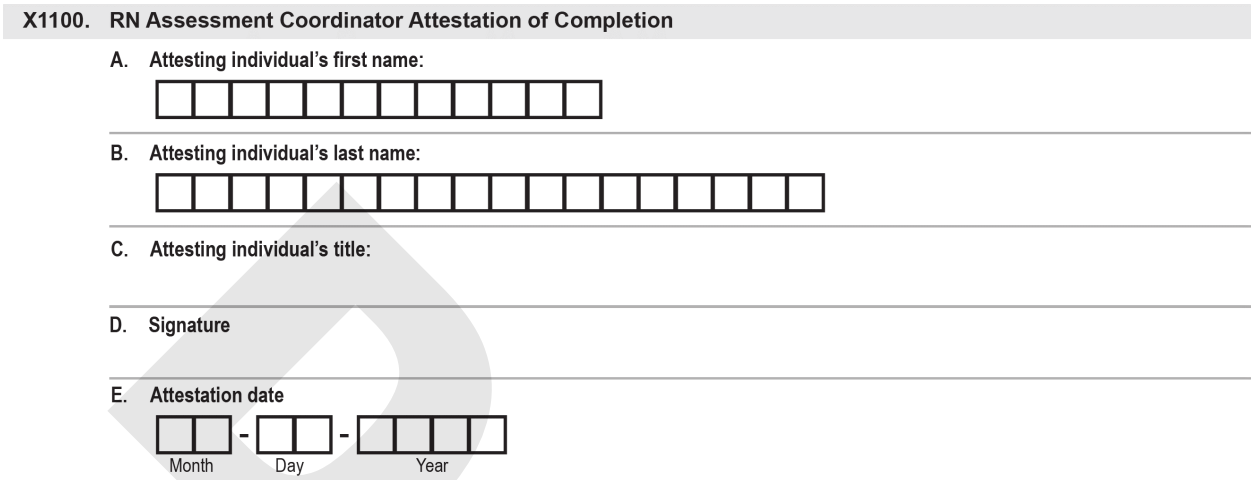
Coding Instructions for X1050Z, Other Reason Requiring Inactivation

- Check the box if any errors in the record accepted into iQIES were caused by other types of errors not included in Item X1050A.
- Facility staff should describe the "other error" in the space provided with the item.

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X1100: RN Assessment Coordinator Attestation of Completion

The items in this section identify the RN coordinator attesting to the correction request and the date of the attestation.


X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month Day Year

Coding Instructions for X1100A, Attesting Individual's First Name

- Enter the first name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

Coding Instructions for X1100B, Attesting Individual's Last Name

- Enter the last name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

Coding Instructions for X1100C, Attesting Individual's Title

- Enter the title of the facility staff member attesting to the completion of the corrected information on the line provided.

Coding Instructions for X1100D, Signature

- The attesting individual must sign the correction request here, certifying the completion of the corrected information. The entire correction request should be completed and signed within 14 days of detecting an error in a record accepted into iQIES. The correction request, including the signature of the attesting facility staff, must be kept with the modified or inactivated MDS record and retained in the resident's medical record or electronic medical record.

Coding Instructions for X1100E, Attestation Date

- Enter the date the attesting facility staff member attested to the completion of the corrected information.
- Do not leave any boxes blank. For a one-digit month or day, place a zero in the first box. For example, January 2, 2011, should be entered as:

0	1		0	2		2	0	1	1

X1100: RN Assessment Coordinator Attestation of Completion (cont.)

Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion

- If an inactivation is being completed, Z0400 must also be completed.

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SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

Z0100: Medicare Part A Billing

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code:



B. Version code:



Item Rationale

- Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

DEFINITION

MEDICARE-COVERED STAY
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to other payers (e.g., Medicare Advantage plans).

Coding Instructions for Z0100A, Medicare Part A HIPPS Code

- Typically, the software data entry product will calculate this value.
- The HIPPS code is a Skilled Nursing Facility (SNF) Part A five-position billing code; the first four positions represent the PDPM case mix version code and the fifth is the assessment type indicator. For information on HIPPS, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
- If the value for Z0100A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS), for a step-by-step worksheet for manually determining the PDPM case mix version code and a table that defines the assessment indicator).
- This HIPPS code is usually used for Medicare SNF Part A billing by the provider.
- Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.

DEFINITION

HIPPS CODE
Is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.

Z0100: Medicare Part A Billing (cont.)

Coding Instructions for Z0100B, Version Code

- Typically, the software data entry product will calculate this value.
- If the value for Z0100B is not automatically calculated by the software data entry product, enter the PDPM version code in the spaces provided.

Z0200: State Medicaid Billing (if required by the state)

Z0200. State Medicaid Billing (if required by the state)

A. Case Mix group:



B. Version code:



Item Rationale

- Used to capture the payment code in states that employ the MDS for Medicaid case-mix reimbursement.

Coding Instructions for Z0200A, Case Mix Group

- If the state has selected a standard payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0200B, Version Code

- If the state has selected a standard payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0200A.

Coding Instructions for Z0200C, Is this a Short Stay assessment?

- **Code 0, no:** if this is not a Short Stay assessment.
- **Code 1, yes:** if this is a Medicare Short Stay assessment.

Coding Tip

- The standard RUG-IV grouper automatically determines whether or not this is a Short Stay assessment. MDS software typically makes this determination automatically.

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Z0250: Alternate State Medicaid Billing (if required by the state)

Z0250. Alternate State Medicaid Billing (if required by the state)

A. Case Mix group:

B. Version code:

Item Rationale

- Used to capture an alternate payment group in states that employ the MDS for Medicaid case-mix reimbursement. States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model or to allow blended payment between two models during a transition period.

Coding Instructions for Z0250A, Case Mix Group

- If the state has selected a standard payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0250B, Version Code

- If the state has selected a standard payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0250A.

Z0300: Insurance Billing

Z0300. Insurance Billing

A. Billing code:

B. Billing version:

Item Rationale

- Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs).

Coding Instructions for Z0300A, Billing Code

- If the other payer has selected a standard payment model, this item may be populated automatically by the software data entry product. Otherwise, enter the billing code in the space provided. This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs.

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Z0300: Insurance Billing (cont.)

Coding Instructions for Z0300B, Billing Version

- If the other payer has selected a standard payment model, this item may be populated automatically by the software data entry product. Otherwise, enter an appropriate billing version in the spaces provided. This is the billing version appropriate to the billing code in Item Z0300A.

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

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

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

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.

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Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting (cont.)

- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
  - the development of an individualized care plan
  - the Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - quality monitoring activities, such as the quality measure reports
  - the data-driven survey and certification process
  - the quality measures used for public reporting
  - research and policy development.

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 they 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.

Coding Tips and Special Populations

- Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a sub-set of items within a section should identify which item(s) they completed within that section.
- 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.
- 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.

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Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting (cont.)

- If an individual who completed a portion of the MDS is not available to sign it (e.g., in situations in which a staff member is no longer employed by the facility and left MDS sections completed but not signed for), there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date this verification occurred.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

☐☐ - ☐☐ - ☐☐☐☐
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 must be equal to the latest date at Z0400 or 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.

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Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion (cont.)

- 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.
- 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.

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CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING

4.1 Background and Rationale

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that nursing facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

4.2 Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)



As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.

The MDS is a starting point. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. For example, assessing a resident's orientation and recall helps staff complete portions of the MDS that relate to cognition (Section C), and weighing a resident and identifying their food intake helps staff complete portions

of the MDS related to nutritional status (Section K). When it is completed, the MDS provides a foundation for a more thorough assessment and the development of an individualized care plan. The MDS 3.0 manual explains in detail how to complete the MDS.

The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.

The CAA process framework. The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

When implemented properly, the CAA process should help staff:

- Consider each resident as a whole, with unique characteristics and strengths that affect their capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
- Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

4.3 What Are the Care Area Assessments (CAAs)?

The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. Specific "CAT logic" for each care area is identified under section 4.10 (The Twenty Care Areas). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer/Injury
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas. Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative.

By statute, the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame. While a workup cannot always be completed within 14 days, it is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.

CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.

4.4 What Does the CAA Process Involve?

Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying

effective problem solving and decision making approaches to all of the information available for each resident.

Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected.

CATs provide a "flag" for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines.

A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer/injury. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.

A care area issue/condition (e.g., falls) may result from a single underlying cause (e.g., administration of a new medication that causes dizziness) or from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high or too low, etc.). There can also be a single cause of multiple triggers and impairments. For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications. Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.: Delirium (#1), Cognitive Loss/Dementia (#2), Visual Function (#3), Communication (#4), ADL Functional/Rehabilitation (#5), Urinary Incontinence (#6), Psychosocial Well-Being (#7), Mood State (#8), Behavior Symptoms (#9), Activities (#10), Falls (#11), Nutritional Status (#12), Dehydration (#14), Psychotropic Medication Use (#17), and Pain (#19). Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome. Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.

For example, it is necessary to assess a resident's orientation and recall in order to complete portions of the MDS that relate to cognitive patterns (Section C) and to obtain a resident's weight and identify their food intake in order to complete MDS items related to nutritional status (Section K). A positive finding in Section C may trigger one or several CAAs, including Delirium (#1), Cognitive Loss/Dementia (#2), and ADL Functional/Rehabilitation Potential (#5).

Additional evaluation is then required to identify whether the resident has delirium, dementia, or both; how current symptoms and patterns compare to their usual or previous baseline, whether potentially reversible causes are present, what else might be needed to identify underlying causes (including medical diagnoses and history), and what symptomatic and cause-specific interventions are appropriate for the resident. If the Nutritional Status (#12) CAA also triggered, due to weight loss and the resident being found to have delirium, then it is possible that both findings could have a common cause (e.g., an infection or medication side effects), that delirium resulted in impaired nutritional status, or that impaired nutritional status led to delirium, or still other possibilities. Thus, identifying the sequence of events is essential to understanding causes and choosing appropriate interventions.

The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes. It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.

Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline. For example, Section F identifies the resident's preferences for customary routine and activities and Section Q captures information about the resident's desire to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community. These and other MDS items can help focus the assessment and care plan on what is most important to the resident and areas with the greatest potential for functional improvement.

In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:

- Identify and address associated causes and effects;
- Determine whether and how multiple triggered conditions are related;
- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests;
- Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions;
- Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;
- Determine whether a resident could potentially benefit from rehabilitative interventions;
- Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.

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4.5 Other Considerations Regarding Use of the CAAs

Assigning responsibility for completing the MDS and CAAs. Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals. It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered). The proper assessment and management of CAAs that are triggered for a given resident may involve aspects of diagnosis and treatment selection that exceed the scope of training or practice of any one discipline involved in the care (for example, identifying specific medical conditions or medication side effects that cause anorexia leading to a resident's weight loss). It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice. For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.

Identifying policies and practices related to the assessment and care planning processes. Under the OBRA regulations, 42 CFR 483.70(h)(1) identifies the medical director as being responsible for overseeing the "implementation of resident care policies" in each facility, "and the coordination of medical care in the facility." Therefore, it is recommended that the facility's IDT members collaborate with the medical director to identify current evidence-based or expert-endorsed resources and standards of practice that they will use for the expanded assessments and analyses that may be needed to adequately address triggered areas. The facility should be able to provide surveyors the resources that they have used upon request as part of the survey review process.[1]

CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

- Relevant documentation for each triggered CAA describes: causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

[1] In Appendix C, CMS has provided CAA resources that facilities may choose to use but that are neither mandatory nor endorsed by the government. Please note that Appendix C does not provide an all-inclusive list.

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM).

If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.

Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

4.6 When Is the RAI Not Enough?

Federal requirements support a nursing home's ongoing responsibility to assess residents. The Quality of Care regulation requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 CFR 483.25).

Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.70(b), the facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Furthermore, surveyor guidance within OBRA (e.g., 42 CFR 483.25(b)(1) Pressure Ulcers and 42 CFR 483.45(d) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

Therefore, facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

Limitations of the RAI-related instruments. The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs are triggered, and a framework for the CAA process. However, the process of completing the MDS and related portions of the

RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents. By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes. Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.

- The MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- The MDS is not a diagnostic tool or treatment selection guide
- The MDS does not identify causation or history of problems

Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision making processes to analyze and address MDS findings and CAAs. Table 2 provides a framework for a more complete approach to clinical problem solving and decision making essential to the appropriate care of individuals with multiple and/or complex illnesses and impairments.

4.7 The RAI and Care Planning

As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(b)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.

Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see 42 CFR 483.21(b), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.

Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives

Process Step / Objectives *	Key Tasks **
Recognition / Assessment *Gather essential information about the individual*	– Identify and collect information that is needed to identify an individual's conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis – Obtain a personal and medical history – Perform a physical assessment
Problem definition *Define the individual's problems, risks, and issues*	– Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. – Clearly state the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns – Define significant risk factors
Diagnosis / Cause-and-effect analysis *Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences*	– Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks – Identify pertinent evaluations and diagnostic tests – Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another – Identify how addressing those causes is likely to affect consequences
Identifying goals and objectives of care *Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met*	– Clarify prognosis – Define overall goals for the individual – Identify criteria for meeting goals
Selecting interventions / planning care *Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks*	– Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial) – Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual – Define anticipated benefits and risks of various interventions – Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences
Monitoring of progress *Review individual's progress towards goals and modify approaches as needed*	– Identify the individual's response to interventions and treatments – Identify factors that are affecting progress towards achieving goals – Define or refine the prognosis – Define or refine when to stop or modify interventions – Review effectiveness and adverse consequences related to treatments – Adjust interventions as needed – Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care

* Refers to key steps in the care delivery process, related to clinical problem solving and decision making
** Refers to key tasks at each step in the care delivery process

The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. A care plan that is based on a thorough

assessment, effective clinical decision making, and is compatible with current standards of clinical practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and care plan:

- Looks at each resident as a whole human being with unique characteristics and strengths;
- Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS);
- Gives the IDT a common understanding of the resident;
- Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers);
- Provides additional clarity of potential issues and/or conditions by looking at possible causes and risks (CAA process);
- Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up;
- Reflects the resident's/resident representative's input, goals, and desired outcomes;
- Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning);
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the individualized care plan as appropriate and necessary.

Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently:

- Review and revise the current care plan, as needed; and
- Communicate with the resident or their family or representative regarding the resident, care plans, and their wishes.

The overall care plan should be oriented towards:

1. Assisting the resident in achieving their goals.
2. Individualized interventions that honor the resident's preferences.
3. Addressing ways to try to preserve and build upon resident strengths.
4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).
5. Managing risk factors to the extent possible or indicating the limits of such interventions.
6. Applying current standards of practice in the care planning process.
7. Evaluating treatment of measurable objectives, timetables and outcomes of care.
8. Respecting the resident's right to decline treatment.
9. Offering alternative treatments, as applicable.

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10. Using an interdisciplinary approach to care plan development to improve the resident's abilities.
11. Involving resident, resident's family and other resident representatives as appropriate.
12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.
13. Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes.

4.8 CAA Tips and Clarifications

Care planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment:

1) Care Plan goals should be measurable. The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate goal(s) and objectives must be pertinent to the resident's goals, preferences, condition, and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.
2) Care plan goal statements should include the **subject (first or third person),** the **verb,** the **modifiers,** the **time frame, and the goal(s)**.

Example:

Subject	***Verb***	***Modifiers***	***Time frame***	***Goal***
Resident Jones **OR** I	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area

3) A separate care plan is not necessarily required for each area that triggers a CAA. Since a single trigger can have multiple causes and contributing factors and multiple items can have a common cause or related risk factors, it is acceptable and may sometimes be more appropriate to address multiple issues within a single care plan segment or to cross reference related interventions from several care plan segments. For example, if impaired ADL function, mood state, falls and altered nutritional status are all determined to be caused by an infection and medication-related adverse consequences, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.
4) The RN coordinator is required to sign and date the Care Area Assessment (CAA) Summary after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days).
5) The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does

not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment.

6) The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

7) Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

8) If the RAI (MDS and CAAs) is not completed until the last possible date (the end of calendar day 14 of the stay), many of the appropriate care area issues, risk factors, or conditions may have already been identified, causes may have been considered, and a preliminary care plan and related interventions may have been initiated. A complete care plan is required no later than 7 days after the RAI is completed.

9) Review of the CAAs after completing the MDS may raise questions about the need to modify or continue services. Conditions that originally triggered the CAA may no longer be present because they resolved, or consideration of alternative causes may be necessary because the initial approach to an issue, risk, or condition did not work or was not fully implemented.

10) On the Annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again. Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care. The IDT with the input of the resident, family or resident's representative determines when a problem or potential problem needs to be addressed in the care plan.

11) The RN Coordinator for the CAA process (V0200B1) does not need to be the same RN as the RN Assessment Coordinator who verifies completion of the MDS assessment (Z0500). The date entered in V0200B2 on the CAA Summary is the date on which the RN Coordinator for the CAA process verified completion of the CAAs, which includes assessment of each triggered care area and completion of the location and date of the CAA assessment documentation section. See Chapter 2 for detailed instructions on the RAI completion schedule.

12) The Signature of Person Completing Care Plan Decision (V0200C1) can be that of any person(s) who facilitates the care plan decision making. It is an interdisciplinary process. The date entered in V0200C2 is the day the RN certifies that the CAAs have been completed and the day V0200C1 is signed.

4.9 Using the Care Area Assessment (CAA) Resources

Based on the preceding discussions in this Chapter, the following summarizes the steps involved in the CAA process, for those facilities that choose to use the CAA resources in this manual.

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Please note: **Because MDS 3.0 trigger logic is complex, please refer to the CAT Logic tables within each CAA description (Section 4.10) for detailed information on triggers.**

Step 1: Identification of Triggered CAAs. After completing the MDS, identify triggered care areas. Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified. CMS has developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly.

It is prudent to consider whether or not the software has triggered relevant CAAs for individual residents. For example, did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

For nursing homes that do not use an automated system, the CAT logic will provide the information necessary to manually identify triggered CAAs. The CAT logic is found within the CAT logic tables of each care area's description in section 4.10. These tables provide the MDS items that trigger the 20 (twenty) care areas. Facilities are not required to use this information or to maintain it in the resident's clinical record. Rather, the information is a resource that may be used by the IDT members to determine which CAAs are triggered from a completed MDS.

To identify the triggered CAAs manually using the CAT logic tables in section 4.10:

1. Compare the completed MDS with the CAT logic tables to determine which CAAs have been triggered for review.
2. The CAT logic table will list the MDS item numbers and specific codes that will trigger the particular CAA. To identify a triggered CAA, match the resident's MDS item responses with the MDS item number(s) and code(s) for each care area as listed in the CAT logic tables within section 4.10. If a particular item response matches a code in the CAT logic table for a particular care area, read through the logic statement and qualifiers (i.e., 'IF', 'AND', and 'OR') for that particular care area to determine if that care area is triggered. This means that further assessment using the CAA process is required for that particular care area.
3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.
4. Continue through the CAT logic tables for each of the 20 (twenty) care areas matching recorded MDS item responses with trigger indicators until all triggered CAAs have been identified.
5. When the CAT logic review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Step 2: Analysis of Triggered CAAs. Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps

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staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

- Warrant intervention;
- Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
- Can help to minimize the onset or progression of impairments and disabilities; and
- Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions.

Example:

Chief Complaint: New onset of falls

Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after they stood up and started walking; a few falls occurred while attempting to stand up from a sitting or lying position.

It is clear that the problem statement reflects assessment findings from which the investigation may continue and relevant conclusions drawn.

While the CAAs can help the IDT identify conditions or findings that could potentially be a problem or risk for the resident, additional thought is needed to define these issues and determine whether and to what extent the care area issue and/or condition is a problem or issue needing an intervention (assessment, testing, treatment, etc.) or simply a minor or inconsequential finding that does not need additional care planning. For example, a resident may exhibit sadness without being depressed or may appear to be underweight despite having a stable nutritional status consistent with their past history. The IDT should identify and document the functional and behavioral implications of identified problematic issues/conditions, limitations, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident; how the condition limits or impairs the resident's ability to complete activities of daily living; or how the condition affects the resident's well-being in some way).

Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately. The IDT may find during their discussions that several problematic issues and/or conditions have a related cause, or they might identify that those issues and/or conditions stand alone and are unrelated. Goals and approaches for each problematic issue

and/or condition may overlap, and consequently the IDT may decide to address the problematic issues and/or conditions collectively in the care plan.

For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments. Thus, the following CATs naturally coexist and could be combined, assessed through the CAA process, and care planned together as a starting point for any resident: Delirium (CAA #1), Cognitive Loss/Dementia (CAA #2), Communication (CAA #4), Psychosocial Well-Being (CAA #7), Mood State (CAA #8) Behavioral Symptoms (CAA #9), and Psychotropic Drug Use (CAA #17).

Usually, illnesses and impairments happen in sequence (i.e., one thing leads to another, which leads to another, and so on). The symptom or trigger often represents only the most recent or most apparent finding in a series of complications or related impairments. Thus, a detailed history is often essential to identifying causes and selecting the most beneficial interventions, e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia. While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history. For example, knowing that the Behavioral Symptoms CAA (#9) is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.

It is the facility's responsibility to refer to sources as needed to help with clinical problem solving and decision making that is consistent with professional standards of practice. It is often necessary to involve the attending physician to identify specific underlying causes of problems, including multiple causes of a single problem or multiple problems or complications related to one or more underlying causes.

Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, goals, preferences, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.

Key components of the care plan may include, but are not limited to the following:

- Resident goals and preferences
- Measureable objective with established timeframes
- Specific interventions, including those that address common causes of multiple issues
- Additional follow-up and clarification
- Items needing additional assessment, testing, and review with the practitioner
- Items that may require additional monitoring but do not require other interventions

- The resident's preference and potential for future discharge and discharge plan

Staff who have participated in the assessment and who have provided pertinent information about the resident's status for triggered care areas should be a part of the IDT that develops the resident's care plan. In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented. **See Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives.**

Documentation related to CAAs should include the items previously discussed in Section 4.5.

4.10 The Twenty Care Areas

NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0520, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not checked. Example: "I4800=0" means that a check mark has not been placed in the check box item I4800.

1. Delirium

Delirium is acute brain failure caused by medical conditions, which presents with psychiatric symptoms, acute confusion, and fluctuations in levels of consciousness. It is a serious condition that can be caused by medical issues/conditions such as medication-related adverse consequences, infections, or dehydration. It can easily be mistaken for the onset or progression of dementia, particularly in individuals with more advanced pre-existing dementia.

Unlike dementia, delirium typically has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness periodically during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusions), seeing or feeling things that are not there (hallucinations), or a fixed false belief (delusions).

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Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) as indicated by:

(a)

C1310A = 1

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

(b)

C1310B, C1310C or C1310D = 2

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. Staff who are closely involved with residents should report promptly any new onset or worsening of cognitive impairment and the other aforementioned symptoms in that resident.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting an acute change in mental status and/or the presence of inattention, disorganized thinking or altered mental status.

The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s) and/or condition(s), as well as to identify related underlying causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process (e.g., treating infections, addressing dehydration, identifying and treating hypo- or hyperthyroidism, relieving pain and depression, managing medications, and promoting adaptation and a comfortable environment for the resident to function. Other simple preventive measures that can be applied in all settings

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include addressing hearing and visual impairments to the extent possible (e.g., with the use of glasses and hearing aids) and minimizing the use of indwelling urinary catheters.

2. Cognitive Loss/Dementia

Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has evidence of cognitive loss.

Cognitive Loss/Dementia CAT Logic Table

Triggering Conditions (any of the following):

1. BIMS summary score is less than 13 as indicated by:

   C0500 >= 00 AND C0500 < 13

2. BIMS summary score has a missing value and there is a problem with short-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0700 = 1)

3. BIMS summary score has a missing value and there is a problem with long-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0800 = 1)

4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C1000 >= 1 AND C1000 <= 3)

5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking or altered level of consciousness as indicated by:

   (C1310B = 1 OR C1310B = 2) OR

Cognitive Loss/Dementia CAT Logic Table

(C1310C = 1 OR C1310C = 2) OR

(C1310D = 1 OR C1310D = 2)

6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:

(E0200A >= 1 AND E0200A <= 3) OR

(E0200B >= 1 AND E0200B <= 3) OR

(E0200C >= 1 AND E0200C <= 3)

7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:

E0800 >= 1 AND E0800 <= 3

8. Wandering occurred at least 1 day in the past 7 days as indicated by:

E0900 >= 1 AND E0900 <= 3

The information gleaned from the assessment should be used to evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. It is important to define the nature of the impairment, e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue and/or condition is apparently not related to reversible causes, assessment should focus on the details of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss, to facilitate care planning specific to the resident's needs, issues and/or conditions, and strengths. The focus of the care plan should be to optimize remaining function by addressing underlying issues identified through this assessment process, such as relieving pain, optimizing medication use, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

The aging process leads to a decline in visual acuity, for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has a diagnosis of glaucoma, macular degeneration or cataracts or B1000 is coded 1-4.

Visual Function CAT Logic Table
Triggering Conditions (any of the following): 1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by: **I6500 = 1** 2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by: **B1000 >= 1 AND B1000 <= 4**

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves related activities, including expressive communication (making oneself understood to others, both verbally and via non-verbal exchange) and receptive communication (comprehending or understanding the verbal, written, or visual communication of others). Typical expressive issues and/or conditions include disruptions in language, speech, and voice production. Typical receptive communication issues and/or conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and their cognitive skills for everyday decision making.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

   B0200 >= 1 AND B0200 <= 3

2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

   B0700 >= 1 AND B0700 <= 3

3. Impaired ability to understand others through verbal content as indicated by:

   B0800 >= 1 AND B0800 <= 3

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet use, bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving or maintaining function when possible, and preventing additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater:

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15)) AND

ADL assistance was required for any of the self-care or mobility activities as indicated by any of the following:

GG0130X1 = 01–05 OR

GG0130A5 = 01–05 OR

GG0130B5 = 01–05 OR

GG0130C5 = 01–05 OR

GG0130E5 = 01–05 OR

GG0130F5 = 01–05 OR

GG0130G5 = 01–05 OR

GG0130H5 = 01–05 OR

GG0130I5 = 01–05 OR

GG0170X1 = 01–05 OR

GG0170A5 = 01–05 OR

GG0170B5 = 01–05 OR

GG0170C5 = 01–05 OR

GG0170D5 = 01–05 OR

GG0170E5 = 01–05 OR

GG0170F5 = 01–05 OR

GG0170FF5 = 01–05 OR

GG0170I5 = 01–05 OR

GG0170J5 = 01–05 OR

GG0170K5 = 01–05 OR

GG0170R5 = 01–05 OR

GG0170S5 = 01–05

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6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is the involuntary loss or leakage of urine or the inability to urinate in a socially acceptable manner. There are several types of urinary incontinence (e.g., functional, overflow, stress, and urge) and the individual resident may experience more than one type at a time (mixed incontinence).

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence can be a risk factor for various complications, including skin rashes, falls, and social isolation. Often, it is at least partially correctable. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters, which can increase the risk of life threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Urinary Incontinence and Indwelling Catheter CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for toileting hygiene or toilet transfer was needed as indicated by:
   GG0130C1 = 01–05 OR GG0130C5 = 01–05 OR GG0170F1 = 01–05 OR GG0170F5 = 01–05
2. Resident requires an indwelling catheter as indicated by:
   H0100A = 1
3. Resident requires an external catheter as indicated by:
   H0100B = 1
4. Resident requires intermittent catheterization as indicated by:
   H0100D = 1
5. Urinary incontinence has a value of 1 through 3 as indicated by:
   H0300 >= 1 AND H0300 <= 3
6. Resident has moisture associated skin damage as indicated by:
   M1040H = 1

Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or the reason for the indwelling catheter. Some of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies can prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be used for appropriate indications and when no other viable options exist. The assessment should include consideration of the risks and

benefits of an indwelling (suprapubic or urethral) catheter, the potential for removal of the catheter, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, it can cloud other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Similarly, declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood. Psychosocial well-being may also be negatively impacted when a person has significant life changes such as the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident exhibits minimal interest in social involvement.

Psychosocial Well-Being CAT Logic Table

Triggering Conditions (any of the following):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:

   D0150A1 = 1

2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 or 4 as indicated by:

   F0500F = 3 OR F0500F = 4

4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities:

   F0800Q = 0

5. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

   (E0200A >= 1 AND E0200A <= 3) AND

   (I4800 = 0 OR I4800 = -) AND

   (I4200 = 0 OR I4200 = -)

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

(E0200B >=1 AND E0200B <= 3) AND

(I4800 = 0 OR I4800 = -) AND

(I4200 = 0 OR I4200 = -)

7. Any six items for interview for activity preferences has the value of 4 and resident is primary respondent for daily and activity preferences as indicated by:

(Any 6 of F0500A through F0500H = 4) AND

(F0600 = 1)

The information gleaned from the assessment should be used to identify whether their minimal involvement is typical or customary for that person or a possible indication of a problem. If it is problematic, then address the underlying cause(s) of the resident's minimal social involvement and factors associated with reduced social relationships and engagement, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes in order to stimulate and facilitate social engagement.

8. Mood State

Sadness and anxiety are normal human emotions, and fluctuations in mood are also normal. But mood states (which reflect more enduring patterns of emotions) may become as extreme or overwhelming as to impair personal and psychosocial function. Mood disorders such as depression reflect a problematic extreme and should not be confused with normal sadness or mood fluctuation.

The mood section of the MDS screens for—but is not intended to definitively diagnose—any mood disorder, including depression. Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness. They may also result in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains. However, because none of these symptoms is specific for a mood disorder, diagnosis of mood disorders requires additional assessment and confirmation of findings. In addition, other problems (e.g., lethargy, fatigue, weakness, or apathy) with different causes, which require a very different approach, can be easily confused with depression.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue and/or condition may be present.

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Mood State CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has had thoughts they would be better off dead, or thoughts of hurting themself as indicated by:

   D0150I1 = 1

2. Staff assessment of resident mood suggests resident states life isn't worth living, wishes for death, or attempts to harm self as indicated by:

   D0500I1 = 1

3. The resident mood interview total severity score has a non-missing value (0 to 27) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the resident interview summary score on the current non-admission comprehensive assessment (D0160) is greater than the prior assessment (V0100E) as indicated by:

   ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND
   ((D0160 >= 00) AND (D0160 <= 27)) AND
   ((V0100E >= 00) AND (V0100E <= 27)) AND
   (D0160 > V0100E)

4. The resident mood interview is not successfully completed (missing value on D0160), the staff assessment of resident mood has a non-missing value (0 to 30) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the staff assessment current total severity score on the current non-admission comprehensive assessment (D0600) is greater than the prior assessment (V0100F) as indicated by:

   ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND
   ((D0160 < 00) OR (D0160 > 27)) AND
   ((D0600 >= 00) AND (D0600 <= 30)) AND
   ((V0100F >= 00) AND (V0100F <= 30)) AND
   (D0600 > V0100F)

5. The resident mood interview is successfully completed and the current total severity score has a value of 10 through 27 as indicated by:

   D0160 >= 10 AND D0160 <= 27

6. The staff assessment of resident mood is recorded and the current total severity score has a value of 10 through 30 as indicated by:

   D0600 >= 10 AND D0600 <= 30

The information gleaned from the assessment should be used as a starting point to assess further in order to confirm a mood disorder and get enough detail of the situation to consider whether treatment is warranted. If a mood disorder is confirmed, the individualized care plan should, in part, focus on identifying and addressing underlying causes, to the extent possible.

9. Behavioral Symptoms

In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors, but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention.

Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms.

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Behavioral Symptoms CAT Logic Table

Triggering Conditions (any of the following):

1. Rejection of care has a value of 1 through 3 indicating resident has rejected evaluation or care necessary to achieve their goals for health and well-being as indicated by:

   E0800 >= 1 AND E0800 <= 3

2. Wandering has a value of 1 through 3 as indicated by:

   E0900 >= 1 AND E0900 <= 3

3. Change in behavior indicates behavior, care rejection or wandering has gotten worse since prior assessment as indicated by:

   E1100 = 2

4. Presence of at least one behavioral symptom as indicated by:

   E0300 = 1

The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm.

10. Activities

The capabilities of residents vary, especially as abilities and expectations change, illness intervenes, opportunities become less frequent, and/or extended social relationships become less common. The purpose of the activities CAA is to identify strategies to help residents become more involved in relevant activities, including those that have interested and stimulated them in the past and/or new or modified ones that are consistent with their current functional and cognitive capabilities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident may have evidence of decreased involvement in social activities.

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Activities CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has little interest or pleasure in doing things as indicated by:

   D0150A1 = 1

2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Any 6 items for interview for activity preferences has the value of 4 (not important at all) or 5 (important, but cannot do or no choice) as indicated by:

   Any 6 of F0500A through F0500H = 4 or 5

4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by:

   Any 6 of F0800L through F0800T = 0

The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The care plan should focus on addressing the underlying cause(s) of activity limitations and the development or inclusion of activity programs tailored to the resident's interests and to their cognitive, physical/functional, and social abilities and improve quality of life.

11. Falls

A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost their balance and would have fallen without staff intervention.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has had recent history of falls and balance problems.

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Falls CAT Logic Table

Triggering Conditions (any of the following):

1. Wandering occurs as indicated by a value of 1 through 3 as follows:

   E0900 >= 1 AND E0900 <= 3

2. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:

   If A0310A = 01 AND J1700A = 1

3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:

   If A0310A = 01 AND J1700B = 1

4. Resident has fallen at least one time since admission or the prior assessment as indicated by:

   J1800 = 1

5. Resident received antianxiety medication during the last 7 days or since admission/entry or reentry as indicated by:

   N0415B1 = 1

6. Resident received antidepressant medication during the last 7 days or since admission/entry or reentry as indicated by:

   N0415C1 = 1

7. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

   P0100B = 1 OR P0100B = 2

8. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:

   P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place them at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or

is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

2. Body mass index (BMI) is too low or too high as indicated by:

   BMI < 18.5000 OR BMI > 24.9000

3. Any weight loss as indicated by a value of 1 or 2 as follows:

   K0300 = 1 OR K0300 = 2

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

   K0310 = 1 OR K0310 = 2

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0520A2 = 1 OR K0520A3 = 1

6. Mechanically altered diet while a resident is used as nutritional approach as indicated by:

   K0520C3 = 1

7. Therapeutic diet while a resident is used as nutritional approach as indicated by:

   K0520D3 = 1

8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR
   (M0300C1 > 0 AND M0300C1 <= 9) OR
   (M0300D1 > 0 AND M0300D1 <= 9) OR
   (M0300E1 > 0 AND M0300E1 <= 9) OR
   (M0300F1 > 0 AND M0300F1 <= 9) OR
   (M0300G1 > 0 AND M0300G1 <= 9))

13. Feeding Tubes

This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to

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make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0520B2 = 1 OR K0520B3 = 1

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s), including any reversible issues and conditions that led to using a feeding tube.

14. Dehydration/Fluid Maintenance

Dehydration is a condition in which there is an imbalance of water and related electrolytes in the body. As a result, the body may become less able to maintain adequate blood pressure and electrolyte balance, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. In older persons, diagnosing dehydration is accomplished primarily by a detailed history, laboratory testing (e.g., electrolytes, BUN, creatinine, serum osmolality, urinary sodium), and to a lesser degree by a physical examination. Abnormal vital signs, such as falling blood pressure and an increase in the pulse rate, may sometimes be meaningful symptoms of dehydration in the elderly.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

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Dehydration/Fluid Maintenance CAT Logic Table

Triggering Conditions (any of the following):

1. Fever is selected as a problem health condition as indicated by:

   J1550A = 1

2. Vomiting is selected as a problem health condition as indicated by:

   J1550B = 1

3. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

4. Internal bleeding is selected as a problem health condition as indicated by:

   J1550D = 1

5. Infection present as indicated by:

   (I1700 = 1) OR
   (I2000 = 1) OR
   (I2100 = 1) OR
   (I2200 = 1) OR
   (I2300 = 1) OR
   (I2400 = 1) OR
   (I2500 = 1) OR
   ((M1040A = 1))

6. Constipation present as indicated by:

   H0600 = 1

7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0520A2 = 1 OR K0520A3 = 1

8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0520B2 = 1 OR K0520B3 = 1

The information gleaned from the assessment should be used to identify whether the resident is dehydrated or at risk for dehydration, as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration.

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15. Dental Care

The ability to chew food is important for adequate oral nutrition. Having clean and attractive teeth or dentures can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions. Medical illnesses and medication-related adverse consequences may increase a resident's risk for related complications such as impaired nutrition and communication deficits. The dental care CAA addresses a resident's risk of oral disease, discomfort, and complications.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has indicators of an oral/dental issue and/or condition.

Dental Care CAT Logic Table
Triggering Conditions (any of the following): 1. Any dental problem indicated by: **(L0200A = 1) OR** **(L0200B = 1) OR** **(L0200C = 1) OR** **(L0200D = 1) OR** **(L0200E = 1) OR** **(L0200F = 1)**

The information gleaned from the assessment should be used to identify the oral/dental issues and/or conditions and to identify any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's issues and/or conditions.

16. Pressure Ulcer/Injury

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

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Pressure Ulcer/Injury CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for movement in bed was needed, or activity was not attempted, as indicated by:

GG0170A1 does not = 06 OR GG0170A5 does not = 06 OR GG0170B1 does not = 06 OR GG0170B5 does not = 06 OR GG0170C1 does not = 06 OR GG0170C5 does not = 06

2. Frequent urinary incontinence as indicated by:

H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

M0150 = 1

6. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

((M0300B1 > 0 AND M0300B1 <= 9) OR
(M0300C1 > 0 AND M0300C1 <= 9) OR
(M0300D1 > 0 AND M0300D1 <= 9) OR
(M0300E1 > 0 AND M0300E1 <= 9) OR
(M0300F1 > 0 AND M0300F1 <= 9) OR
(M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

M0300A > 0 AND M0300A <= 9

8. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

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17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications, prescribed primarily to affect cognition, mood, or behavior, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication, in consultation with the physician and the consultant pharmacist, and to identify any adverse consequences, as well as any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.

Psychotropic Medication Use CAT Logic Table

Triggering Conditions (any of the following):

1. Antipsychotic medication administered to resident during the last 7 days or since admission/entry or reentry as indicated by:

   N0415A1 = 1

2. Antianxiety medication administered to resident during the last 7 days or since admission/entry or reentry as indicated by:

   N0415B1 = 1

3. Antidepressant medication administered to resident during the last 7 days or since admission/entry or reentry as indicated by:

   N0415C1 = 1

4. Hypnotic medication administered to resident during the last 7 days or since admission/entry or reentry as indicated by:

   N0415D1 = 1

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18. Physical Restraints

A physical restraint is defined as 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 and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. This category also includes the use of passive restraints such as chairs that prevent rising.

Physical restraints are only rarely indicated, and at most, should be used only as a short-term, temporary intervention to treat a resident's medical symptoms. They should not be used for purposes of discipline or convenience. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining their highest practicable level of physical and psychosocial well-being.

Restraints are often associated with negative physical and psychosocial outcomes (e.g., loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence). Adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation.

The physical restraint CAA identifies residents who are physically restrained during the look-back period. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Physical Restraints CAT Logic Table

Triggering Conditions (any of the following):

1. Bed rail restraint used in bed has value of 1 or 2 as indicated by:

   P0100A = 1 OR P0100A = 2

2. Trunk restraint used in bed has value of 1 or 2 as indicated by:

   P0100B = 1 OR P0100B = 2

3. Limb restraint used in bed has value of 1 or 2 as indicated by:

   P0100C = 1 OR P0100C = 2

4. Other restraint used in bed has value of 1 or 2 as indicated by:

   P0100D = 1 OR P0100D = 2

5. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100E = 1 OR P0100E = 2

6. Limb restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100F = 1 OR P0100F = 2

Physical Restraints CAT Logic Table

7. Chair restraint that prevents rising used in chair or out of bed has value of 1 or 2 as indicated by:

P0100G = 1 OR P0100G = 2

8. Other restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100H = 1 OR P0100H = 2

The information gleaned from the assessment should be used to identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by or risks related to restraint use.

The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or psychological condition(s) that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The ultimate goal is to eliminate restraint use by employing alternatives. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

19. Pain

Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." Pain can be affected by damage to various organ systems and tissues, for example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep.

As with all symptoms, pain symptoms are subjective and require a detailed history and additional physical examination, and sometimes additional testing, in order to clarify pain characteristics and causes and identify appropriate interventions. This investigation typically requires coordination between nursing staff and a health care practitioner.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has active symptoms of pain.

Pain CAT Logic Table

Triggering Conditions (any of the following):

1. Pain has made it hard for resident to sleep at night over the past 5 nights as indicated by:

   J0510 = 2, 3, or 4

2. Resident has limited day-to-day activity because of pain over past 5 days as indicated by:

   J0530 = 2, 3, or 4

3. Pain numeric intensity rating has a value from 7 to 10 as indicated by:

   J0600A >= 07 AND J0600A <=10

4. Verbal descriptor of pain is severe or very severe as indicated by a value of 3 or 4 as follows:

   J0600B = 3 OR J0600B = 4

5. Pain is frequent as indicated by a value of 3 or 4 and numeric pain intensity rating has a value of 4 through 10 or verbal descriptor of pain has a value of 2 through 4 as indicated by:

   (J0410 = 3 OR J0410 = 4) AND
   ((J0600A >= 04 AND J0600A <= 10) OR
   (J0600B >= 2 AND J0600B <= 4))

6. Staff assessment reports resident indicates pain or possible pain in body language as indicated by:

   (J0800A = 1) OR
   (J0800B = 1) OR
   (J0800C = 1) OR
   (J0800D = 1)

The information gleaned from the assessment should be used to identify the characteristics and possible causes, contributing factors, and risk factors related to the pain. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to alleviate symptoms and, to the extent possible, address the underlying condition(s) that cause the pain.

Management of pain may include various interventions, including medications and other treatments that focus on improving the person's quality of life and ability to function. Therefore, it is important to tailor an individualized care plan related to pain to the characteristics, causes, and consequences of pain in the context of a resident's whole picture, including medical conditions, cognitive capabilities, goals, wishes, and personal and psychosocial function.

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20. Return to Community Referral

All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. This ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments (Federal and State) have a responsibility to enforce and support these choices.

An individual in a nursing home with adequate decision making capacity, or through qualified decision making supports, can choose to leave the facility and/or request to talk to someone about returning to the community to receive needed supports at any time. The return to community referral portion of MDS 3.0 uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long-term care in the last restrictive setting possible. The CAA associated with this portion of MDS 3.0 focuses on residents who want to talk to someone about returning to the community and promotes opening the discussion about the individual's preferences for settings for receipt of services.

Individual choices related to returning to community living will vary, e.g., returning to a former home or a different community home, or, the individual may choose to stay in the nursing home. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible. This includes ensuring that the individual or surrogate is fully informed and involved in long-term care decision making, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident expresses interest in returning to the community.

Return to Community Referral CAT Logic Table

Triggering Condition:

1. Resident wants to or may want to talk to someone about returning to community as indicated by:

Q0500B = 1 or 9

The information gleaned from the assessment should be used to assess the resident's situation and begin appropriate care planning, discharge planning, and other follow-up measures. The next step is to develop an individualized care plan based directly on these findings.

The goal of care planning is to initiate and maintain collaboration between the nursing facility and the local contact agency (LCA) to support the individual's expressed interest in being transitioned to community living. The nursing home staff is responsible for making referrals to the LCAs under the process that the State has established. The LCA is, in turn, responsible for contacting referred residents and assisting with transition services planning. This includes facility support for the individual in achieving their highest level of functioning and the involvement of the designated local contact agency providing informed choices for community living. The LCA is the entity that does the necessary community support planning (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, arranging of care support, etc.). This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and their family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

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CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the payer source. Skilled nursing facilities (SNFs) and non-critical access hospitals (non-CAH) with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).

5.1 Transmitting MDS Data

All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS.

Assessments that are completed for purposes other than OBRA or SNF PPS reasons are not to be submitted to iQIES, examples include, but are not limited to, private insurance and Medicare Advantage Plans (i.e., Medicare Part C). After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 website at:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

The provider indicates the certification or licensure of the unit on which the resident resides in item A0410, Unit Certification or Licensure Designation. In addition to reflecting certification or licensure of the unit, this item indicates the submission authority for a record.

- Value = 1 Unit is neither Medicare nor Medicaid certified and MDS data is not required by CMS or the State.
- Value = 2 Unit is neither Medicare nor Medicaid certified but MDS data is required by the State.
- Value = 3 Unit is Medicare and/or Medicaid certified.

See Chapter 3, Section A for details concerning the coding of item A0410, Unit Certification or Licensure Designation. Note: CMS certified non-CAH Swing Bed unit assessments are always Value 3, Unit is Medicare and/or Medicaid certified.

When the transmission file is received by iQIES, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by iQIES for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the Error Messages guide.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
  - For all non-Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
  - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).
  - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).
  - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively.
  - For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000 for a Death in Facility tracking record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of State RAI Coordinators.)
- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:
  - For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
  - For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).

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- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).

- **Submission Format:** For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Each MDS record must be a separate file in a required XML format. The submission file is a compressed ZIP file that may contain multiple XML files. See the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 website for details concerning file and record formats, XML structure, and ZIP files.
- **Transmitting Data:** Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted.
  - **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
  - **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Submission Time Frame for MDS Records

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Admission Assessment	01	01, 99	10, 11, 99	V0200C2	V0200C2 + 14
Annual Assessment	03	01, 99	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Change in Status Assessment	04	01, 99	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Correction to Prior Comprehensive Assessment	05	01, 99	10, 11, 99	V0200C2	V0200C2 + 14
Quarterly Review Assessment	02	01, 99	10, 11, 99	Z0500B	Z0500B +14
Sign. Correction Prior Quarterly Assessment	06	01, 99	10, 11, 99	Z0500B	Z0500B + 14
PPS Assessment	99	01 or 08	10, 11, 99	Z0500B	Z0500B + 14
Discharge Assessment	All values	01, 99	10 or 11	Z0500B	Z0500B + 14
Death in Facility Tracking	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	01	A1600	A1600 + 14
Correction Request (Modification or Inactivation)	N/A	N/A	N/A	X1100E	X1100E + 14

Table Legend:

Item	Description
V0200C2	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the CAA Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
Z0500B	MDS Assessment Completion Date: Date of the RN assessment coordinator's signature, indicating that the MDS assessment is complete.
A2000	Date of discharge or death
A1600	Date of entry
X1100E	Date of the RN coordinator's signature on the Correction Request (Section X) certifying completion of the correction request information and the corrected assessment or tracking information.

- **Assessment Schedule:** An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 2 for details.

5.3 Validation Edits

iQIES has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.

Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES. This confirmation information includes the file submission identification number (ID), the date and time the file was received for processing as well as the file name.

Validation and Editing Process. Each time a user accesses iQIES and transmits an MDS file, iQIES performs three types of validation:

1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.

2. **Fatal Record Errors.** If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:

    - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).

- Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600).

Fatal Record Errors result in rejection of individual records by iQIES. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted, unless the Fatal Error is due to submission of a duplicate assessment.

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening Discharge assessment (A0310F = 10 or 11). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

Storage to iQIES. If there are any Fatal Record Errors, the record will be rejected and not stored in iQIES. If there are no Fatal Record Errors, the record is saved into iQIES, even if the record has Non-Fatal Errors (Warnings).

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 website and in the Error Messages guide.

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS "are required to submit the resident assessment data described at §483.20…. in the manner necessary to administer the payment rate methodology described in §413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments at specified windows during the Medicare Part A stay.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. Under PDPM, the first position represents the Physical Therapy/Occupational Therapy (PT/OT) Payment Group, the second position represents the Speech Language Pathology (SLP) Payment Group, the third position represents the Nursing Payment Group, the fourth position represents the Non-therapy Ancillary (NTA) Payment Group, and the fifth position represents the

Assessment Indicator (AI) code indicating which type of assessment was completed. Standard "grouper" logic and software for PDPM and the AI code are provided by CMS on the MDS 3.0 website.

The standard grouper uses MDS 3.0 items to determine both the PDPM group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the PDPM group and AI code. Detailed logic for determining the PDPM group and AI code is provided in Chapter 6.

The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The PDPM version code in Item Z0100B documents which version of PDPM was used to determine the PDPM payment groups represented in the Medicare Part A HIPPS code.

The HIPPS code (Z0100A) and PDPM version code (Z0100B) must be submitted to iQIES on all Medicare PPS assessment records (indicated by A0310B = 01 or 08). Both of these values are validated by iQIES. The final validation report will indicate if any of these items is in error and the correct value for the item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in iQIES.

The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in iQIES. The claim must include the correct HIPPS code for the assessment. If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3935a).

5.5 MDS Correction Policy

Once completed, edited, and accepted into iQIES, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay—the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into iQIES is the legal assessment. Corrections made to the electronic record after iQIES acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to iQIES in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in iQIES:

- If an error is discovered within 7 days of the completion of an MDS and before submission to iQIES, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.

- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the iQIES database.
- If an error is discovered in a record that has been accepted by iQIES, Modification or Inactivation procedures **must** be implemented by the provider to assure that iQIES information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in iQIES. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.

5.6 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into iQIES

If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in iQIES include records that have been submitted and rejected, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by iQIES. The paper copy should be corrected according to standard procedures detailed below.

Errors Identified During the Encoding Period

Facilities have up to 7 days to encode (enter into the software) and edit an MDS assessment after the MDS has been completed. Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a provider may correct item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as was used for the original item completion (i.e., the same ARD (A2300) and look-back period). Both the electronic and paper copies of the MDS must be corrected.

Errors Identified After the Encoding Period

Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to iQIES. The correction process may be more complex if the record in error is an OBRA comprehensive or Quarterly assessment record (i.e., Item A0310A = 01 through 06).

Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**.

If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to iQIES.

The correction process is more complicated for nursing home OBRA comprehensive or Quarterly assessments with ***any significant errors*** identified after the end of the 7-day encoding and editing period but before the records have been accepted into iQIES. First, the nursing home must correct the original OBRA comprehensive or Quarterly assessment to reflect the resident's actual status as of the ARD for that original assessment and submit the record. Second, to ensure an up-to-date view of the resident's status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident's status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.

In summary, the nursing home must take the following actions for an OBRA comprehensive or Quarterly assessment that has ***not*** been submitted to iQIES when it contains significant errors:

- Correct the errors in the original OBRA comprehensive or Quarterly assessment.
- Submit the corrected assessment.

- Perform a ***new*** assessment – a Significant Change in Status Assessment or a Significant Correction to Prior Assessment and update the care plan as necessary.

If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 or 08) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare-only and Discharge assessments.

5.7 Correcting Errors in MDS Records That Have Been Accepted Into iQIES

Facilities should correct any errors necessary to ensure that the information in iQIES accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within 2 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

Errors identified in iQIES records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. The following two processes have been established to correct MDS records (assessments, Entry tracking records or Death in Facility tracking records) that have been accepted into iQIES:

- Modification
- Inactivation

A Modification request moves the inaccurate record into history in iQIES and replaces it with the corrected record as the active record. An Inactivation request also moves the inaccurate record into history in iQIES, but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0.

The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable location of the erroneous MDS record previously submitted and accepted into iQIES. Section X items are defined in the MDS 3.0 Data Submission Specifications posted on the CMS MDS 3.0 website.

When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. In addition, the facility would keep a hard copy of the Correction Request items (Section X) with an inactivated record. For details on electronic records, see Chapter 2, Section 2.4.

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Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in iQIES, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include:

- Target Date
  - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
  - Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),
  - Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)

*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look-back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2021, was inadvertently entered as 02/02/2021. The interdisciplinary team (IDT) completed the assessment based on the ARD of 02/12/2021 (that is, the seven day look-back period was 02/06/2021 through 02/12/2021). This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2021.
- An assessment was completed by the team and entered into the software based on the ARD of 01/10/2021 (and seven day look-back period of 01/04/2021 through 01/10/2021). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 01/07/2021. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done. Consider the following example:

- An Admission assessment (ISC = NC) was completed and accepted into iQIES. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

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- An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
  - Unit Certification or Licensure Designation (Item A0410)
  - State-assigned facility submission ID (FAC_ID) or State Code (STATE_CD)
  - Record submitted was not for OBRA or Medicare Part A purposes
  - Test record submitted as a production record

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in Section 5.8) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in a nursing home OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06) in iQIES, then the nursing home must determine if there are any significant errors. If the ***only errors are minor errors***, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any ***significant error*** is discovered in an OBRA comprehensive or Quarterly assessment in iQIES, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if correction of the MDS item(s) revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in iQIES have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant

Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in iQIES is corrected.

The Cross-Over Rule

- *When item sets are updated, a* situation *may* exist that will prevent providers from correcting the target date of any assessment crossing over *from* October 1 *of a given year*. That is, providers may not submit a modification to change a target date on an assessment completed prior to October 1 *of a given year* to a target date on or after October 1 *of the same year*, nor can they submit a modification to change a target date on an assessment completed on or after October 1 *of a given year* to a target date prior to October 1 *of a given year when the MDS item sets have had substantial changes*.
- *When t*he *MDS* item sets have had significant changes, including the omission and addition of many items *or significant changes to existing items, clinicians will be required to collect and code new items, may have different look-back periods, or may need to code the MDS according to changes in the coding requirements*. It is the target date of the assessment that identifies the required version of the item set, and, because of the substantial changes *that may exist between versions of* the item sets, they are not interchangeable. Therefore, *commonly when there are updates to item sets,* providers may not change target dates on assessments crossing over October 1 *of specific years*.

Inactivation Requests

An Inactivation should be used when a record has been accepted into iQIES but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Discharge Date (Item A2000) on a Discharge assessment record (Item A0310F = 10, 11) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and item A0050 are completed. This is sufficient information to locate the record in iQIES, inactivate the record and document the reason for inactivation.

For instances when the provider determines that the Type of Provider is incorrect, the provider must inactivate the record in iQIES, then complete and submit a new MDS 3.0 record with the correct Type of Provider, ensuring that the clinical information is accurate.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in iQIES cannot be corrected with an automated Modification or Inactivation request. These errors are:

1. The record is a test record inadvertently submitted as production.
2. The record has the wrong unit certification or licensure designation in Item A0410.
3. The record has the wrong state code or facility ID in the control Items STATE_CD or FAC_ID.
4. *The record submitted was not for OBRA or Medicare Part A purposes.*

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the appropriate MDS 3.0 Manual Individual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility must submit the completed form to the State Agency. Completed forms with Protected Health Information (PHI) must be sent via certified mail through the United States Postal Service (USPS). The State Agency will review the request for completion and accuracy. After approving the provider's request, the State Agency must sign the form and send it to the iQIES Help Desk. Completed forms with PHI must be sent via certified mail through the USPS.

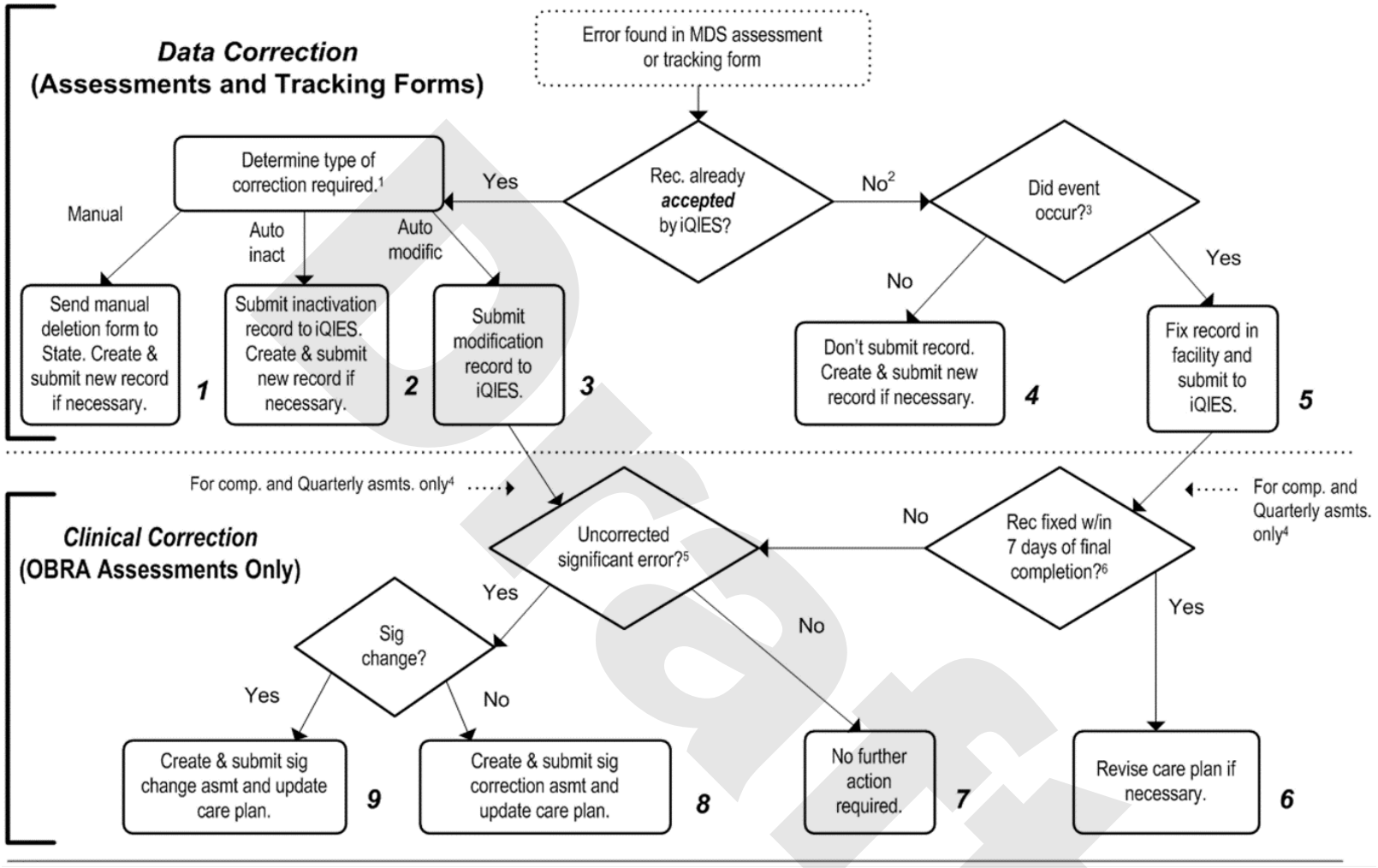
When a test record is in iQIES, the problem must be evaluated and iQIES appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual deletion is necessary to completely remove the test record and associated information.

An iQIES record with an incorrect unit certification or licensure designation in Item A0410 is a very serious problem. Submission of MDS assessment records to iQIES constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into iQIES. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the iQIES history file with the wrong access control. Consider a record in iQIES with an A0410 value of 3 (Unit is Medicare and/or Medicaid certified) when actually the unit is neither Medicare nor Medicaid certified and MDS data is not required by the State (A0410 should have been 1). The record

should not be in iQIES at all and manual deletion is necessary to completely remove the record from iQIES. Consider a record with an A0410 value of 3 indicating that the Unit is Medicare and/or Medicaid certified but actually the unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the iQIES history file.

If an iQIES record has the wrong state code or facility ID (control item STATE_CD, FAC_ID), then the record must be removed without leaving any trace in iQIES. The record also should be resubmitted with the correct STATE_CD and FAC_ID value.

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[1] Manual deletion request is required if test record submitted as production record, if record contains incorrect STATE_CD or FAC_ID, or if record was submitted with an incorrect Unit Certification or Licensure Designation (A0410), for example sent in as Unit is Medicare and/or Medicaid certified (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 = 2); or record is not for OBRA or Medicare Part A (e.g., a PPS assessment submitted for resident whose stay is covered by a Medicare Advantage Plan) purposes.

[2] Record has not been data entered, has not been submitted, or has been submitted and rejected by iQIES.

[3] The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a Discharge assessment was created for a resident who was not actually discharged), then the event did not occur.

[4] OBRA comprehensive assessments with A0310A = 01, 03, 04, 05 and Quarterly assessments with A0310A = 02, 06.

[5] The assessment contains a significant error which has not been corrected by a subsequent assessment.

[6] Final completion date is item V0200C2 for a comprehensive and Z0500B for all other assessments.

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CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Prospective Payment System (PPS) for skilled nursing facilities (SNFs) and hospitals with a swing bed agreement, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for SNFs under Part A of the program (**Federal Register** Vol. 63, No. 91, May 12, 1998, Final Rule). Effective with cost reporting periods beginning on or after July 1, 2002, SNF-level services furnished in rural swing bed hospitals are paid based on the SNF PPS instead of the previous, cost-related method (**Federal Register** Vol. 66, No. 147, July 31, 2001, Final Rule). However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 included an exemption of critical access hospital swing beds from the SNF PPS.

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970s that focus on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that developed and implemented similar case-mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of the Federal payment system (i.e., PPS) for nursing home care is based on recognizing the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case-mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels should be higher than for those residents with less intensive care needs. In a case-mix adjusted payment system, the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the Minimum Data Set (MDS). Case-mix reimbursement has become a widely adopted method for financing nursing home care. The case-mix approach serves as the basis for the PPS for skilled nursing facilities and swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

6.2 Using the MDS in the Medicare Prospective Payment System

The MDS assessment data is used to calculate the resident's Patient Driven Payment Model (PDPM) classification necessary for payment. The MDS contains extensive information on the resident's nursing and therapy needs, ADL status, cognitive status, behavioral problems, and medical diagnoses. This information is used to define PDPM case-mix adjusted groups, within

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which a hierarchy exists that assigns case-mix weights that capture differences in the relative resources used for treating different types of residents.

Over half of the State Medicaid programs also use the MDS for their case-mix payment systems. The Resource Utilization Group, Version IV (RUG-IV) system replaced the Resource Utilization Group, Version III (RUG-III) system for Medicare starting on October 1, 2010. Starting October 1, 2019, PDPM replaced the RUG-IV system. However, State Medicaid agencies have the option to use the RUG-III, RUG-IV, or PDPM classification systems. CMS also makes available for the States alternative RUG-IV classification systems with 66, 57, or 48 groups with varying numbers of Rehabilitation groups (similar to the RUG-III 53, 44, and 34 groups). States have the option of selecting the system (RUG-III or RUG-IV) with the number of Rehabilitation groups that better suits their Medicaid long-term care population. State Medicaid programs always have the option to develop nursing home reimbursement systems that meet their specific program goals. The decision to implement a certain classification system for Medicaid is a State decision. Please contact your State Medicaid agency if you have questions about your State Medicaid reimbursement system.

6.3 Patient Driven Payment Model (PDPM)

PDPM adjusts payment for each major element of a resident's SNF care, specifically for physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillaries (NTA). In section 6.6 below, we provide a PDPM calculation worksheet. This calculation worksheet was developed in order to provide clinical staff with a better understanding of how PDPM works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system.

6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of PPS assessments. The 5-Day assessment is the only required PPS assessment that is used to support PPS reimbursement. However, as described in Chapter 2, Section 2.9, an optional assessment, the Interim Payment Assessment (IPA), may be used to reclassify the resident into a new PDPM classification, and would also affect the associated payment rate. See Chapter 2 of this manual for greater detail on assessment types and requirements.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements.

For example, if a resident's status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a PDPM classification is not an indication that the requirements for a SNF Part A stay have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all-inclusive and definitive. Refer to the **Medicare Claims Processing Manual**, Chapter 6

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(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf), for detailed claims processing requirements and policies.

The SNF claim must include two data items derived from the MDS assessment:

Assessment Reference Date (ARD)

The ARD must be reported on the SNF claim. CMS has developed internal mechanisms to link the MDS assessment and the claims processing system.

Health Insurance Prospective Payment System (HIPPS) Code

Each SNF claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC). The HIPPS code consists of a series of codes representing the resident's PDPM classification and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

PDPM Classification

The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement. The PDPM classification is calculated from the MDS assessment clinical data. See Section 6.6 for calculation details on each PDPM group. CMS provides standard software, development tools, and logic for PDPM calculation. CMS software, or private software developed with the CMS data specifications, is used to encode and transmit the MDS assessment data and automatically calculates the resident's PDPM classification. CMS edits and validates the PDPM classification code of transmitted MDS assessments. Skilled nursing facilities are not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the PDPM classification code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (ZZZZZ). See Section 6.8 for details.

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Table 1. First Character: PT/OT Component

Clinical Category	Section GG Function Score	PT/OT Case-Mix Group	HIPPS Character
Major Joint Replacement or Spinal Surgery	0-5	TA	A
Major Joint Replacement or Spinal Surgery	6-9	TB	B
Major Joint Replacement or Spinal Surgery	10-23	TC	C
Major Joint Replacement or Spinal Surgery	24	TD	D
Other Orthopedic	0-5	TE	E
Other Orthopedic	6-9	TF	F
Other Orthopedic	10-23	TG	G
Other Orthopedic	24	TH	H
Medical Management	0-5	TI	I
Medical Management	6-9	TJ	J
Medical Management	10-23	TK	K
Medical Management	24	TL	L
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	M
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	N
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	O
Non-Orthopedic Surgery and Acute Neurologic	24	TP	P

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Table 2. Second Character: SLP Component

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	HIPPS Character
None	Neither	SA	A
None	Either	SB	B
None	Both	SC	C
Any one	Neither	SD	D
Any one	Either	SE	E
Any one	Both	SF	F
Any two	Neither	SG	G
Any two	Either	SH	H
Any two	Both	SI	I
All three	Neither	SJ	J
All three	Either	SK	K
All three	Both	SL	L

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Table 3. Third Character: Nursing Component

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	A
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	B
ES1	Infection	-	-	-	0-14	ES1	C
HE2/HD2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	0-5	HDE2	D
HE1/HD1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	E
HC2/HB2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	F
HC1/HB1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	G
LE2/LD2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	0-5	LDE2	H
LE1/LD1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	0-5	LDE1	I
LC2/LB2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	6-14	LBC2	J

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RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
LC1/LB1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	6-14	LBC1	K
CE2/CD2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	L
CE1/CD1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	0-5	CDE1	M
CC2/CB2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	N
CA2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	O
CC1/CB1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	6-14	CBC1	P
CA1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	15-16	CA1	Q
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	R
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	S
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	T

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RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	U
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	V
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	W
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	X
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	Y

Table 4. Fourth Character: NTA Component

NTA Score Range	NTA Case-Mix Group	HIPPS Character
12+	NA	A
9-11	NB	B
6-8	NC	C
3-5	ND	D
1-2	NE	E
0	NF	F

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The PDPM HIPPS code is recorded on the MDS 3.0 in item Z0100A (Medicare Part A HIPPS code). The HIPPS code included on the SNF claim depends on the specific type of assessment involved (as described below).

The HIPPS code in item Z0100A is validated by CMS when the assessment is submitted. If the submitted code is incorrect, the validation report will include a warning giving the correct code; the facility must enter this correct code in the HIPPS code item on the bill.

The provider must ensure that all PPS assessment requirements are met. When the provider fails to meet the PPS assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the PDPM classification-based HIPPS code validated by CMS in item Z0100A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

AI Code

The last position of the HIPPS code represents the AI, identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of item A0310B. CMS provides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility must enter this correct AI code in the HIPPS code item on the bill. The code consists of one digit, which is defined below. In situations when the provider is to bill the default code, the AI provided on the validation report is to be used along with the default code, ZZZZZ, on the SNF claim.

Refer to the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

The AI code identifies the assessment used to establish the per diem payment rate for the standard PPS payment periods. These assessments are the 5-Day assessment and Interim Payment Assessment. Table 5 displays the AI code for each of the PPS assessment types and the standard payment period for each assessment type.

Table 5. Assessment Indicator Table

AI Code	Assessment Type (abbreviation)	Standard Payment Period
0	Interim Payment Assessment	See Chapter 2, Section 2.9
1	5-Day	Entire Part A Stay

6.5 SNF PPS Eligibility Criteria

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized in this section. Refer to the **Medicare General Information, Eligibility, and Entitlement Manual**, Chapter 1 (Pub. 100-1), and the **Medicare Benefit Policy Manual**, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

Technical Eligibility Requirements

The beneficiary must meet the following criteria:

- Beneficiary is enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay (i.e., three midnights).
- Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Clinical Eligibility Requirements

A beneficiary is eligible for SNF extended care if all of the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition:
  - for which the resident was treated during the qualifying hospital stay, or
  - that arose while the resident was in the SNF for treatment of a condition for which they were previously treated in a hospital.

Physician Certification

The attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing facility.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
  - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
  - validates via written statement that the resident's assignment to one of the upper PDPM groups (defined below) is correct.

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- Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
- PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
- The NTA component's uppermost (12+) comorbidity group.

- **Re-certifications** are used to document the continued need for skilled extended care services.
  - The first re-certification is required no later than the 14th day of the SNF stay.
  - Subsequent re-certifications are required at no later than 30-day intervals after the date of the first re-certification.
  - The initial certification and first re-certification may be signed at the same time.

6.6 PDPM Calculation Worksheet for SNFs

In the PDPM, there are five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each resident is to be classified into one and only one group for each of the five case-mix adjusted components. In other words, each resident is classified into a PT group, an OT group, an SLP group, an NTA group, and a nursing group. For each of the case-mix adjusted components, there are a number of groups to which a resident may be assigned, based on the relevant MDS 3.0 data for that component. There are 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups.

PDPM classifies residents into a separate group for each of the case-mix adjusted components, each of which has its own associated case-mix indexes and base rates. Additionally, PDPM applies variable per diem payment adjustments to three components, PT, OT, and NTA, to account for changes in resource use over a stay. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP and nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.

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Calculation of PDPM Cognitive Level

The PDPM cognitive level is utilized in the SLP payment component of PDPM. One of four PDPM cognitive performance levels is assigned based on the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status for the PDPM cognitive level. If neither the BIMS nor the staff assessment for the PDPM cognitive level is complete, then the resident will be classified as if the resident is cognitively intact.

STEP #1

Determine the resident's BIMS Summary Score on the MDS 3.0 based on the resident interview. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS involves the following items:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score that ranges from 00 to 15. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Calculate the resident's PDPM cognitive level using the following mapping:

Table 6: Calculation of PDPM Level from BIMS

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13-15
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

PDPM Cognitive Level: _____

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), then proceed to Step #2 to use the Staff Assessment for Mental Status for the PDPM cognitive level.

STEP #2

If the resident's Summary Score is 99 or the Summary Score is blank or has a dash value, then determine the resident's cognitive status based on the Staff Assessment for Mental Status for the PDPM cognitive level using the following steps:

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A) The resident classifies as severely impaired if one of the following conditions exists:

   a. Comatose (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88). It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

   b. Severely impaired cognitive skills for daily decision making (C1000 = 3).

B) If the resident is not severely impaired based on Step A, then determine the resident's Basic Impairment Count and Severe Impairment Count.

For each of the conditions below that applies, add one to the Basic Impairment Count.

   a. In Cognitive Skills for Daily Decision Making, the resident has modified independence or is moderately impaired (C1000 = 1 or 2).

   b. In Makes Self Understood, the resident is usually understood, sometimes understood, or rarely/never understood (B0700 = 1, 2, or 3).

   c. Based on the Staff Assessment for Mental Status, the resident has a memory problem (C0700 = 1).

Sum a., b., and c. to get the Basic Impairment Count: _____

For each of the conditions below that applies, add one to the Severe Impairment Count.

   a. In Cognitive Skills for Daily Decision Making, the resident is moderately impaired (C1000 = 2).

   b. In Makes Self Understood, the resident is sometimes understood or rarely/never understood (B0700 = 2 or 3).

Sum a. and b. to get the Severe Impairment Count: _____

C) The resident classifies as moderately impaired if the Severe Impairment Count is 1 or 2 and the Basic Impairment Count is 2 or 3.

D) The resident classifies as mildly impaired if the Basic Impairment Count is 1 and the Severe Impairment Count is 0, 1, or 2, or if the Basic Impairment Count is 2 or 3 and the Severe Impairment Count is 0.

E) The resident classifies as cognitively intact if both the Severe Impairment Count and Basic Impairment Count are 0.

PDPM Cognitive Level: _____

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PDPM Payment Component: PT

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's PT clinical category based on the mapping shown below.

Table 7: PT Clinical Category

Primary Diagnosis Clinical Category	PT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

PT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for PT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 8: Function Score for PT Payment

Admission or Interim Performance (Column 1 or 5) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

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divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for PT Payment**. The PDPM Function Score for PT Payment ranges from 0 through 24.

PT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's PT group using the table below.

Table 9: PT Case-Mix Groups

Clinical Category	Section GG Function Score	PT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0-5	TA
Major Joint Replacement or Spinal Surgery	6-9	TB
Major Joint Replacement or Spinal Surgery	10-23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0-5	TE
Other Orthopedic	6-9	TF
Other Orthopedic	10-23	TG
Other Orthopedic	24	TH
Medical Management	0-5	TI
Medical Management	6-9	TJ
Medical Management	10-23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

PDPM PT Classification: _____

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PDPM Payment Component: OT

***Note: The steps for calculating the resident's PDPM classification for the OT component follow the same logic used for calculating the resident's PDPM classification for the PT component, described above.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

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STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's OT clinical category based on the mapping shown below.

Table 10: OT Clinical Category

Primary Diagnosis Clinical Category	OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

OT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for OT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 11: Function Score for OT Payment

Admission or Interim Performance (Column 1 or 5) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

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divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for OT Payment**. The PDPM Function Score for OT Payment ranges from 0 through 24.

OT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's OT group using the table below.

Table 12: OT Case-Mix Groups

Clinical Category	Section GG Function Score	OT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0-5	TA
Major Joint Replacement or Spinal Surgery	6-9	TB
Major Joint Replacement or Spinal Surgery	10-23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0-5	TE
Other Orthopedic	6-9	TF
Other Orthopedic	10-23	TG
Other Orthopedic	24	TH
Medical Management	0-5	TI
Medical Management	6-9	TJ
Medical Management	10-23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

PDPM OT Classification: _____

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PDPM Payment Component: SLP

***Note: The primary diagnosis clinical category used for the SLP component is the same as the clinical category used for the PT and OT components.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

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STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's SLP clinical category based on the mapping shown below.

Table 13: SLP Clinical Category

Primary Diagnosis Clinical Category	SLP Clinical Category
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Non-Neurologic
Non-Orthopedic Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Pulmonary	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Acute Neurologic	Acute Neurologic
Cancer	Non-Neurologic
Medical Management	Non-Neurologic

SLP Clinical Category: _____

STEP #3

Determine whether the resident has one or more SLP-related comorbidities. To do so, examine the services and conditions in the table below. If any of these items is indicated as present, the resident has an SLP-related comorbidity. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Table 14: SLP-Related Comorbidities

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia
I8000	Dysphagia
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits
O0110E1b	Tracheostomy Care While a Resident
O0110F1b	Invasive Mechanical Ventilator or Respirator While a Resident

Presence of one or more SLP-related comorbidities? (Yes/No) _____

STEP #4

Determine whether the resident has a cognitive impairment. Calculate the resident's PDPM cognitive level, as described previously. If the PDPM cognitive level is cognitively intact, then the resident does not have a cognitive impairment. Otherwise, if the resident is assessed as mildly, moderately, or severely impaired, then the resident classifies as cognitively impaired.

Presence of Cognitive Impairment? (Yes/No) _____

STEP #5

Determine how many of the following conditions are present:

a. Based on Step 2, the resident is classified in the Acute Neurologic clinical category.

b. Based on Step 3, the resident has one or more SLP-related comorbidities.

c. Based on Step 4, the resident has a cognitive impairment.

Number of conditions present: _____

STEP #6

Determine whether the resident has a swallowing disorder using item K0100. If any of the conditions indicated in items K0100A through K0100D is present, then the resident has a swallowing disorder. If none of these conditions is present, the resident does not have a swallowing disorder for purposes of this calculation.

Presence of Swallowing Disorder? (Yes/No) _____

STEP #7

Determine whether the resident has a mechanically altered diet. If K0520C3 (mechanically altered diet while a resident) is checked, then the resident has a mechanically altered diet.

Presence of Mechanically Altered Diet? (Yes/No) _____

STEP #8

Determine how many of the following conditions are present based on Steps 6 and 7:

a. The resident has neither a swallowing disorder nor a mechanically altered diet.

b. The resident has either a swallowing disorder or a mechanically altered diet.

c. The resident has both a swallowing disorder and a mechanically altered diet.

Presence of Mechanically Altered Diet or Swallowing Disorder? (Neither/Either/Both): _____

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STEP #9

Determine the resident's SLP group using the responses from Steps 1-8 and the table below.

Table 15: SLP Case-Mix Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
None	Neither	SA
None	Either	SB
None	Both	SC
Any one	Neither	SD
Any one	Either	SE
Any one	Both	SF
Any two	Neither	SG
Any two	Either	SH
Any two	Both	SI
All three	Neither	SJ
All three	Either	SK
All three	Both	SL

PDPM SLP Classification: _____

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PDPM Payment Component: NTA

STEP #1

Determine whether resident has one or more NTA-related comorbidities.

1. Determine whether the resident has HIV/AIDS. HIV/AIDS is not reported on the MDS but is recorded on the SNF claim (ICD-10-CM code B20).

   Resident has HIV/AIDS? (Yes/No) _____

2. Determine whether the resident meets the criteria for the comorbidity: "Parenteral/IV Feeding – High Intensity" or the comorbidity: "Parenteral/IV Feeding – Low Intensity." To do so, first determine if the resident received parenteral/IV feeding during the last 7 days while a resident of the SNF using item K0520A3. If the resident did not receive parenteral/IV feeding during the last 7 days while a resident, then the resident does not meet the criteria for Parenteral/IV Feeding – High Intensity or Parenteral/IV Feeding – Low Intensity.

   If the resident did receive parenteral/IV feeding during the last 7 days while a resident, then use item K0710A to determine if the proportion of total calories the resident received through parenteral or tube feeding was 51% or more while a resident (K0710A2 = 3). If K0710A2 = 3, then the resident meets the criteria for Parenteral/IV Feeding – High Intensity. If the proportion of total calories the resident received through parenteral or tube feeding was 26-50% (K0710A2 = 2) and average fluid intake per day by IV or tube feeding was 501 cc per day or more while a resident (K0710B2 = 2), then the resident qualifies for Parenteral/IV Feeding – Low Intensity.

   Presence of Parenteral/IV Feeding – High Intensity? (Yes/No) _____

   Presence of Parenteral/IV Feeding – Low Intensity? (Yes/No) _____

3. Determine whether the resident has any additional NTA-related comorbidities. To do this, examine the conditions and services in the table below, of which all except HIV/AIDS are recorded on the MDS. HIV/AIDS is recorded on the SNF claim. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

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Table 16: NTA Comorbidity Score Calculation

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	N/A (SNF claim)	8
Parenteral IV Feeding: Level High	K0520A3, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0110H1b	5
Special Treatments/Programs: Invasive Mechanical Ventilator or Respirator Post-admit Code	O0110F1b	4
Parenteral IV Feeding: Level Low	K0520A3, K0710A2, K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0110I1b	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	O0110E1b	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0110M1b	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0110B1b	1
Stage 4 Unhealed Pressure Ulcer Currently Present[1]	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1

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Condition/Extensive Service	MDS Item	Points
Other Foot Skin Problems: Foot Infection Code, Diabetic Foot Ulcer Code, Other Open Lesion on Foot Code	M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0110D1b	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0520B3	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

[1] If the number of Stage 4 Unhealed Pressure Ulcers is recorded as greater than 0, it will add one point to the NTA comorbidity score calculation. Only the presence, not the count, of Stage 4 Unhealed Pressure Ulcers affects the PDPM NTA comorbidity score calculation.

STEP #2

Calculate the resident's total NTA score using the table above. To calculate the total NTA score, sum the points corresponding to each condition or service present. If none of these conditions or services is present, the resident's score is 0.

NTA Score: _____

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STEP #3

Determine the resident's NTA group using the table below.

Table 17: NTA Case-Mix Groups

NTA Score Range	NTA Case-Mix Group
12+	NA
9-11	NB
6-8	NC
3-5	ND
1-2	NE
0	NF

PDPM NTA Classification: _____

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PDPM Payment Component: Nursing

STEP #1

Calculate the resident's Function Score for nursing payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

Table 18: Function Score for Nursing Payment

Admission Performance (Column 1) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

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Next, calculate the average score for the two bed mobility items and the three transfer items as follows: Average the scores for Sit to Lying and Lying to Sitting on Side of Bed.[1] Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer.[2] Enter the average bed mobility and transfer scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Calculate the sum of the following scores: Eating Function Score, Toileting Hygiene Function Score, Average Bed Mobility Score, and Average Transfer Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for nursing payment**. The PDPM Function Score for nursing payment ranges from 0 through 16.

PDPM NURSING FUNCTION SCORE: _____

STEP #2

Determine the resident's nursing case-mix group using the hierarchical classification below. Nursing classification under PDPM employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the PDPM nursing classification model steps discussed below; the assigned classification is the first group for which the resident qualifies. In other words, start with the Extensive Services groups at the top of the PDPM nursing classification model. Then go down through the groups in hierarchical order: Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 25 individual PDPM nursing groups for which the resident qualifies, assign that group as the PDPM nursing classification.

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[1] Calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed. Divide this sum by 2. This is the Average Bed Mobility Function Score.

[2] Calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer. Divide by 3. This is the Average Transfer Function Score.

CATEGORY: EXTENSIVE SERVICES

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP #1

Determine whether the resident is coded for **one** of the following treatments or services:

O0110E1b	Tracheostomy care while a resident
O0110F1b	Invasive mechanical ventilator or respirator while a resident
O0110M1b	Isolation or quarantine for active infectious disease while a resident

If the resident does not receive one of these treatments or services, skip to the Special Care High Category now.

STEP #2

If at least **one** of these treatments or services is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify in the Extensive Services category. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	PDPM Nursing Classification
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Isolation or quarantine for active infectious disease* **without** tracheostomy care* **without** ventilator/respirator*	ES1

*while a resident

PDPM Nursing Classification: _____

If the resident does not classify in the Extensive Services Category, proceed to the Special Care High Category.

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CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0520B2 or K0520B3 Feeding tube*
K0520A2 or K0520A3	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories OR

(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to the Special Care Low Category now.

STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify as Special Care High. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

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STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

PDPM Nursing Classification: _____

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CATEGORY: SPECIAL CARE LOW

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, Nursing Function Score	Cerebral palsy, with Nursing Function Score <=11
I5200, Nursing Function Score	Multiple sclerosis, with Nursing Function Score <=11
I5300, Nursing Function Score	Parkinson's disease, with Nursing Function Score <=11
I6300, O0110C1b	Respiratory failure and oxygen therapy while a resident
K0520B2 or K0520B3	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer or any unstageable pressure ulcer due to slough and/or eschar with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0110B1b	Radiation treatment while a resident
O0110J1b	Dialysis treatment while a resident

*Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories OR

(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:
M1200A, B Pressure relieving chair and/or bed
M1200C Turning/repositioning program
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer/injury care
M1200G Application of nonsurgical dressings (not to feet)
M1200H Application of ointments/medications (not to feet)
#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to the Clinically Complex Category now.

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STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, they classify as Special Care Low. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, they classify as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

PDPM Nursing Classification: _____

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CATEGORY: CLINICALLY COMPLEX

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

Table 19: Clinically Complex Conditions or Services

MDS Item	Condition or Service
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D, E	Open lesions (other than ulcers, rashes, and cuts) or surgical wounds with any selected skin treatments*
M1040F	Burns (second or third degree)
O0110A1b	Chemotherapy while a resident
O0110C1b	Oxygen therapy while a resident
O0110H1b	IV Medications while a resident
O0110I1b	Transfusions while a resident

*Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)

If the resident does not have one of these conditions, skip to the Behavioral Symptoms and Cognitive Performance Category now.

STEP #2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-2 to 9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-2 to 9© are in Chapter 3, Section D. Item D0100 is a gateway question to determine when the Patient Mood Interview (D0100 is coded 1, Yes) or the Staff Assessment of Patient Mood is to be conducted (D0100 is coded 0, No). Refer to Appendix E for cases in which the PHQ-2 to 9© or PHQ-9-OV© is complete but all questions are not answered. For the PHQ-2 to 9©, if either D0150A2 or D0150B2 is coded 2 or 3, continue asking the questions below, otherwise end the PHQ interview. Assessors should proceed to D0700, Social Isolation in the case of resident refusal or unwillingness to participate. The following items comprise the PHQ-2 to 9© and PHQ-9-OV© for the Patient and Staff assessments, respectively:

Resident	Staff	Description
D0150A	D0500A	Little interest or pleasure in doing things
D0150B	D0500B	Feeling down, depressed, or hopeless
D0150C	D0500C	Trouble falling or staying asleep, or sleeping too much
D0150D	D0500D	Feeling tired or having little energy
D0150E	D0500E	Poor appetite or overeating
D0150F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0150G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0150H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0150I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0160 and for the staff assessment at item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0160 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #3

Select the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
15-16	Yes	CA2
6-14	No	CBC1
15-16	No	CA1

PDPM Nursing Classification: _____

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CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP #1

Determine the resident's PDPM Nursing Function Score. If the resident's PDPM Nursing Function Score is 11 or greater, go to Step #2.

If the PDPM Nursing Function Score is less than 11, skip to the Reduced Physical Function Category now.

STEP #2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

If the resident's Summary Score is less than or equal to 9, they classify in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.

If the resident's Summary Score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

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STEP #3

Determine the resident's cognitive status based on the staff assessment rather than on resident interview.

Check if **one** of the three following conditions exists:

1.	B0100	Coma (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
2.	C1000	Severely impaired cognitive skills for daily decision making (C1000 = 3)
3.	B0700, C0700, C1000	Two or more of the following impairment indicators are present: B0700 > 0 Usually, sometimes, or rarely/never understood C0700 = 1 Short-term memory problem C1000 > 0 Impaired cognitive skills for daily decision making **and** One or more of the following severe impairment indicators are present: B0700 >= 2 Sometimes or rarely/never makes self understood C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making

If the resident meets one of the three above conditions, then they classify in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If they do not meet any of the three conditions, proceed to Step #4.

STEP #4

Determine whether the resident presents with **one** of the following behavioral symptoms:

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

If the resident presents with one of the symptoms above, then they classify in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If they do not present with behavioral symptoms, skip to the Reduced Physical Function Category.

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STEP #5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #6

Select the final PDPM Classification by using the total PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

PDPM Nursing Classification: _____

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CATEGORY: REDUCED PHYSICAL FUNCTION

STEP #1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a PDPM Nursing Function Score less than 11, are placed in this category.

STEP #2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #3

Select the PDPM Classification by using the PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
15-16	2 or more	PA2
6-14	0 or 1	PBC1
15-16	0 or 1	PA1

PDPM Nursing Classification: _____

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Calculation of Variable Per Diem Payment Adjustment

PDPM incorporates variable per diem payment adjustments to account for changes in resource use over the course of a stay for three payment components: PT, OT, and NTA. To calculate the per diem rate for these components, multiply the component base rate by the case-mix index associated with the resident's case-mix group and the adjustment factor based on the day of the stay, as shown in the following equation:

Component Per Diem Payment = Component Base Rate x Resident Group CMI x Component Adjustment Factor

The adjustment factors for the PT and OT components can be found in the table below.

Table 20: PT and OT Variable Per Diem Adjustment Factors

Day in Stay	PT and OT Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

The adjustment factors for the NTA component can be found in the table below.

Table 21: NTA Variable Per Diem Adjustment Factors

Day in Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

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Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate

The total case-mix adjusted PDPM per diem rate equals the sum of each of the five case-mix adjusted components and the non-case-mix adjusted rate component. To calculate the total case-mix adjusted per diem rate, add all component per diem rates calculated in prior steps together, along with the non-case-mix rate component, as shown in the following equation:

*Total Case-Mix Adjusted Per Diem Payment = (PT Component Per Diem Rate * PT Variable Per Diem Adjustment Factor) + (OT Component Per Diem Rate * OT Variable Per Diem Adjustment Factor) + SLP Component Per Diem Rate + (NTA Component Per Diem Rate * NTA Variable Per Diem Adjustment Factor) + Nursing Component Per Diem Rate + Non-Case-Mix Component Per Diem Rate*

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6.7 SNF PPS Policies

Requirements and policies for SNF PPS are described in greater detail in Chapter 8 of the **Medicare Benefit Policy Manual** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08pdf.pdf). There are some situations that the SNF may encounter that may impact Medicare Part A SNF coverage for a resident, affect the PPS assessment schedule, or impact the reimbursement received by the SNF.

Delay in Requiring and Receiving Skilled Services (30-Day Transfer)

There are instances in which the resident does not require SNF level of care services when initially admitted to the SNF. When the resident requires and receives SNF level of care services within 30 days from the hospital discharge, Day 1 for the PPS assessment schedule is the day on which SNF level of care services begin. For example, if a resident is discharged from the hospital on August 1 and the SNF determines on August 30 that the resident requires skilled service for a condition that was treated during the qualifying hospital stay, then the SNF would start the PPS assessment schedule with a 5-Day PPS assessment, with August 30 as Day 1 for scheduling purposes. However, if the resident requires and receives a SNF level of care 31 or more days after the hospital discharge, the resident does not qualify for a SNF Part A stay (see Medical Appropriateness Exception below).

Medical Appropriateness Exception (Deferred Treatment)

An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment in a SNF immediately after a qualifying hospital stay discharge. It is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame, and it is medically predictable at the time of hospital discharge that the resident will require SNF level of care within a predetermined time period (for more detailed information see Chapter 8 of the **Medicare Benefit Policy Manual**). For example, a resident is admitted to the SNF after a qualifying hospital stay for an open reduction and internal fixation of a hip. It is determined upon hospital discharge that the resident is not ready for weight-bearing activity but will most likely be ready in 4-6 weeks. The physician writes an order to start therapy when the resident is able to tolerate weight bearing. Once the resident is able to start therapy, the Medicare Part A stay begins, and the 5-Day assessment will be performed. Day 1 of the stay will be the first day on which the resident starts therapy services.

Interrupted Stay

An "interrupted" SNF stay is defined as one in which a resident is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the "interruption window").

The interruption window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 11:59 p.m. at the end of the third calendar day. The

interruption window begins on the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered stay.

If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A stay for the purposes of both the variable per diem schedule and the assessment schedule. The variable per diem schedule continues from the day of the previous discharge. For example, if the resident was discharged on Day 7, payment rates resume at Day 7 upon readmission. The assessment schedule also continues from the day of the previous discharge. Thus, no new 5-Day assessment is required upon the subsequent readmission, although the optional IPA may be completed at clinician's discretion.

If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the resident is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating the completion of a new 5-Day assessment.

Example 1: Resident A is admitted to the SNF on 11/07/19. They are admitted to a hospital on 11/20/19. They return to the same SNF on 11/25/19. Because Resident A is readmitted to the same SNF more than three calendar days after discharge, this would be considered a new stay. The assessment schedule would be reset to Day 1, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 2: Resident B is admitted to the SNF on 11/07/19. They are admitted to the hospital on 11/20/19. They are admitted to a different SNF on 11/22/19. Because Resident B is admitted to a different SNF, this would be considered a new stay. The assessment schedule would be reset, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 3: Resident C is admitted to the SNF on 11/07/19. They are admitted to a hospital on 11/20/19. They return to the same SNF on 11/22/19. Because Resident C is admitted to the same SNF within three days from the point of discharge, this would be considered a continuation of the previous stay. No 5-Day assessment would be required upon readmission, though the IPA would be an option. Additionally, the variable per diem would continue from Day 14 (Day of Discharge).

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation in which a resident is discharged from SNF Medicare Part A services and later requires SNF Part A skilled level of care services, and it is not an instance of an interrupted stay (as described above), the resident may be eligible for Medicare Part A SNF coverage if the following criteria are met:

1. Less than 30 days have elapsed since the last day on which SNF level of care services were required and received,

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missing assessments may result in additional review. The default rate (ZZZZZ) takes the place of the otherwise applicable Federal rate. It is equal to the sum of the rate paid for the case-mix group reflecting the lowest acuity level under each PDPM component, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a PPS assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed. In the case of a late assessment, the variable per diem schedule still begins on Day 1 of the stay and not with the late assessment ARD and default billing will be assessed prior to billing based on the late 5-Day assessment.

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Missed Assessment

If the SNF fails to set the ARD of a PPS assessment prior to the end of the last day of the ARD window, and the resident is no longer a SNF Part A resident, and as a result a PPS assessment does not exist in iQIES for the payment period, the provider may not usually bill for days when an assessment does not exist in iQIES. When a PPS assessment does not exist in iQIES, there is not a HIPPS code the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid PPS assessment that is accepted into iQIES. The provider must bill the HIPPS code that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, a PPS assessment may not be performed.

However, there are instances when the SNF may bill the default code when a PPS assessment does not exist in iQIES. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in their SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the HIPPS code associated with the assessment.

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APPENDIX A: GLOSSARY AND COMMON ACRONYMS

Glossary

Term	Abbreviation	Definition
Ability to Understand Others		Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language.
Active Assisted Range of Motion		A type of active range of motion in which assistance is provided by an outside force, either manually or mechanically because the prime mover muscles need assistance to complete the motion. This type of range of motion may be used when muscles are weak or when joint movement causes discomfort; or for example, if the resident is able to move their limbs but requires help to perform entire movement.
Active Discharge Plan		An **active** discharge plan means a plan that is being currently implemented. In other words, the resident's care plan has current goals to make specific arrangements for discharge, staff are taking active steps to accomplish discharge, and there is a target discharge date for the near future. If there is not an **active** discharge plan, residents should be asked if they want to talk to someone about community living and then referred to the Local Contact Agency (LCA) accordingly. Furthermore, referrals to the LCA are recommended as part of many residents' discharge plans. Such referrals are a helpful source of information for residents and facilities in informing the discharge planning process.
Active Disease Diagnosis		An illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments.
Active Range of Motion		Movement within the unrestricted range of motion for a segment, which is produced by active contraction of the muscles crossing that joint is completed without assistance by the resident. This type of range of motion occurs when a resident can move their limbs without assistance.

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Term	Abbreviation	Definition
Activities of Daily Living	**ADLs**	Activities of daily living are those needed for self-care and mobility and include activities such as bathing, dressing, grooming, oral care, ambulation, toileting, eating, transferring, and communicating. Select self-care and mobility items from Section GG are utilized to classify a resident into the PT, OT, and nursing components for PDPM.
Acute Change in Mental Status		Alteration in mental status (e.g., orientation, inattention, organization of thought, level of consciousness, psychomotor behavior, change in cognition) that was new or worse for this resident, usually over hours to days.
ADL Aspects		Components of ADL activities. These are listed next to each ADL in the item set. For example, the aspects of GG0130A (Eating) are using suitable utensils to bring food and/or liquid to the mouth and swallowing food and/or liquid once the meal is placed before the resident.
Adverse Consequence		An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (e.g., medication-medication, medication-food, and medication-disease).
Adverse Drug Reaction	**ADR**	ADR is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication, or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis or treatment. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.
Assessment ID		A sequential numeric identifier assigned to each record submitted to iQIES.
Assessment Period		See Observation Period.

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Term	Abbreviation	Definition
Assessment Reference Date	**ARD**	The specific end-point for the look-back periods in the MDS assessment process.
Assessment Window		The period of time defined by Medicare regulations that specifies when the ARD must be set.
Assisted Living		A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
Audiology Services		Audiology services include the testing of hearing and balance; recommending assistive listening equipment; managing hearing screening programs; providing education regarding the effects of noise on hearing and the prevention of hearing loss; managing cochlear implants; and providing counseling and aural rehabilitation. Audiologist is defined in regulation (42 CFR 484).
Autism		A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.
Baseline		An individual's usual, customary, initial, or most common (depending on the item) range or level of something; for example, behavior, laboratory values, mood, endurance, function, vital signs, etc. "Baseline" information is often used as a basis for comparing findings or results over time.
Bladder Rehabilitation/ Bladder Retraining		A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.
Board and Care		A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
Body Mass Index	**BMI**	Number calculated from a person's weight and height. BMI is a reliable indicator of body fat. BMI is used as a screening tool to identify possible weight problems for adults.

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Term	Abbreviation	Definition
Brief Interview for Mental Status	**BIMS**	The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment.
Broken Tooth		A tooth with a crack, chip, or other loss of structural integrity.
Browser		A program that allows access to the Internet or a private intranet site. A browser with 128-bit encryption is necessary to access the Centers for Medicare & Medicaid Services (CMS) intranet to submit data or report retrieval.
Care Area Assessment	**CAA**	The review of one or more of the twenty conditions, symptoms, and other areas of concern that are commonly identified or suggested by MDS findings. Care areas are triggered by responses on the MDS item set.
Care Area Triggers	**CAT**	A set of items and responses from the MDS that are indicators of particular issues and conditions that affect nursing facility residents.
Case Mix Index	**CMI**	Weight or numeric score assigned to each Resource Utilization Group (RUG-III, RUG IV) that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
Case Mix Reimbursement System		A payment system that measures the intensity of care and services required for each resident and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.
Cavity		A tooth with a hole due to decay or other erosion.
Centers for Medicare & Medicaid Services	**CMS**	CMS is the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.
Check and Change		Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.
CMS Certification Number	**CCN**	Replaces the term "Medicare Provider Number" in survey and certification, and assessment-related activities.

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Term	Abbreviation	Definition
Code of Federal Regulations	**CFR**	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government.
Colostomy		A surgical procedure that brings the end of the large intestine through the abdominal wall.
Comatose (Coma)		Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; they may or may not open their eyes, does not speak, and does not move their extremities on command or in response to noxious stimuli (e.g., pain).
Comprehensive Assessment		Requires completion of the MDS and review of CAAs, followed by development and/or review of the comprehensive care plan.
Confusion Assessment Method	**CAM**	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.
Constipation		A condition of more than short duration where someone has fewer than three bowel movements a week or stools that are usually hard, dry, and difficult and/or painful to eliminate.
Continence		Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.
Critical Access Hospital	**CAH**	A Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all of the criteria established by CMS for designation as a CAH. Additional information on CAHs is available at https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/cahs.html.

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Term	Abbreviation	Definition
Daily Decision Making		Includes: choosing clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.
Delirium		Acute onset or worsening of impaired brain function resulting in cognitive and behavioral symptoms such as worsening confusion, disordered expression of thoughts, frequent fluctuation in level of consciousness, and hallucinations.
Delusion		A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
Designated Local Contact Agency	**LCA**	Each state has community contact agencies that can provide individuals with information about community living options and available community-based supports and services. These local contact agencies may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state designated entities.
Disorganized Thinking		Having thoughts that are fragmented or not logically connected.
Dose		Total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."
Down Syndrome		A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.
Dually Certified Facilities		Nursing facilities that participate in both the Medicare and Medicaid programs.

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Term	Abbreviation	Definition
Duplicate Record Error		A fatal record error that results from a resubmission of a record previously accepted into the CMS MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.
Electronic Health Record	**EHR**	An electronic version of a resident's medical history that is maintained by the provider over time. Sometimes referred to as an electronic medical record (EMR).
Electronic Medical Record	**EMR**	See Electronic Health Record.
Entry Date		The initial date of admission/entry to the facility, or the date on which the resident most recently re-entered the facility after being discharged (whether or not the return was anticipated).
Epilepsy		A chronic neurological disorder that is characterized by recurrent unprovoked seizures, as a result of abnormal neuronal activity in the brain.
External Condom Catheter		Device attached to the shaft of the penis like a condom and connected to a drainage bag.
Facility ID	**FAC_ID**	The facility identification number is assigned to each facility. The FAC_ID must be placed in the individual MDS and tracking form records. This normally is completed as a function within the facility's MDS data entry software.
Fall		Unintentional change in position coming to rest on the ground or onto the next lower surface (e.g., onto a bed, chair, or bedside mat), but not as a result of an overwhelming external force.
Fatal File Error		An error in the MDS file format that causes the entire file to be rejected. The individual records are not validated nor stored in the database. The facility must contact its software support to resolve the problem with the submission file.

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Term	Abbreviation	Definition
Fatal Record Error		An error in MDS record that is severe enough to result in record rejection. A fatal record is not saved in the CMS database. The facility must correct the error that caused the rejection and resubmit a corrected original record.
Fecal Impaction		A mass of dry, hard stool that can develop in the rectum due to chronic constipation. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.
Federal Register		The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration and is available by subscription and online.
Feeding Tube		Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to: nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrotomy (PEG) tubes.
Fever		A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature.
Final Validation Report	**FVR**	A report generated after the successful submission of MDS 3.0 assessment data. This report lists all of the residents for whom assessments have been submitted in a particular submission batch and displays all errors and/or warnings that occurred during the validation process. An FVR is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.
First Time in This Facility		Newly admitted resident who has not been admitted to this facility before.
Fiscal Intermediary	**FI**	In the past, an organization designated by CMS to process Medicare claims for payment that are submitted by a nursing facility. Fiscal intermediaries (FIs) are now called Medicare Administrative Contractors (MACs).

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Term	Abbreviation	Definition
F-Tag		Numerical designations for criteria reviewed during the nursing facility survey.
Functional Limitation in Range of Motion		Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.
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.
Group Home		A noninstitutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
Habit Training/ Scheduled Voiding		A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.
Hallucination		A perception in a conscious and awake state, of something in the absence of external stimuli. May be auditory or visual or involve smells, tastes, or touch.
Health Information Exchange	**HIE**	An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. HIEs can function at the federal, state and local level.
Healthcare Common Procedure Coding System	**HCPCS**	A uniform coding system that describes medical services, procedures, products, and supplies. These codes are used primarily for billing.
Health Insurance Portability and Accountability Act of 1996	**HIPAA**	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.

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Term	Abbreviation	Definition
Health Insurance Prospective Payment System Code	**HIPPS Code**	The Health Insurance Prospective Payment System code is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.
Health Literacy		The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
Hierarchy		The ordering of groups within the RUG Classification system is a hierarchy. The RUG hierarchy begins with groups with the highest resource use and descends to those groups with the lowest resource use. The RUG-IV Classification system has eight hierarchical levels or categories: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function.
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.
Ileostomy		A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.
Inactivation		A type of correction allowed under the MDS Correction Policy. When an invalid record has been accepted into the CMS database, a correction record is submitted with inactivation selected as the type of correction. An inactivation will remove the invalid record from the database.
Inattention		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli.

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Term	Abbreviation	Definition
Indication		*The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of a resident's condition and therapeutic goals.*
Indwelling Catheter		A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
Interdisciplinary Team	**IDT**	A team that includes staff members from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.
Intermittent Catheterization		Insertion and removal of a catheter through the urethra into the bladder for bladder drainage.
International Classification of Diseases – Clinical Modification	**ICD-CM**	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries, and a classification system for surgical, diagnostic, and therapeutic procedures.
Internet Quality Improvement and Evaluation System	**iQIES**	The umbrella system that encompasses the MDS system and other provider-specific assessment collection systems, as well as survey and certification data collection and storage. SNF/NF providers not utilizing proprietary software can complete and submit the MDS records in iQIES, as well as obtain MDS-related reports.
Interoperability		A system's ability to exchange electronic health information with, and use electronic information from, other systems without special effort on the part of the user. Interoperability is further specified as health systems' ability to electronically send health information to, receive health information from, find health information in, integrate health information into, or health information from other electronic systems outside of their organizations.
Interrupted Stay		Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

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Term	Abbreviation	Definition
Interruption Window		The interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.
Invalid Record		As defined by the MDS Correction Policy, a record that was accepted into iQIES that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.
Item Set Code	**ISC**	A code based upon combinations of reasons for assessment (A0310 items) that determines which items are active on a particular type of MDS assessment or tracking record.
Leave of Absence	**LOA**	Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a: • Temporary home visit of at least one night; or • Therapeutic leave of at least one night; or • Hospital observation stay less than 24 hours and the hospital does not admit the resident.
Legal Name		Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a government-issued document (i.e., driver's license, birth certificate, social security card).

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Term	Abbreviation	Definition
Level of Consciousness		Alert: startles easily to any sound or touch. Drowsy/Lethargic: repeatedly dozes off when you are asking questions but responds to voice or touch. Stuporous: very difficult to arouse and keep aroused for the interview. Comatose: cannot be aroused despite shaking and shouting.
Look-Back Period		See Observation Period.
Major Surgery		Generally, major surgery refers to a procedure that meets the following criteria: 1. The resident was an inpatient in an acute care hospital for at least 1 day in the 100 days prior to admission to the skilled nursing facility (SNF), **and** 2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.
Makes Self Understood		Able to express or communicate requests, needs, opinions, and to conduct social conversation in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in 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.
MDS Completion Date		The date at which the RN assessment coordinator attests that all portions of the MDS have been completed. This is the date recorded at Z0500B.
Mechanically Altered Diet		A diet specifically prepared to alter the texture or consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids.
Medicaid		A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.

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Term	Abbreviation	Definition
Medicare		A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities. Medicare Part A: The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, home health agencies, and hospices. Medicare Part B: The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.
Medicare Administrative Contractor	**MAC**	An organization designated by CMS to process Medicare claims for payment that are submitted by a nursing facility. MACs were previously called Fiscal Intermediaries (FIs).
Medicare-Covered Stay		Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to other payers (e.g., Medicare Advantage plans).
Medicare Number		An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier is different from the resident's Social Security Number (SSN) and may contain both letters and numbers.
Medication Interaction		The impact of medication or other substance (such as nutritional supplements including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.
Minimum Data Set	**MDS**	A core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.

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Term	Abbreviation	Definition
Modification		A type of correction allowed under the MDS Correction Policy. A modification is required when a valid MDS record has been accepted by the CMS MDS database, but the information in the record contains errors. The modification will correct the record in the CMS database. A modification is not done when a record has been rejected.
Monitoring		The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications or adverse consequences of the condition or of the treatments; and support decisions about adding, modifying, continuing, or discontinuing, any interventions.
Most Recent Medicare Stay		This is a Medicare Part A covered stay that has started on or after the most recent admission/entry or reentry to the nursing facility.
Music Therapy		Music therapy is an intervention that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages. Music therapy interventions can be designed to promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and promote physical rehabilitation. In order for music therapy to be coded on the MDS, the service must be provided or directly supervised by a qualified staff.
National Drug Code	**NDC**	A unique 10-digit number assigned to each drug product listed under Section 510 of the Federal Food, Drug and Cosmetic Act. The NDC code identifies the vendor, drug name, dosage, and form of the drug.
National Provider Identifier	**NPI**	A unique federal number that identifies providers of health care services. The NPI applies to the SNF/NFs for all of its residents.
Nephrostomy Tube		A catheter inserted through the skin into the kidney or its collecting system.

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Term	Abbreviation	Definition
Non-medication Pain Intervention		An intervention, other than medication, used to try to manage pain which may 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.
Non-pharmacological Intervention		Approaches that do not involve the use of medication to address a medical condition.
Nursing Facility	**NF**	A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
Nursing Monitoring		Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).
Nutrition or Hydration Intervention to Manage Skin Problems		Interventions related to diet, nutrients, and hydration that are provided to prevent or manage specific skin conditions (e.g., wheat-free diet to prevent dermatitis, increased calorie diets to meet basic standards for daily energy requirements, vitamin or mineral supplements for specifically identified deficiencies.)
Observation Period		The time period over which an MDS assessment captures a resident's condition or status. A day begins at 12:00 a.m. and ends at 11:59 p.m.; the observation period must also cover this time period. An MDS assessment captures only occurrences during the observation period. In other words, if it did not occur during the observation period, it is not coded on the MDS. Also referred to as **Look-Back Period or Assessment Period**.

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Term	Abbreviation	Definition
Occupational Therapy	**OT**	Services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Includes services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if they are under the direction of a licensed occupational therapist. Occupational therapist and occupational therapy assistant are defined in regulations (42 CFR 484.4). Occupational therapy interventions address deficits in physical, cognitive, psychosocial, sensory, and other aspects of performance in order to support engagement in everyday life activities that affect health, well-being, and quality of life.
Omnibus Budget Reconciliation Act of 1987	**OBRA '87**	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
On Admission		On admission is defined as: as close to the actual time of admission as possible.
Oral Lesions		An abnormal area of tissue on the lips, gums, tongue, palate, cheek lining, or throat. This may include ulceration, plaques or patches (e.g. candidiasis), tumors or masses, and color changes (red, white, yellow, or darkened).
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.
Passive Range of Motion		Movement within the unrestricted range of motion for a segment, which is provided entirely by an external force. There is no voluntary muscle contraction. This type of range of motion is often used when a resident is not able to perform the movement at all; no effort is required from them.
Patient Health Questionnaire	**PHQ-2 to 9©**	A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

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Term	Abbreviation	Definition
Patient Driven Payment Model	**PDPM**	The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) residents in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Effective beginning October 1, 2019, PDPM replaced the Federal case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).
Persistent Vegetative State	**PVS**	PVS is an enduring situation in which an individual has failed to demonstrate meaningful cortical function but can sustain basic body functions supported by noncortical brain activity.
Physical Therapy	**PT**	Services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Includes services provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if they are under the direction of a licensed physical therapist. Physical therapist and physical therapist assistant are defined in regulation 42 CFR 484.4. Physical therapists (PTs) are licensed health care professionals who diagnose and manage movement dysfunction and enhance physical and functional status for people of all ages. PTs alleviate impairments and activity limitations and participation restrictions, promote and maintain optimal fitness, physical function, and quality of life, and reduce risk as it relates to movement and health. Following an evaluation of an individual with impairments, activity limitations, and participation restrictions or other health-related conditions, the physical therapist designs an individualized plan of physical therapy care and services for each patient. Physical therapists use a variety of interventions to treat patients. Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, physical agents, and electrotherapeutic modalities.
Physician Prescribed Weight-loss Regimen		A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight-loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.

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Term	Abbreviation	Definition
Portal		A secure online website that gives providers, residents, and others 24-hour access to personal health information from anywhere with an Internet connection.
Private Home/ Apartment		A noninstitutional community residential setting that can include houses, condominiums, or apartments in the community whether owned by the resident or another person, as well as retirement communities and independent housing for the elderly.
Program Transmittal		Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added, or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following Web site: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html
Prompted Voiding		Prompted voiding is a behavioral intervention to maintain or regain urinary continence and may include timed verbal reminders and positive feedback for successful toileting.
Prospective Payment System	**PPS**	A payment system, developed for Medicare skilled nursing facilities, which pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
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.
Psychomotor Retardation		Visibly slowed level of activity or mental processing in residents who are alert. Psychomotor retardation should be differentiated from altered level of consciousness (i.e. stupor) and lethargy.

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Term	Abbreviation	Definition
Quality Improvement Network	**QIN**	The Quality Improvement Organization (QIO) Program's 14 Quality Innovation Network-QIOs (QIN-QIOs) bring Medicare beneficiaries, providers, and communities together in data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, and improve clinical quality. By serving regions of two to six states each, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors.
Quality Improvement Organization	**QIO**	A program administered by CMS that is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of QIOs responsible for each U.S. State, territory, and the District of Columbia. Their mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries.
Quality Measure	**QM**	Information derived from MDS data, that provides a numeric value to quality indicators. These data are available to the public as part of the Nursing Home Quality Initiative (NHQI) and SNF Quality Reporting Program (QRP) and are intended to provide objective measures for consumers to make informed decisions about the quality of care in SNF/NFs.
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 therapy includes, but is not limited to, providing treatment services and recreation activities to individuals using a variety of techniques, including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings. Recreation therapists treat and help maintain the physical, mental, and emotional well-being of their clients by seeking to reduce depression, stress, and anxiety; recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively. Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment.

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Term	Abbreviation	Definition
Re-entry		When a resident returns to a facility following a temporary discharge (return anticipated) and returns within 30 days of the discharge.
Registered Nurse Assessment Coordinator	**RNAC**	An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility and is responsible for coordinating and certifying completion of the resident assessment instrument.
Rehabilitation Therapy		Special health care services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. These services or programs can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.
Religion		Belief in and reverence for a supernatural power or powers regarded as creator and governor of the universe. Can be expressed in practice of rituals associated with various religious faiths, attendance and participation in religious services, or in private prayer or religious study.
Resource Use		The measure of the wage-weighted minutes of care used to develop the RUG classification system.
Resource Utilization Group, Version IV	**RUG-IV**	A category-based classification system in which nursing facility residents classify into one of 66, 57, or 47 RUG-IV groups. Residents in each group utilize similar quantities and patterns of resources. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0. Some states utilize the RUG-IV system for Medicaid payment in nursing facilities.

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Term	Abbreviation	Definition
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.
Respite		Short-term, temporary care provided to residents to allow family members to take a break from the daily routine of care giving.
Significant Error		An error in an assessment where the resident's clinical status is not accurately represented (i.e. miscoded) on the erroneous assessment and the error has not been corrected via submission of a more recent assessment.
Skilled Nursing Facility	**SNF**	A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation services of injured, disabled, or sick persons.
Sleep Hygiene		Practices, habits, and environmental factors that promote and/or improve sleep patterns.
Social Isolation		An actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
Social Security Number		A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

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Term	Abbreviation	Definition
Speech-Language Pathology and Audiology Services		Services that are provided by a licensed speech-language pathologist and/or audiologist. Rehabilitative treatment addresses physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing (dysphagia). Communication includes speech, language (both receptive and expressive) and non-verbal communication such as facial expression and gesture. Swallowing problems managed under speech therapy are problems in the oral, laryngeal, and/or pharyngeal stages of swallowing. Depending on the nature and severity of the disorder, common treatments may range from physical strengthening exercises, instructive or repetitive practice and drilling, to the use of audio-visual aids and introduction of strategies to facilitate functional communication. Speech therapy may also include sign language and the use of picture symbols. Speech-language pathologist is defined in regulation 42 CFR 484.4.
State Operations Manual	**SOM**	A manual provided by CMS that provides information regarding the how the State comes into compliance with Medicare and Medicaid requirements for survey and certification of all entities and appendices that provides regulatory requirements and related guidance.
State Provider Number		Medicaid Provider Number established by a state.
State Resident Assessment Instrument (RAI) Coordinator		A state agency person who provides information regarding RAI requirements and MDS coding instructions (See Appendix B).
Stress Incontinence		Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
Submission Confirmation		The initial feedback generated by iQIES after an MDS data file is electronically submitted. This message acknowledges receipt of the submission file but does not examine the file for any warnings and/or errors. Warnings and/or errors are provided on the Final Validation Report.

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Term	Abbreviation	Definition
Submission Requirement	**SUB_REQ**	A field in the MDS electronic record (A0410) that identifies the authority for data collection. CMS has authority to collect assessments for all residents (regardless of their payer source) who reside in Medicare- and/or Medicaid-certified units. States may or may not have regulatory authority to collect assessments for residents in non-certified units.
Suprapubic Catheter		An indwelling catheter that is placed into the bladder through the abdominal wall above the pubic symphysis.
Swing Bed		A rural non-critical access hospital with fewer than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.
System of Records	**SOR**	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Temporal Orientation		In general, the ability to place oneself in correct time. For BIMS, it is the ability to indicate correct date in current surroundings.
Therapeutic Diet		A therapeutic diet is a diet intervention prescribed by a physician or other authorized nonphysician practitioner that provides food or nutrients via oral, enteral, and parenteral routes as part of treatment of disease or clinical condition, to modify, eliminate, decrease, or increase identified micro- and macronutrients in the diet (Academy of Nutrition and Dietetics, 2020).
Tooth Fragment		A remnant of a tooth.
Total Severity Score		A summary of the Patient Health Questionnaire frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder but provides a standard of communication between clinicians and mental health specialists.

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Term	Abbreviation	Definition
Transitional Living		Settings that provide longer-term residential services offering professional support, education, and a stable living environment for individuals transitioning from situations such as homelessness, alcohol use disorder, and substance use disorder. Such settings afford safe living accommodations and services to support a successful transition to self-sufficient living.
Up to Date (for COVID-19 Vaccine)		*For the definition of "up to date," providers should refer to the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.*
Urostomy		A stoma for the urinary system, intended to bypass the bladder or urethra.
Usual Performance		The environment or situations encountered at a facility can have an impact on a resident's functional status. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance or worst performance, but rather, record the resident's usual performance.
Utilization Guidelines		Instructions concerning when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.
Vomiting		The forceful expulsion of stomach contents through the mouth or nose.
Z Codes		ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00–Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

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Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
ADR	Adverse Drug Reaction
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIMS	Brief Interview for Mental Status
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
BMI	Body mass index
CAA	Care Area Assessment
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CAT	Care Area Trigger
CBSA	Core-Based Statistical Area
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMI	Case Mix Index
CMS	Centers for Medicare & Medicaid Services
CNN	CMS Certification Number
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPS	Cognitive Performance Scale (MDS)
CPT	(Physicians) Current Procedural Terminology
CR	Change Request
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
EHR	Electronic Health Record
EMR	Electronic Medical Record

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Acronym	Definition
ESRD	End Stage Renal Disease
FAC_ID	Facility ID (for MDS submission)
FMR	Focused Medical Review
FR	Final Rule
FVR	Final Validation Report (MDS submission)
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance PPS (Rate Codes)
ICD	International Classification of Diseases
ICD-CM	International Classification of Diseases, Clinical Modification
IDT	Interdisciplinary Team
IFC	Interim Final Rule with Comment
IOM	Internet-Only Manual
iQIES	Internet Quality Improvement and Evaluation System
IPA	Interim Payment Assessment
ISC	Item Set Code
LOA	Leave of Absence
MAC	Medicare Administrative Contractor
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review (File)
MIM	Medicare Intermediary Manual
MRI	Magnetic Resonance Imaging
NCS	National Supplier Clearinghouse
NDC	National Drug Code
NDM	Network Data Mover
NF	Nursing Facility
NH	Nursing Home
NPI	National Provider Identifier
NSC	National Supplier Clearinghouse
NTA	Non-Therapy Ancillary
OBRA	Omnibus Budget Reconciliation Act of 1987
OMB	Office of Management and Budget
OT	Occupational Therapy/Therapist
PCE	Personal Care Expenditures

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Acronym	Definition
PDPM	Patient Driven Payment Model
PHQ-2 to 9©	Patient Health Questionnaire
PHQ-9-OV©	PHQ-9© Observational Version
PIM	Program Integrity Manual
POS	Point of Service
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PT	Physical Therapy/Therapist
PTA	Physical Therapist Assistant
Pub.100-1	Medicare General Information, Eligibility, and Entitlement IOM
Pub.100-2	Medicare Benefit IOM
Pub.100-4	Medicare Claims Processing IOM
Pub.100-7	Medicare State Operation IOM
Pub.100-8	Medicare Program Integrity IOM
Pub.100-12	State Medicaid IOM
PVS	Persistent Vegetative State
QI	Quality Indicator
QM	Quality Measure
QIO	Quality Improvement Organization
RAI	Resident Assessment Instrument
RNAC	Registered Nurse Assessment Coordinator
RUG	Resource Utilization Group
SB-PPS	Swing Bed Prospective Payment System
SCSA	Significant Change in Status Assessment
SNF	Skilled Nursing Facility
SNF PPS	Skilled Nursing Facility Prospective Payment System
SNF QRP	Skilled Nursing Facility Quality Reporting Program
SLP (or ST)	Speech Language Pathology Services
SOM	State Operations Manual
SOR	Systems of Records
SSN	Social Security Number
STM	Staff Time Measure
SUB_REQ	Submission Requirement
TPN	Total Parenteral Nutrition

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APPENDIX B: STATE AGENCY AND CMS LOCATIONS RAI/MDS CONTACTS

Appendix B: State Agency and CMS Locations RAI/MDS Contacts is located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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APPENDIX C
CARE AREA ASSESSMENT (CAA) RESOURCES

Chapter 4 of this manual provides information on specific care areas triggered and the CAA process. This appendix contains both specific and general resources that nursing homes may choose to use to further assess care areas triggered from the MDS 3.0 Resident Assessment Instrument (RAI). The resources include the care area specific tools beginning in this section and the general resource list at the end of this appendix.

It is important to note that the resources provided in this appendix are provided solely as a courtesy for use by nursing homes, should they choose to, in completing the RAI CAA process. **It is also important to reiterate that CMS does not mandate, nor does it endorse, the use of any particular resource(s), including those provided in this appendix.** However, nursing homes should ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/resources.

DISCLAIMER: **The list of resources in this appendix is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.**

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CARE AREA SPECIFIC RESOURCES

The specific resources or tools contained on the next several pages are provided by care area. The general instructions for using them include:

Step 1: After completing the MDS, review all MDS items and responses to determine if any care areas have been triggered.

Step 2: For any triggered care area(s), conduct a thorough assessment of the resident using the care area-specific resources.

Step 3: Check the box in the left column if the item is present for this resident. ***Some of this information will be on the MDS - some will not.***

Step 4: In the right column the facility can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor(s) for item(s) checked, etc.

Step 5: Obtain and consider input from resident and/or family/resident's representative regarding the care area.

Step 6: Analyze the findings in the context of their relationship to the care area and standards of practice. This should include a review of indicators and supporting documentation, including symptoms and causal and contributing factors, related to this care area. Draw conclusions about the causal/contributing factors and effect(s) on the resident, and document these conclusions in the Analysis of Findings section.

Step 7: Decide whether referral to other disciplines is warranted and document this decision.

Step 8: In the Care Plan Considerations section, document whether a care plan for the triggered care area will be developed and the reason(s) why or why not.

Step 9: Information in the *Supporting Documentation* column can be used to populate the *Location and Date of CAA Documentation* column in Section V, Item V0200A (CAA Results) – for e.g. "See Delirium CAA 4/30/11, H&P dated 4/18/11."

NOTE: An optional Signature/Date line has been added to each checklist. This was added if the facility wants to document the staff member who completed the checklist and date completed.

DISCLAIMER: **The checklists of care area specific resources in this appendix are not mandated, prescriptive, or all-inclusive and are provided as a service to facilities. They do not constitute or imply endorsement by CMS or HHS.**

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1. DELIRIUM

Review of Indicators of Delirium

✓	Changes in vital signs compared to baseline	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	Temperatures 2.4^{0}F higher than baseline or a temperature of 100.4^{0}F (38^{0}C) on admission prior to establishment of baseline. (J1550A)	
☐	Pulse rate less than 60 or greater than 100 beats per minute	
☐	Respiratory rate over 25 breaths per minute or less than 16 per minute (J1100)	
☐	Hypotension or a significant decrease in blood pressure: (I0800)	
☐	• Systolic blood pressure of less than 90 mm Hg, OR	
☐	• Decline of 20 mm Hg or greater in systolic blood pressure from person's usual baseline, OR	
☐	• Decline of 10 mm Hg or greater in diastolic blood pressure from person's usual baseline, OR	
☐	Hypertension - a systolic blood pressure above 160 mm Hg, OR a diastolic blood pressure above 95 mm Hg (I0700)	
✓	**Abnormal laboratory values**	**Supporting Documentation**
☐	• Electrolytes, such as sodium	
☐	• Kidney function	
☐	• Liver function	
☐	• Blood sugar	
☐	• Thyroid function	
☐	• Arterial blood gases	
☐	• Other	
✓	**Pain**	**Supporting Documentation**
☐	• Pain CAA triggered (J0100, J0200) [review findings for relationship to delirium (C1310)]	
☐	• Pain frequency, intensity, and characteristics (time of onset, duration, quality) (J0410, J0600, J0800, J0850) indicate possible relationship to delirium (C1310)	
☐	• Adverse effect of pain on function (J0510, J0520, J0530) may be related to delirium (C1310)	

✓	**Diseases and conditions** (diagnosis/signs/symptoms)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Circulatory/Heart — Anemia (I0200) — Cardiac dysrhythmias (I0300) — Angina, Myocardial Infarction (MI) (I0400) — Atherosclerotic Heart Disease (ASHD) (I0400) — Congestive Heart Failure (CHF) pulmonary edema (I0600) — Cerebrovascular Accident (CVA) (I4500) — Transient Ischemic Attack (TIA) (I4500)	
☐	• Respiratory — Asthma (I6200) — Emphysema/Chronic Obstructive Pulmonary Disease (COPD) (I6200) — Shortness of breath (J1100) — Ventilator or respirator (O0110F1) — Respiratory Failure (I6300)	
☐	• Infectious — Infections (I1700–I2500, M1040A) — Isolation or quarantine for active infectious disease (O0110M1)	
☐	• Metabolic — Diabetes (I2900) — Thyroid disease (I3400) — Hyponatremia (I3100)	
☐	• Gastrointestinal bleed	
☐	• Renal disease (I1500), Dialysis (O0110J1–3)	
☐	• Hospice care (O0110K1)	
☐	• Terminal condition (J1400)	
☐	• Cancer (I0100, O0110A1–10, O0110B1)	
☐	• Dehydration (J1550C, clinical record)	
✓	**Signs of Infection**	**Supporting Documentation**
☐	• Fever (J1550A)	
☐	• Cloudy or foul smelling urine	
☐	• Congested lungs or cough	
☐	• Dyspnea (J1100)	
☐	• Diarrhea	
☐	• Abdominal pain	
☐	• Purulent wound drainage	
☐	• Erythema (redness) around an incision	

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✓	Indicators of Dehydration	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Dehydration CAA triggered, indicating signs or symptoms of dehydration are present (J1550C)	
☐	• Recent decrease in urine volume or more concentrated urine than usual (Intake and Output)	
☐	• Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss (K0300)	
☐	• Nausea, vomiting (J1550B), diarrhea, or blood loss	
☐	• Receiving intravenous drugs (O0110H1)	
☐	• Receiving diuretics or drugs that may cause electrolyte imbalance (N0415G1)	
✓	**Functional Status**	**Supporting Documentation**
☐	• Recent decline in functional abilities status (GG0130, GG0170) (may be related to delirium) (C1310)	
☐	• Increased risk for falls (J1700–J1900) (may be related to delirium) (see Falls CAA)	
✓	**Medications** (that may contribute to delirium)	**Supporting Documentation**
☐	• New medication(s) or dosage increase(s)	
☐	• Medications with anticholinergic properties (for example, some antipsychotics (N0415A), antidepressants (N0415C), antiparkinsonians, antihistamines)	
☐	• Opioids (N0415H)	
☐	• Benzodiazepines, especially long-acting agents (N0415B)	
☐	• Analgesics, cardiac and GI medications, anti-inflammatory drugs	
☐	• Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0415B)	
☐	• Medication interactions (pharmacist review may be required)	
☐	• Resident taking more than one medication from a particular class	
☐	• Possible medication toxicity, especially if the person is dehydrated (J1550C) or has renal insufficiency (I1500). Check serum medication levels	

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✓	Associated or progressive signs and symptoms	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Sleep disturbances (for example, up and awake at night/asleep during the day) (D0150C, D0500C, J0510)	
☐	• Agitation and inappropriate movements (for example, unsafe climbing out of bed or chair, pulling out tubes) (E0500)	
☐	• Hypoactivity (for example, low or lack of motor activity, lethargy or sluggish responses) (D0150D, D0500D)	
☐	• Perceptual disturbances such as hallucinations (E0100A) and delusions (E0100B)	
✓	**Other Considerations**	**Supporting Documentation**
☐	Psychosocial • Recent change in mood; sad or anxious (for example, crying, social withdrawal) (D0150, D0160, D0500, D0600) • Recent change in social situation (for example, isolation, recent loss of family member or friend) • Use of restraints (P0100)	
☐	Physical or environmental factors • Hearing or vision impairment (B0200, B1000) - may have an impact on ability to process information (directions, reminders, environmental cues) • Lack of frequent reorientation, reassurance, reminders to help make sense of things • Recent change in environment (for example, a room or unit change, new admission, or return from hospital) (A1700) • Interference with resident's ability to get enough sleep (for example, light, noise, frequent disruptions) • Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes)	

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Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

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2. COGNITIVE LOSS/DEMENTIA

Review of Indicators of Cognitive Loss/Dementia

✓	Reversible causes of cognitive loss	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Delirium (C1310) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.)	
✓	**Neurological factors**	**Supporting Documentation**
☐	• Intellectual disability/Developmental Disability (A1550)	
☐	• Alzheimer's Disease or other dementias (I4200, I4800)	
☐	• Parkinson's Disease (I5300)	
☐	• Traumatic brain injury (I5500)	
☐	• Brain tumor	
☐	• Normal pressure hydrocephalus	
☐	• Other (I8000)	
✓	**Observable characteristics and extent** of this resident's cognitive loss	**Supporting Documentation**
☐	• Analyze component of Brief Interview for Mental Status (BIMS) (C0200–C0500) (V0100D)	
☐	• If unable to complete BIMS, analyze components of Staff Assessment for Mental Status (C0700, C0800, C0900, C1000)	
☐	• Identify components of Delirium assessment (C1310) that are present and not new onset or worsening	
☐	• Confusion, disorientation, forgetfulness (C0200, C0300, C0400, C0500, C0700, C0800, C0900, C1310)	
☐	• Decreased ability to make self-understood (B0700) or to understand others (B0800)	
☐	• Impulsivity	
☐	• Other	

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✓	Mood and behavior	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Mood State (D0160, D0600) CAA triggered. Analysis of Findings indicates possible impact on cognition – important to consider when drawing conclusions about cognitive loss	
☐	• Behavioral Symptoms (E0200) CAA triggered: Analysis of Findings points to cause(s), contributing factors, etc. – important to consider when drawing conclusions about cognitive loss	
✓	**Medical problems** that can impact cognition	**Supporting Documentation**
☐	• Constipation (H0600), fecal impaction, diarrhea	
☐	• Diabetes (I2900)	
☐	• Thyroid Disorder (I3400)	
☐	• Congestive heart failure (I0600)/other cardiac diseases (I0300, I0400)	
☐	• Respiratory problems (I6200, I6300, I2000, I2200, I8000)/decreased oxygen saturation	
☐	• Cancer (I0100)	
☐	• Liver disease (I1100, I2400, I8000)	
☐	• Renal failure (I1500)	
☐	• Psychiatric or mood disorder (I5700–I6100)	
☐	• Electrolyte imbalance	
☐	• Poor nutrition (I5600) or hydration status (J1550C)	
☐	• End of life (J1400, O0110K1)	
☐	• Alcoholism (I8000)	
☐	• Failure to thrive (I8000)	
✓	**Pain** and its relationship to cognitive loss and behavior	**Supporting Documentation**
☐	• Indications that pain is present (J0100, J0300–J0600, J0800, J0850)	
☐	• Pain CAA triggered. Determine relationship between pain and cognitive status via observation and assessment.	

✓	Functional status and its relationship to cognitive loss	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Functional Abilities (Section GG) — Functional Abilities Care Area triggered (GG0130, GG0170). Analysis of Findings provides important information about relationship of functional decline to cognitive loss (C0500, C0700, C0800, C0900, C1000, V0100D) — Resident has potential for more independence with cueing, restorative nursing program, and/or task segmentation or other programs	
☐	• Decline in continence (H0300, H0400)	
☐	• Impaired daily decision-making (C1000)	
☐	• Participates better in small group programs (F0800P)	
☐	• Staff and/or resident believe resident is capable of doing more	
✓	**Other Considerations**	**Supporting Documentation**
☐	• Cognitive decline occurred slowly over time (V0100D)	
☐	• Unexplainable behavior may be attempt at communication about pain, toileting needs, uncomfortable position, etc.	
☐	• Use of physical restraints (P0100)	
☐	• Hearing or vision impairment (B0200, B0300, B1000, B1200) - may have an impact on ability to process information (directions, reminders, environmental cues)	
☐	• Lack of frequent reorientation, reassurance, reminders to help make sense of things (C0900, C1310)	
☐	• Interference with the resident's ability to get enough sleep (noise, light, etc.) (D0150, D0500C, J0510)	
☐	• Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes)	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

3. VISUAL FUNCTION

Review of Indicators of Visual Function

✓	**Diseases and conditions of the eye** (diagnosis OR signs/symptoms present)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Cataracts, Glaucoma, or Macular Degeneration (I6500)	
☐	• Diabetic retinopathy (I2900)	
☐	• Blindness (B1000)	
☐	• Decreased visual acuity (B1000, B1200)	
☐	• Visual field deficit (B1200)	
☐	• Eye pain	
☐	• Blurred vision	
☐	• Double vision	
☐	• Sudden loss of vision	
☐	• Itching/burning eye	
☐	• Indications of eye infection	
✓	**Diseases and conditions** that can cause visual disturbances	**Supporting Documentation**
☐	• Cerebrovascular accident or transient ischemic attack (I4500)	
☐	• Alzheimer's Disease and other dementias (I4200, I4800)	
☐	• Myasthenia gravis (I8000)	
☐	• Multiple sclerosis (I5200)	
☐	• Cerebral palsy (I4400)	
☐	• Mood ((I5800, I5900, I5950, I6000, I6100, D0160 or D0600) or anxiety disorder (I5700)	
☐	• Traumatic brain injury (I5500)	
☐	• Other (I8000)	

Draft

✓	Functional limitations related to vision problems	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Peripheral vision or other visual problem that impedes ability to eat, walk, or interact with others (B1000)	
☐	• Ability to recognize staff limited by vision problem (B1000)	
☐	• Difficulty negotiating the environment due to vision problem (B1000)	
☐	• Balance problems exacerbated by vision problem (B1000, B1200)	
☐	• Participation in self-care limited by vision problem (B1000)	
☐	• Difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problem (B1000)	
☐	• Increased risk for falls due to vision problems or due to bifocals or trifocals (B1200)	
✓	**Environment**	**Supporting Documentation**
☐	• Is resident's environment adapted to their unique needs, such as availability of large print books, high wattage reading lamp, night light, etc.?	
☐	• Are there aspects the facility's environment that should be altered to enhance vision, such as low-glare floors, low glare tables and surfaces, large print signs marking rooms, etc.?	
✓	**Medications** that can impair vision (consultant pharmacist review of medication regimen can be very helpful)	**Supporting Documentation**
☐	• Opioids (N0415H)	
☐	• Antipsychotics (N0415A)	
☐	• Antidepressants (N0415C)	
☐	• Anticholinergics	
☐	• Hypnotics (N0415D)	
☐	• Other	
✓	**Use of visual appliances** (B1200)	**Supporting Documentation**
☐	• Reading glasses	
☐	• Distance glasses	
☐	• Contact lenses	
☐	• Magnifying glass	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

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Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

4. COMMUNICATION

Review of Indicators of Communication

✓	**Diseases and conditions** that may be related to communication problems	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Alzheimer's Disease or other dementias (I4200, I4800, I8000)	
☐	• Aphasia (I4300) following a cerebrovascular accident (I4500)	
☐	• Parkinson's disease (I5300)	
☐	• Mental health problems (I5700–I6100)	
☐	• Conditions that can cause voice production deficits, such as	
☐	— Asthma (I6200)	
☐	— Emphysema/COPD (I6200)	
☐	— Cancer (I0100) — Poor-fitting dentures (L0200)	
☐	• Transitory conditions, such as	
☐	— Delirium (C1310)	
☐	— Infection (I1700–I2500, M1040A) — Acute illness (I8000)	
☐	• Other (I8000, clinical record)	
✓	**Medications** (consultant pharmacist review of medication regimen can be very helpful)	**Supporting Documentation**
☐	• Opioids (N0415H)	
☐	• Antipsychotics (N0415A)	
☐	• Antianxiety (N0415B)	
☐	• Antidepressants (N0415C)	
☐	• Parkinson's medications	
☐	• Hypnotics (N0415D)	
☐	• Gentamycin (N0415F)	
☐	• Tobramycin (N0415F)	
☐	• Aspirin	
☐	• Other	

Draft

✓	Characteristics of the communication impairment	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Expressive communication (B0700)	
☐	— Speaks different language (A1110A–B)	
☐	— Disruption in ability to speak (B0600)	
☐	— Problem with voice production, low volume (B0600)	
☐	— Word-finding problems	
☐	— Difficulty putting sentence together (B0700, C1310C)	
☐	— Problem describing objects and events (B0700)	
☐	— Pronouncing words incorrectly (B0600)	
☐	— Stuttering (B0700)	
☐	— Hoarse or distorted voice	
☐	• Receptive communication (B0800)	
☐	— Does not understand English (A1110A–B)	
☐	— Hearing impairment (B0200, B0300, B0800)	
☐	— Speech discrimination problems	
☐	— Decreased vocabulary comprehension (A1110B)	
☐	— Difficulty reading and interpreting facial expressions	
☐	• Communication is more successful with some individuals than with others. Identify and build on the successful approaches	
☐	• Limited opportunities for communication due to social isolation or need for communication devices	
☐	• Communication problem may be mistaken as cognitive impairment	

Draft

✓	**Confounding problems** that may need to be resolved before communication will improve	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Decline in cognitive status and BIMS decline (C0500, V0100D)	
☐	• Mood problem, increase in PHQ-2 to 9© or PHQ-9-OV© score (D0160, D0600, V0100E)	
☐	• Increased dependence in functional abilities (changes in GG0130, GG0170)	
☐	• Deterioration in respiratory status	
☐	• Oral motor function problems, such as swallowing, clarity of voice production (B0600, K0100)	
✓	**Use of communication devices**	**Supporting Documentation**
☐	• Hearing aid (B0300)	
☐	• Written communication	
☐	• Sign language (A1100A)	
☐	• Braille (A1100A)	
☐	• Signs, gestures, sounds	
☐	• Communication board	
☐	• Electronic assistive devices	
☐	• Other	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

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☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

5. ACTIVITIES OF DAILY LIVING (ADLs) – FUNCTIONAL/REHABILITATION POTENTIAL

Review of Indicators of ADLs – Functional/Rehabilitation Potential

✓	**Possible underlying problems** that may affect function. Some may be reversible.	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310) (Delirium CAA)	
☐	• Acute episode or flare-up of chronic condition	
☐	• Changing cognitive status (C0100) (see Cognitive Loss CAA)	
☐	• Mood decline (D0160, D0600) (see Mood State CAA)	
☐	• Daily behavioral symptoms/decline in behavior (E0200) (see Behavioral Symptoms CAA)	
☐	• Use of physical restraints (P0100) (see Physical Restraints CAA)	
☐	• Pneumonia (I2000)	
☐	• Fall (J1700–J1900) (see Falls CAA)	
☐	• Hip fracture (I3900)	
☐	• Recent hospitalization (A1700, A1805)	
☐	• Fluctuating functional abilities (GG0130, GG0170)	
☐	• Nutritional problems (K0520A, K0520B) (see Nutrition CAA)	
☐	• Pain (J0300, J0800) (see Pain CAA)	
☐	• Dizziness	
☐	• Communication problems (B0200, B0700, B0800) (see Communication CAA)	
☐	• Vision problems (B1000) (see Vision CAA)	
✓	**Abnormal laboratory values**	**Supporting Documentation**
☐	• Electrolytes	
☐	• Complete blood count	
☐	• Blood sugar	
☐	• Thyroid function	
☐	• Arterial blood gases	
☐	• Other	

Draft

✓	**Medications** that can contribute to functional decline	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Psychoactive medications (N0415A–D)	
☐	• Opioids (N0415H)	
☐	• Other medications – ask consultant pharmacist to review medication regimen to identify these medications	
✓	**Limiting factors** resulting in need for assistance with self-care or mobility	**Supporting Documentation**
☐	• Mental errors such as sequencing problems, incomplete performance, or anxiety limitations	
☐	• Physical limitations such as weakness (GG0130, GG0170), limited range of motion (GG0115), poor coordination, poor balance, visual impairment (B1000), or pain (J0300, J0800)	
☐	• Facility conditions such as policies, rules, or physical layout	
✓	**Problems resident is at risk for** because of functional decline	**Supporting Documentation**
☐	• Falls (J1700–J1900)	
☐	• Weight loss (K0300)	
☐	• Unidentified pain (J0800)	
☐	• Social isolation	
☐	• Restraint use (P0100)	
☐	• Depression (D0150, D0160, D0500, D0600)	
☐	• Complications of immobility, such as — Pressure ulcer/injury (M0210, M0300) — Muscular atrophy — Contractures (GG0115) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory (I2000, I2200, I8000) infections	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

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Signature/Title: _____ Date: _____

Draft

Where rehabilitation goals are envisioned, use of the ***ADL Supplement*** will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the supplement can assist in the evaluation of all residents that trigger this care area. Part 2 of the supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.

ADL SUPPLEMENT
(Attaining maximum possible Independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help.	DRESSING	BATHING	TOILETING	LOCOMOTION	TRANSFER	EATING
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. **Physical Limitations:** Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. **Facility Conditions:** Policies, rules, physical layout, etc.						
PART 2: Possible ADL Goals INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment -				If wheelchair, check: ☐		
Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/ shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby ☐	Positions self in preparation	Opens/ pours/ unwraps/ cuts etc.
	Grasps/puts on upper lower body	Turns on water/ adjusts temperature	Removes/ opens clothes in preparation	Walks on unit ☐	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building (uses elevator) ☐	Prepares chair/bed (locks pad, moves covers)	Scoops/ spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors ☐	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces ☐	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other ☐	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other

Draft

6. URINARY INCONTINENCE AND INDWELLING CATHETER

Review of Indicators of Urinary Incontinence and Indwelling Catheter

✓	**Modifiable factors** contributing to transitory urinary incontinence	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310) (see Delirium CAA)	
☐	• Urinary Tract Infection (I2300)	
☐	• Postmenopausal atrophic vaginitis (I8000)	
☐	• Medications (see below)	
☐	• Psychological or psychiatric problems (I5700–I6100)	
☐	• Constipation/impaction (H0600)	
☐	• Caffeine use	
☐	• Excessive fluid intake	
☐	• Pain (J0300, J0800)	
☐	• Environmental factors	
☐	— Restricted mobility (GG0170) (see Functional Abilities CAA)	
☐	— Lack of access to a toilet	
☐	— Other environmental barriers (such as pads or briefs)	
☐	— Restraints (P0100)	
✓	**Other factors** that contribute to incontinence or catheter use	**Supporting Documentation**
☐	• Excessive or inadequate urine output	
☐	• Urinary urgency AND need for assistance in toileting (GG0130, GG0170)	
☐	• Bladder cancer (I0100) or stones (I8000)	
☐	• Spinal cord or brain lesions (I8000)	
☐	• Tabes dorsalis (I8000)	
☐	• Neurogenic bladder (I1550)	
✓	**Laboratory tests**	**Supporting Documentation**
☐	• High serum calcium	
☐	• High blood glucose	
☐	• Low B12	
☐	• High BUN or creatinine	

✓	Diseases and conditions	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Benign prostatic hypertrophy (I1400)	
☐	• Congestive Heart Failure (CHF), pulmonary edema (I0600)	
☐	• Cerebrovascular Accident (CVA) (I4500)	
☐	• Transient Ischemic Attack (TIA) (I4500)	
☐	• Diabetes (I2900)	
☐	• Depression (I5800)	
☐	• Parkinson's disease (I5300)	
☐	• Prostate cancer (I0100)	
✓	**Type of incontinence**	**Supporting Documentation**
☐	• Stress (occurs with coughing, sneezing, laughing, lifting heavy objects, etc.)	
☐	• Urge (overactive or spastic bladder)	
☐	• Mixed (stress incontinence with urgency)	
☐	• Overflow (due to blocked urethra or weak bladder muscles)	
☐	• Transient (temporary/occasional related to a potentially improvable/reversible cause)	
☐	• Functional (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating)	
✓	**Medications** (from medication administration record and preadmission records if new admission; review by consultant pharmacist)	**Supporting Documentation**
☐	• Diuretics (N0415G)– can cause urge incontinence	
☐	• Sedatives, hypnotics (N0415B, N0415D)	
☐	• Anticholinergics – can lead to overflow incontinence — Parkinson's medications (except Sinemet and Deprenyl) — Disopyramide — Antispasmodics — Antihistamines — Antipsychotics (N0415A) — Antidepressants (N0415C) — Opioids (N0415H)	
☐	• Drugs that stimulate or block sympathetic nervous system	
☐	• Calcium channel blockers	

✓	**Use of indwelling catheter (H0100 is checked)**: (Presence of situation in which catheter use ***may*** be appropriate intervention after consideration of risks/benefits and after efforts to avoid catheter use have been unsuccessful	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Coma (B0100)	
☐	• Terminal illness (J1400, O0110K1)	
☐	• Stage 3 or 4 pressure ulcer in area affected by incontinence (M0300C, M0300D)	
☐	• Need for exact measurement of urine output	
☐	• History of inability to void after catheter removal	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

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Referral(s) to another discipline(s) is warranted (to whom and why): _____

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☐ Yes ☐ No

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Draft

7. PSYCHOSOCIAL WELL-BEING

Review of Indicators of Psychosocial Well-Being

✓	**Modifiable factors for relationship problems**	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Resident says or indicates they feel lonely (D0700) — Recent decline in social involvement and associated loneliness can be sign of acute health complications and depression	
☐	• Resident indicates they feel distressed because of decline in social activities	
☐	• Over the past few years, resident has experienced absence of daily exchanges with relatives and friends	
☐	• Resident is uneasy dealing with others	
☐	• Resident has conflicts with family, friends, roommate, other residents, or staff	
☐	• Resident appears preoccupied with the past and unwilling to respond to needs of the present	
☐	• Resident seems unable or reluctant to begin to establish a social role in the facility; may be grieving lost status or roles	
☐	• Recent change in family situation or social network, such as death of a close family member or friend	
✓	**Customary lifestyle** (Section F)	**Supporting Documentation**
☐	• Was lifestyle more satisfactory to the resident prior to admission to the nursing home?	
☐	• Are current psychosocial/relationship problems consistent with resident's long-standing lifestyle or is this relatively new for the resident?	
☐	• Has facility care plan to date been as consistent as possible with resident's prior lifestyle, preferences, and routines?	

Draft

✓	**Diseases and conditions** that may impede ability to interact with others	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Delirium (C1310, Delirium CAA)	
☐	• Intellectual disability /developmental disability (A1550)	
☐	• Alzheimer's disease (I4200)	
☐	• Aphasia (I4300)	
☐	• Other dementia (I4800)	
☐	• Depression (I5800)	
✓	**Health status factors** that may inhibit social involvement	**Supporting Documentation**
☐	• Decline in functional abilities (GG0130, GG0170)	
☐	• Health problem, such as falls (J1700–J1900), pain (J0300, J0800), fatigue, etc.	
☐	• Mood (D0150, D0160, D0500, D0600) or behavior (E0200) problem that impacts interpersonal relationships or that arises because of social isolation (see Mood State and Behavioral Symptoms CAAs)	
☐	• Change in communication (B0700, B0800), vision (B1000), hearing (B0200), cognition (C0100, C0600)	
☐	• Medications with side effects that interfere with social interactions, such as incontinence, diarrhea, delirium, or sleepiness	
✓	**Environmental factors** that may inhibit social involvement	**Supporting Documentation**
☐	• Use of physical restraints (P0100)	
☐	• Change in residence leading to loss of autonomy and reduced self-esteem (A1700)	
☐	• Change in room assignment or dining location or table mates	
☐	• Living situation limits informal social interaction, such as isolation precautions (O0110M1)	

Draft

✓	**Strengths** to build upon (from resident, family, staff interviews and clinical record)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Activities in which resident appears especially at ease interacting with others	
☐	• Certain situations appeal to resident more than others, such as small groups or 1:1 interactions rather than large groups	
☐	• Certain individuals who seem to bring out a more positive, optimistic side of the resident	
☐	• Positive traits that distinguished the resident as an individual prior to their illness	
☐	• What gave the resident a sense of satisfaction earlier in their life?	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

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Signature/Title:_____ Date:_____

Draft

8. MOOD STATE

Review of Indicators of Mood

✓	Psychosocial changes	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Personal loss	
☐	• Recent move into or within the nursing home (A1700)	
☐	• Recent change in relationships, such as illness or loss of a relative or friend	
☐	• Recent change in health perception, such as perception of being seriously ill or too ill to return home (Q0310–Q0610)	
☐	• Clinical or functional change that may affect the resident's dignity, such as new or worsening incontinence, communication, or decline	
✓	**Clinical issues** that can cause or contribute to a mood problem	**Supporting Documentation**
☐	• Relapse of an underlying mental health problem (I5700–I6100)	
☐	• Psychiatric disorder (anxiety, depression, manic depression, schizophrenia, post-traumatic stress disorder) (I5700–I6100)	
☐	• Alzheimer's disease (I4200)	
☐	• Delirium (C1310)	
☐	• Delusions (E0100B)	
☐	• Hallucinations (E0100A)	
☐	• Communication problems (B0700, B0800)	
☐	• Decline in Functional Abilities (GG0130, GG0170)	
☐	• Infection (I1700–I2500, I8000, M1040A)	
☐	• Pain (J0300 or J0800)	
☐	• Cardiac disease (I0200–I0900)	
☐	• Thyroid abnormality (I3400)	
☐	• Dehydration (J1550C)	
☐	• Metabolic disorder (I2900–I3400)	
☐	• Neurological disease (I4200–I5500)	
☐	• Recent cerebrovascular accident (I4500)	
☐	• Dementia, cognitive decline (I4800)	
☐	• Cancer (I0100)	
☐	• Other (I8000)	

Draft

✓	Medications	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Antibiotics (N0415F)	
☐	• Anticholinergics	
☐	• Antihypertensives	
☐	• Anticonvulsants *(N0415K)*	
☐	• Antipsychotics (N0415A)	
☐	• Cardiac medications	
☐	• Cimetidine	
☐	• Clonidine	
☐	• Chemotherapeutic agents	
☐	• Digitalis	
☐	• Other	
☐	• Glaucoma medications	
☐	• Guanethidine	
☐	• Immuno-suppressive medications	
☐	• Methyldopa	
☐	• Opioids (N0415H)	
☐	• Nitrates	
☐	• Propranolol	
☐	• Reserpine	
☐	• Steroids	
☐	• Stimulants	
✓	**Laboratory tests**	**Supporting Documentation**
☐	• Serum calcium	
☐	• Thyroid function	
☐	• Blood glucose	
☐	• Potassium	
☐	• Porphyria	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

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☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

9. BEHAVIORAL SYMPTOMS

Review of Indicators of Behavioral Symptoms

✓	Seriousness of the behavioral symptoms	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Resident is immediate threat to self – IMMEDIATE INTERVENTION REQUIRED (D0150I1, D0500I1)	
☐	• Resident is immediate threat to others – IMMEDIATE INTERVENTION REQUIRED	
☐	• Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A)	
☐	• Verbal behaviors directed toward others (e.g., threatening, screaming at, or cursing at others) (E0200B)	
☐	• Other behavior symptoms not directed toward others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C)	
☐	• Behavior significantly interferes with the resident's care (E0500B)	
☐	• Behavior significantly interferes with the resident's participation in activities or social interaction (E0500C)	
☐	• Behavior significantly intrudes on the privacy or activity of others (E0600B, E1000B)	
☐	• Behavior significantly disrupts care or living environment (E0600C)	
☐	• Resident rejects care that is necessary to achieve their goals for health and well-being (E0800)	
☐	• Resident's behavior status, care rejection, or wandering has worsened since last assessment (E1100)	
✓	**Nature of the behavioral disturbance** (resident interview, if possible)	**Supporting Documentation**
☐	• Provoked or unprovoked	

✓	Seriousness of the behavioral symptoms	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Offensive or defensive	
☐	• Purposeful	
☐	• Occurs during specific activities, such as bath or transfers	
☐	• Pattern, such as certain times of the day, or varies over time	
☐	• Others in the vicinity are involved	
☐	• Reaction to a particular action, such as being physically moved	
☐	• Resident appears to startle easily	

Draft

✓	**Medication side effects** that can cause behavioral symptoms	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• New medication	
☐	• Change in dosage	
☐	• Antiparkinsonian medications - may cause hypersexuality, socially inappropriate behavior	
☐	• Sedatives, centrally active antihypertensives, some cardiac medications, anticholinergic agents can cause paranoid delusions, delirium	
☐	• Bronchodilators or other respiratory medications, which can increase agitation and cause difficulty sleeping	
☐	• Caffeine	
☐	• Nicotine	
☐	• Medications that impair impulse control, such as benzodiazepines, sedatives, alcohol (or any product containing alcohol, such as some cough medicine)	
✓	**Illness or conditions** that can cause behavior problems	**Supporting Documentation**
☐	• Long-standing mental health problem associated with the behavioral disturbances, such as schizophrenia, bipolar disorder, depression, anxiety disorder, post-traumatic stress disorder (I5700–I6100)	
☐	• New or acute physical health problem or flare-up of a known chronic condition (I8000)	
☐	• Delusions (E0100B)	
☐	• Hallucinations (E0100A)	
☐	• Paranoia	
☐	• Constipation (H0600)	
☐	• Congestive heart failure (I0600)	
☐	• Infection (I1700–I2500)	
☐	• Head injury (I5500)	
☐	• Diabetes (I2900)	
☐	• Pain (J0300, J0800)	
☐	• Fever (J1550A)	
☐	• Dehydration (J1550C, see Dehydration CAA)	

Draft

✓	Factors that can cause or exacerbate the behavior	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Frustration due to problem communicating discomfort or unmet need	
☐	• Frustration, agitation due to need to urinate or have bowel movement	
☐	• Fear due to not recognizing caregiver	
☐	• Fear due to not recognizing the environment or misinterpreting the environment or actions of others	
☐	• Major unresolved sources of interpersonal conflict between the resident and family members, other residents, or staff (see Psychosocial Well-Being CAA)	
☐	• Recent change, such as new admission (A1700) or a new unit, assignment of new care staff, or withdrawal from a treatment program	
☐	• Departure from normal routines	
☐	• Sleep disturbance (D0150C, D0500C)	
☐	• Noisy, crowded area	
☐	• Dimly lit area	
☐	• Sensory impairment, such as hearing or vision problem (B0200, B1000)	
☐	• Restraints (P0100)	
☐	• Alarm Use (P0200)	
☐	• Fatigue (D0150D, D0500D)	
☐	• Need for repositioning (M1200C)	
✓	**Cognitive status problems** (also see Cognitive Loss CAA)	**Supporting Documentation**
☐	• Delirium (C1310) (see Delirium CAA)	
☐	• Dementia (I4800)	
☐	• Recent cognitive loss	
☐	• Alzheimer's disease (I4200)	
☐	• Effects of cerebrovascular accident (I4500)	

Draft

✓	Other Considerations	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• May be communicating discomfort, fears, personal needs, preferences, feeling ill	
☐	• Persons exhibiting long-standing problem behaviors related to psychiatric conditions may place others in danger of physical assault, intimidation, or embarrassment and place themselves at increased risk of being stigmatized, isolated, abused, and neglected by loved ones or care givers	
☐	• The actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

10. ACTIVITIES

Review of Indicators of Activities

✓	Activity preferences prior to admission	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Passive	
☐	• Active	
☐	• Outside the home	
☐	• Inside the home	
☐	• Centered almost entirely on family activities	
☐	• Centered almost entirely on non-family activities	
☐	• Group activities (F0500E, F0800P)	
☐	• Solitary activities	
☐	• Involved in community service, volunteer activities	
☐	• Athletic	
☐	• Non-athletic	
✓	**Current activity pursuits**	**Supporting Documentation**
☐	• Resident identifies leisure activities of interest	
☐	• Self-directed or done with others and/or planned by others	
☐	• Activities resident pursues when visitors are present	
☐	• Scheduled programs in which resident participates	
☐	• Activities of interest not currently available or offered to the resident	

Draft

✓	**Health issues** that result in reduced activity participation	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Indicators of depression or anxiety (D0150, D0160, D0500, D0600)	
☐	• Use of psychoactive medications (N0415A–N0415D)	
☐	• Functional/mobility (GG0130, GG0170) or balance problems; physical disability	
☐	• Cognitive deficits (C0500, C0700–C1000), including stamina, ability to express self (B0700), understand others (B0800), make decisions (C1000)	
☐	• Unstable acute/chronic health problem • (O0110, J0100, J1100, J1400, J1550, J2000, I8000, M1040)	
☐	• Chronic health conditions, such as incontinence (H0300, H0400) or pain (J0300, J0800)	
☐	• Embarrassment or unease due to presence of equipment, such as tubes, oxygen tank (O0110C1), or colostomy bag (H0100)	
☐	• Receives numerous treatments (M1200, O0110, O0400) that limit available time/energy	
☐	• Performs tasks slowly due to reduced energy reserves	
✓	**Environmental or staffing issues** that hinder participation	**Supporting Documentation**
☐	• Physical barriers that prevent the resident from gaining access to the space where the activity is held	
☐	• Need for additional staff responsible for social activities	
☐	• Lack of staff time to involve residents in current activity programs	
☐	• Resident's fragile nature results in feelings of intimidation by staff responsible for the activity	

Draft

✓	**Unique skills or knowledge** the resident has that they could pass on to others	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Games	
☐	• Complex tasks such as knitting, or computer skills	
☐	• Topic that might interest others	
✓	**Issues** that result in reduced activity participation	**Supporting Documentation**
☐	• Resident is new to facility or has been in facility long enough to become bored with status quo	
☐	• Psychosocial well-being issues, such as shyness, initiative, and social involvement	
☐	• Socially inappropriate behavior (E0200)	
☐	• Indicators of psychosis (E0100A–B)	
☐	• Feelings of being unwelcome, due to issues such as those already involved in an activity drawing boundaries that are difficult to cross	
☐	• Limited opportunities for resident to get to know others through activities such as shared dining, afternoon refreshments, monthly birthday parties, reminiscence groups	
☐	• Available activities do not correspond to resident's values, attitudes, expectations (F0500, F0800)	
☐	• Long history of unease in joining with others	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

11. FALL(S)

Review of Indicators of Fall Risk

Use information from observations, interviews, the clinical record and the MDS to identify indicators that pertain to the resident.

✓	History of falling (J1700, J1800, J1900)	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Time of day, exact hour of the fall(s)	
☐	• Location of the fall(s), such as bedroom, bathroom, hallway, stairs, outside, etc.	
☐	• Related to specific medication	
☐	• Proximity to most recent meal	
☐	• Responding to bowel or bladder urgency	
☐	• Doing usual/unusual activity	
☐	• Standing still or walking	
☐	• Reaching up or reaching down	
☐	• Identify the conclusions about the root cause(s), contributing factors related to previous falls	
✓	**Physical performance limitations: balance, gait, strength, muscle endurance**	**Supporting Documentation**
☐	• Difficulty maintaining sitting balance	
☐	• Need to rock body or push off on arms of chair when standing up from chair	
☐	• Difficulty maintaining standing position	
☐	• Impaired balance during transitions	
☐	• Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait	
☐	• One leg appears shorter than the other	
☐	• Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg	

✓	Medications	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Antipsychotics (N0415A)	
☐	• Antianxiety agents (N0415B)	
☐	• Antidepressants (N0415C)	
☐	• Hypnotics (N0415D)	
☐	• Cardiovascular medications	
☐	• Diuretics (N0415G)	
☐	• Opioids (N0415H)	
☐	• Neuroleptics	
☐	• Other medications that cause lethargy or confusion	
✓	**Internal risk factors**	**Supporting Documentation**
☐	• Circulatory/Heart — Anemia (I0200) — Cardiac Dysrhythmias (I0300) — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Congestive Heart Failure (CHF) pulmonary edema (I0600) — Cerebrovascular Accident (CVA) (I4500) — Transient Ischemic Attack (TIA) (I4500) — Postural/Orthostatic hypotension (I0800)	

(continued)

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✓	**Internal risk factors** (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Neuromuscular/functional — Cerebral palsy (I4400) — Loss of arm or leg movement (GG0115) — Decline in functional status (GG0130, GG0170) — Incontinence (H0300, H0400) — Hemiplegia/Hemiparesis (I4900) — Parkinson's disease (I5300) — Seizure disorder (I5400) — Paraplegia (I5000) — Multiple sclerosis (I5200) — Traumatic brain injury (I5500) — Syncope — Chronic or acute condition resulting in instability — Peripheral neuropathy — Muscle weakness	
☐	• Orthopedic — Joint pain — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Missing limb(s) (GG0120D)	
☐	• Perceptual — Visual impairment (B1000) — Hearing impairment (B0200) — Dizziness/vertigo	
☐	• Psychiatric or cognitive — Impulsivity or poor safety awareness — Delirium (C1310) — Wandering (E0900) — Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. — Cognitive impairment (C0500, C0700–C1000) — Alzheimer's disease (I4200) — Other dementia (I4800) — Anxiety disorder (I5700) — Depression (I5800) — Manic depression (I5900) — Schizophrenia (I6000)	

Draft

✓	**Internal risk factors** (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Infection (I1700–I2500)	
☐	• Low levels of physical activity	
☐	• Pain (J0300, J0800)	
☐	• Headache	
☐	• Fatigue, weakness	
☐	• Vitamin D deficiency	
✓	**Laboratory tests**	**Supporting Documentation**
☐	• Hypo- or hyperglycemia	
☐	• Electrolyte imbalance	
☐	• Dehydration (J1550C)	
☐	• Hemoglobin and hematocrit	
✓	**Environmental factors** (from review of facility environment)	**Supporting Documentation**
☐	• Poor lighting	
☐	• Glare	
☐	• Patterned carpet	
☐	• Poorly arranged furniture	
☐	• Uneven surfaces	
☐	• Slippery floors	
☐	• Obstructed walkway	
☐	• Poor fitting or slippery shoes	
☐	• Proximity to aggressive resident	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

12. NUTRITIONAL STATUS

Review of Indicators of Nutritional Status

✓	**Current eating pattern** – resident leaves significant proportion of meals, snacks, and supplements daily for even a few days	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Food offered or available is not consistent with the resident's food choices/needs — Food preferences not consistently honored — Resident has allergies or food intolerance (for example, needs lactose-free) — Food not congruent with religious or cultural needs — Resident complains about food quality (for example, not like what spouse used to prepare, food lacks flavor) — Resident doesn't eat processed foods — Food doesn't meet other special diet requirements	
☐	• Pattern re: food left uneaten (for example, usually leaves the meat or vegetables)	
☐	• Intervals between meals may be too long or too short	
☐	• Unwilling to accept food supplements or to eat more than three meals per day	

Draft

✓	**Functional problems** that affect ability to eat	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Swallowing problem (K0100)	
☐	• Arthritis (I3700)	
☐	• Contractures (GG0115)	
☐	• Functional limitation in range of motion (GG0115)	
☐	• Partial or total loss of arm movement (GG0115)	
☐	• Hemiplegia/hemiparesis (I4900, GG0115)	
☐	• Quadriplegia/paraplegia (I5100, I5000) (GG0115)	
☐	• Inability to perform self-care or mobility without significant physical assistance (GG0130, GG0170)	
☐	• Inability to sit up	
☐	• Missing limb(s) (GG0120D)	
☐	• Vision problems (B1000)	
☐	• Decreased ability to smell or taste food	
☐	• Need for special diet or altered consistency which might not appeal to resident (K0520C, K0520D)	
☐	• Recent decline in functional abilities (GG0130, GG0170)	
✓	**Cognitive, mental status, and behavior problems** that can interfere with eating	**Supporting Documentation**
☐	• Review Cognitive Loss CAA	
☐	• Alzheimer's Disease (I4200)	
☐	• Other dementia (I4800)	
☐	• Intellectual disability/developmental disability (A1550)	
☐	• Paranoid fear that food is poisoned	
☐	• Requires frequent/constant cueing	
☐	• Disruptive behaviors (E0200)	
☐	• Indicators of psychosis (E0100)	
☐	• Wandering (E0900)	
☐	• Pacing (E0200)	
☐	• Throwing food (E0200)	
☐	• Resisting care (E0800)	
☐	• Very slow eating	
☐	• Short attention span	
☐	• Poor memory (C0500, C0700–C0900)	
☐	• Anxiety problems (I5700)	

Draft

✓	Communication problems	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Review Communication CAA	
☐	• Comatose (B0100)	
☐	• Difficulty making self-understood (B0700)	
☐	• Difficulty understanding others (B0800)	
☐	• Aphasia (I4300)	
✓	**Dental/oral problems**	**Supporting Documentation**
☐	• See Dental Care CAA	
☐	• Broken or fractured teeth (L0200D)	
☐	• Toothache (L0200F)	
☐	• Bleeding gums (L0200E)	
☐	• Loose dentures, dentures causing sores (L0200A)	
☐	• Lip or mouth lesions (for example, cold sores, fever blisters, oral abscess) (L0200C)	
☐	• Mouth pain (L0200F)	
☐	• Dry mouth	
✓	**Other diseases and conditions** that can affect appetite or nutritional needs	**Supporting Documentation**
☐	• Anemia (I0200)	
☐	• Arthritis (I3700)	
☐	• Burns (M1040F)	
☐	• Cancer (I0100)	
☐	• Cardiovascular disease (I0300–I0900)	
☐	• Cerebrovascular accident (I4500)	
☐	• Constipation (H0600)	
☐	• Delirium (C1310)	
☐	• Depression (I5800)	
☐	• Diabetes (I2900)	
☐	• Diarrhea	
☐	• Gastrointestinal problem (I1100–I1300)	
☐	• Hospice care (O0110K1)	
☐	• Liver disease (I8000)	
☐	• Pain (J0300, J0800)	
☐	• Parkinson's disease (I5300)	
☐	• Pressure ulcers/injuries (M0210, M0300)	

(continued)

Draft

✓	**Other diseases and conditions** that can affect appetite or nutritional needs (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Radiation therapy (O0110B1)	
☐	• Recent acute illness (I8000)	
☐	• Recent surgical procedure (I8000, J2000, M1200F)	
☐	• Renal disease (I1500)	
☐	• Respiratory disease (I6200)	
☐	• Thyroid problem (I3400)	
☐	• Weight loss (K0300)	
☐	• Weight gain (K0310)	
✓	**Abnormal laboratory values**	**Supporting Documentation**
☐	• Electrolytes	
☐	• Pre-albumin level	
☐	• Plasma transferrin level	
☐	• Others	
✓	**Medications**	**Supporting Documentation**
☐	• Antipsychotics (N0415A)	
☐	• Chemotherapy (O0110A1)	
☐	• Cardiac medications	
☐	• Diuretics (N0415G)	
☐	• Anti-inflammatory medications	
☐	• Anti-Parkinson's medications	
☐	• Laxatives	
☐	• Antacids	
☐	• Start of a new medication	
✓	**Environmental factors**	**Supporting Documentation**
☐	• Sufficient eating assistance	
☐	• Availability of adaptive equipment	
☐	• Dining environment fosters pleasant social experience	
☐	• Appropriate lighting	
☐	• Sufficient personal space during meals	
☐	• Proper positioning in wheelchair/chair for dining	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

13. FEEDING TUBE(S)

Review of Indicators of Feeding Tubes

✓	Reason for tube feeding	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Unable to swallow or to eat food and unlikely to eat within a few days due to — Physical problems in chewing or swallowing (for example, stroke or Parkinson's disease) (L0200F, K0100) — Mental problems (I5700–I6100) (for example, Alzheimer's (I4200), Other Dementia (I4800), depression (I5800))	
☐	• Normal caloric intake is substantially impaired due to endotracheal tube or a tracheostomy (O0110E1, O0110F1)	
☐	• Prevention of meal-induced hypoxemia (insufficient oxygen to blood), in resident with COPD (I6200) or other pulmonary problems that interfere with eating	
✓	**Complications of tube feeding**	**Supporting Documentation**
☐	• Diagnostic conditions — Delirium (C1310) — Repetitive physical movements — Anxiety (I5700) — Depression (I5800) — Lung aspiration, pneumonia (I2000) — Infection at insertion site (I2500) — Shortness of breath (J1100)	
☐	• Bleeding around insertion site	
☐	• Constipation (H0600)	
☐	• Abdominal distension or abdominal pain	
☐	• Diarrhea or cramping	
☐	• Nausea, vomiting (J1550B)	
☐	• Tube dislodgement, blockage, leakage	
☐	• Bowel perforation	
☐	• Dehydration (J1550C) or fluid overload	
☐	• Self-extubation	
☐	• Use of physical restraints (P0100)	

Draft

✓	**Psychosocial issues** related to tube feeding	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Signs of depression (D0150, D0160, D0500, D0600, I5800, Mood State CAA)	
☐	• Ways to socially engage the resident with a feeding tube	
☐	• Emotional and social support from social workers, other members of the healthcare team	
✓	**Periodic evaluations and consultations**	**Supporting Documentation**
☐	• Weight check at least monthly (K0300, K0310)	
☐	• Lab tests to monitor electrolytes, serum albumin, hematocrit	
☐	• Periodic evaluations by nutritionist or dietitian	
☐	• Periodic evaluation of possibility of resuming oral feeding	
☐	• Regular changing and replacement of PEG tubes and J-tubes, per physician order and facility protocol (K0520B)	
✓	**Factors that may impede removal of feeding tube**	**Supporting Documentation**
☐	• Comatose (B0100)	
☐	• Failure to eat and resists assistance in eating (E0800)	
☐	• Cerebrovascular accident (I4500)	
☐	• Gastric ulcers, gastric bleeding, or other stomach disorder (I1200, I1300)	
☐	• Chewing problems unresolvable (L0200F)	
☐	• Swallowing problems (K0100)	
☐	• Mouth pain (L0200F)	
☐	• Anorexia (I8000)	
☐	• Lab values indicating compromised nutritional status	
☐	• Significant weight loss (K0300)	
☐	• Significant weight gain (K0310)	
☐	• Prolonged illness	
☐	• Neurological disorder (I4200–I5500)	
☐	• Cancer or side effects of cancer treatment (I0100, O0110A1, O0110B1)	
☐	• Advanced dementia (I4800)	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
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Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

14. DEHYDRATION/FLUID MAINTENANCE

Review of Indicators of Dehydration/Fluid Maintenance

✓	Symptoms of dehydration	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Dizziness on sitting or standing	
☐	• Confusion or change in mental status (delirium) (C1310, V0100D)	
☐	• Lethargy (C1310D)	
☐	• Recent decrease in urine volume or more concentrated urine than usual	
☐	• Decreased skin turgor, dry mucous membranes (J1550)	
☐	• Newly present constipation (H0600), fecal impaction	
☐	• Fever (J1550A)	
☐	• Functional decline (GG0130, GG0170)	
☐	• Increased risk for falls (J1700–J1900)	
☐	• Fluid and electrolyte disturbance	
✓	**Abnormal laboratory values**	**Supporting Documentation**
☐	• Hemoglobin	
☐	• Hematocrit	
☐	• Potassium chloride	
☐	• Sodium	
☐	• Albumin	
☐	• Blood urea nitrogen	
☐	• Urine specific gravity	

Draft

✓	**Cognitive, communication, and mental status** issues that can interfere with intake	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Depression (I5800, D0160, D0600) or anxiety (I5700)	
☐	• Behavioral disturbance that interferes with intake (E0200)	
☐	• Recent change in mental status (C1310)	
☐	• Alzheimer's or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating/drinking, etc. (I4200, I4800)	
☐	• Difficulty making self-understood (B0700)	
☐	• Difficulty understanding others (B0800)	
✓	**Diseases and conditions** that predispose to limitations in maintaining normal fluid balance	**Supporting Documentation**
☐	• Infection (I1700–I2500, M1040A)	
☐	• Fever (J1550A)	
☐	• Diabetes (I2900)	
☐	• Congestive heart failure (I0600)	
☐	• Swallow problem (K0100)	
☐	• Malnutrition (I5600)	
☐	• Renal disease (I1500)	
☐	• Weight loss (K0300)	
☐	• Weight gain (K0310)	
☐	• New cerebrovascular accident (I4500)	
☐	• Unstable acute or chronic condition	
☐	• Nausea or vomiting (J1550B)	
☐	• Diarrhea	
☐	• Excessive sweating	
☐	• Recent surgery (J2000, J2100, I8000)	
☐	• Recent decline in functional abilities, including body control or hand control problems (GG0115A), inability to sit up, etc. (GG0130, GG0170)	
☐	• Parkinson's or other neurological disease that requires unusually long time to eat (I4200–I5500)	
☐	• Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, (J1550B)	

(continued)

✓	**Diseases and conditions** that predispose to limitations in maintaining normal fluid balance (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Newly taking a diuretic or recent increase in diuretic dose (N0415G)	
☐	• Takes excessive doses of a laxative	
☐	• Hot weather (increases risk for elderly in absence of increased fluid intake)	
✓	**Oral intake**	**Supporting Documentation**
☐	• Recent change in oral intake	
☐	• Skips meals or consumes less than 25 percent of meals	
☐	• Fluid restriction	
☐	• Newly prescribed diet	
☐	• Decreased perception of thirst	
☐	• Limited fluid-drinking opportunities	
☐	• Fluid intake limited to try to control incontinence	
☐	• Dependence on staff for fluid intake	
☐	• Excessive output compared to fluid intake	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

15. DENTAL CARE

Review of Indicators of Oral/Dental Condition/Problem

✓	**Cognitive problems** that contribute to oral/dental problems	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Needs reminders to clean teeth	
☐	• Cannot remember steps to complete oral hygiene (GG0130B)	
☐	• Decreased ability to understand others (B0800) or to perform tasks following demonstration	
☐	• Cognitive deficit (C0500, C0700–C1000)	
✓	**Functional impairment** limiting ability to perform personal hygiene	**Supporting Documentation**
☐	• Loss of voluntary arm movement (GG0115A)	
☐	• Impaired hand dexterity (GG0115A)	
☐	• Functional limitation in upper extremity range of motion (GG0115A)	
☐	• Decreased mobility (GG0170)	
☐	• Resists assistance with activities of daily living (E0800)	
☐	• Lacks motivation or knowledge regarding adequate oral hygiene, dental care (GG0130B)	
☐	• Requires adaptive equipment for oral hygiene	
✓	**Dry mouth** causing buildup of oral bacteria	**Supporting Documentation**
☐	• Dehydration (see Dehydration/Fluid Maintenance CAA)	
☐	• Medications — Antipsychotics (N0415A) — Antidepressants (N0415C) — Antianxiety agents (N0415B) — Sedatives/hypnotics (N0415D) — Diuretics (N0415G) — Antihypertensives — Antiparkinsonian medications — Opioids (N0415H) — Anticonvulsants *(N0415K)* — Antihistamines — Decongestants — Antiemetics	
☐	• Antineoplastics	

Draft

✓	**Diseases and conditions** that may be related to poor oral hygiene, oral infection	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Recurrent pneumonia related to aspiration of saliva contaminated due to poor oral hygiene (I2000)	
☐	• Unstable diabetes related to oral infection (I2900)	
☐	• Endocarditis related to oral infection (I8000)	
☐	• Sores in mouth related to poor-fitting dentures (L0200C)	
☐	• Poor nutrition (I5600) (see Nutrition CAA)	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

16. PRESSURE ULCER/INJURY

Review of Indicators of Pressure Ulcer/Injury

✓	**Existing pressure ulcer/injury** (M0210, M0300)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin — Note if eschar or slough is present (M0300F) — Assess for signs of infection, such as the presence of a foul odor, increasing pain, surrounding skin is reddened (erythema) or warm, or there is a presence of purulent drainage — Note whether granulation tissue (required for healing) is present and the wound is healing as expected	
☐	• If the ulcer/injury does not show signs of healing despite treatment, consider complicating factors — Elevated bacterial level in the absence of clinical infection — Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed — Underlying osteomyelitis (bone infection)	
✓	**Extrinsic risk factors**	**Supporting Documentation**
☐	• Pressure — Requires staff assistance to move sufficiently to relieve pressure over any one site — Confined to a bed or chair all or most of the time — Needs special mattress or seat cushion to reduce or relieve pressure (M1200A, M1200B) — Requires regular schedule of turning (M1200C)	
☐	• Friction and shear — Slides down in the bed — Moved by sliding rather than lifting	
☐	• Maceration — Persistently wet, especially from fecal incontinence, wound drainage, or perspiration — Moisture associated skin damage (M1040H)	

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✓	Intrinsic risk factors	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Immobility (GG0170)	
☐	• Altered mental status — Delirium limits mobility (see Delirium CAA) — Cognitive loss (C0500, C0700–C1000) limits mobility (see Cognitive Loss CAA)	
☐	• Incontinence (H0300, H0400, M1040H) (see Incontinence CAA)	
☐	• Poor nutrition (I5600) (see Nutrition CAA)	
✓	**Medications** that increase risk for pressure ulcer/injury development	**Supporting Documentation**
☐	• Antipsychotics (N0415A)	
☐	• Antianxiety agents (N0415B)	
☐	• Antidepressants (N0415C)	
☐	• Hypnotics (N0415D)	
☐	• Steroids	
☐	• Opioids (N0415H)	
✓	**Diagnoses and conditions** that present complications or increase risk for pressure ulcer/injury	**Supporting Documentation**
☐	• Delirium (C1310)	
☐	• Comatose (B0100)	
☐	• Cancer (I0100)	
☐	• Peripheral Vascular Disease (I0900)	
☐	• Diabetes (I2900)	
☐	• Alzheimer's disease (I4200)	
☐	• Cerebrovascular Accident (I4500)	
☐	• Other dementia (I4800)	
☐	• Hemiplegia/hemiparesis (I4900)	
☐	• Paraplegia (I5000), Quadriplegia (I5100)	
☐	• Multiple sclerosis (I5200)	
☐	• Depression (D0160, D0600, I5800)	
☐	• Edema	
☐	• Severe pulmonary disease (I6200)	
☐	• Sepsis (I2100)	
☐	• Terminal illness (J1400, O0110K1)	

Draft

✓	**Diagnoses and conditions** that present complications or increase risk for pressure ulcer/injury (continued)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Chronic or end-stage renal, liver, or heart disease (I1500, I1100, I2400, I0400, I0600)	
☐	• Pain (J0300, J0800)	
☐	• Dehydration (J1550C, I8000)	
☐	• Shortness of breath (J1100)	
☐	• Recent weight loss (K0300)	
☐	• Recent weight gain (K0310)	
☐	• Malnutrition (I5600)	
☐	• Decreased sensory perception	
☐	• Recent decline in Functional Abilities (GG0130, GG0170)	
✓	**Treatments and other factors** that cause complications or increase risk	**Supporting Documentation**
☐	• Newly admitted or readmitted (A1700)	
☐	• History of healed pressure ulcer/injury	
☐	• Chemotherapy (O0110A1)	
☐	• Radiation therapy (O0110B1)	
☐	• Ventilator or respirator (O0110F1)	
☐	• Renal dialysis (O0110J1)	
☐	• Functional limitation in range of motion (GG0115)	
☐	• Head of bed elevated most or all of the time	
☐	• Physical restraints (P0100)	
☐	• Devices that can cause pressure, such as oxygen (O0110C1) or indwelling catheter (H0100A) tubing, TED hose, casts, or splints	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

17. PSYCHOTROPIC MEDICATION USE

Review of Indicators of Psychotropic Drug Use

✓	**Class(es) of medication** this resident is taking	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Antipsychotic (N0415A, N0450A)	
☐	• Antianxiety (N0415B)	
☐	• Antidepressant (N0415C)	
☐	• Sedative/Hypnotic (N0415D)	
✓	**Unnecessary medication evaluation**	**Supporting Documentation**
☐	• Excessive dose, including duplicate medications	
☐	• Excessive duration and/or without gradual dose reductions (N0450B, N0450C)	
☐	• Inadequate monitoring for effectiveness and/or adverse consequences	
☐	• Inadequate or inappropriate indications for use	
☐	• In presence of adverse consequences related to the medication	
✓	**Treatable/reversible reasons for use** of psychotropic medication	**Supporting Documentation**
☐	• Environmental stressors such as excessive heat, noise, overcrowding, etc.	
☐	• Psychosocial stressors such as abuse, taunting, not following resident's customary routine, etc. (F0300–F0800)	
☐	• Treatable medical conditions, such as heart disease (I0200–I0900), diabetes (I2900), or respiratory disease (I6200, I6300)	

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✓	**Adverse consequences of ANTIDEPRESSANTS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Worsening of depression and/or suicidal behavior or thinking (D0150I, D0500I, V0100E, V0100F)	
☐	• Delirium unrelated to medical illness or severe depression (C1310)	
☐	• Hallucinations (E0100A)	
☐	• Dizziness	
☐	• Nausea	
☐	• Diarrhea	
☐	• Anxiety (I5700)	
☐	• Nervousness, fidgety or restless (D0150H, D0500H)	
☐	• Insomnia	
☐	• Somnolence	
☐	• Weight gain (K0310)	
☐	• Anorexia or increased appetite	
☐	• Increased risk for falls (J1700–J1900)	
☐	• Seizures (I5400)	
☐	• Hypertensive crisis if combined with certain foods, cheese, wine (MAO inhibitors)	
☐	• Anticholinergic (tricyclics), such as constipation, dry mouth, blurred vision, urinary retention, etc.	
☐	• Postural hypotension (tricyclics)	
✓	**Adverse consequences of ANTIPSYCHOTICS** exhibited by this resident	**Supporting Documentation**
☐	• Anticholinergic effects, such as constipation, dry mouth, blurred vision, urinary retention, etc.	
☐	• Increase in total cholesterol and triglycerides	
☐	• Akathisia (inability to sit still)	
☐	• Parkinsonism (any combination of tremors, postural unsteadiness, muscle rigidity, pill-rolling of hands, shuffling gait, etc.)	

(continued)

Draft

✓	**Adverse consequences of ANTIPSYCHOTICS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Neuroleptic malignant syndrome (high fever with severe muscular rigidity)	
☐	• Blood sugar elevation	
☐	• Cardiac arrhythmias (I0300)	
☐	• Orthostatic hypotension	
☐	• Cerebrovascular accident or transient ischemic attack (I4500)	
☐	• Falls (J1700–J1900)	
☐	• Tardive dyskinesia (persistent involuntary movements such as tongue thrusting, lip movements, chewing or puckering movements, abnormal limb movements, rocking or writhing trunk movements)	
☐	• Lethargy (C1310D)	
☐	• Excessive sedation	
☐	• Depression (D0160, D0600, I5800)	
☐	• Hallucinations (E0100A)	
☐	• Delirium unrelated to medical illness or severe depression (C1310)	
✓	**Adverse consequences of ANXIOLYTICS** exhibited by this resident	**Supporting Documentation**
☐	• Sedation manifested by short-term memory loss (C0500, C0700), decline in cognitive abilities, slurred speech (B0600), drowsiness, little/no activity involvement	
☐	• Delirium unrelated to medical illness or severe depression (C1310)	
☐	• Hallucinations (E0100A)	
☐	• Depression (D0160, D0600, I5800)	
☐	• Disturbances of balance, gait, positioning ability (GG0170)	

Draft

✓	**Adverse consequences of SEDATIVES/HYPNOTICS** exhibited by this resident	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• May increase the metabolism of many medications (for example, anticonvulsants, antipsychotics), which may lead to decreased effectiveness and subsequent worsening of symptoms or decreased control of underlying illness	
☐	• Hypotension (I0800)	
☐	• Dizziness, lightheadedness	
☐	• "Hangover" effect	
☐	• Drowsiness	
☐	• Confusion, delirium unrelated to acute illness or severe depression (C1310)	
☐	• Mental depression (I5800, I5900)	
☐	• Unusual excitement	
☐	• Nervousness	
☐	• Headache	
☐	• Insomnia	
☐	• Nightmares	
☐	• Hallucinations (E0100A)	
☐	• Falls (J1700–J1900)	
✓	**Medication-related discomfort** requiring treatment and/or prevention	**Supporting Documentation**
☐	• Dehydration (J1550C)	
☐	• Reduced dietary bulk	
☐	• Lack of exercise	
☐	• Constipation/fecal impaction (H0600	
☐	• Urinary retention	
☐	• Dry mouth (interview)	
✓	**Overall status change** for relationship to psychotropic drug use	**Supporting Documentation**
☐	• Major differences in a.m./p.m. performance	
☐	• Decline in cognition/communication (V0100D)	
☐	• Decline in mood (V0100E, V0100F)	
☐	• Decline in behavior (E1100)	
☐	• Decline in functional abilities (GG0130, GG0170)	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

18. PHYSICAL RESTRAINTS

Review of Indicators of Physical Restraints

✓	Evaluation of current restraint use	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA)	
☐	• Evidence of informed consent not evident in chart	
☐	• Medical symptom not identified for treatment via restraints	
☐	• Used for staff convenience	
☐	• Used for discipline purposes	
☐	• Multiple restraints in use	
☐	• Non-restraint interventions not attempted prior to restraining	
☐	• Less restrictive devices not attempted	
☐	• No regular schedule for removing restraints	
☐	• No schedule for frequency by hour of the day for checking on resident's well-being	
☐	• No plan for reducing/eliminating restraints	
✓	**Medical conditions/treatments that may lead to restraint use**	**Supporting Documentation**
☐	• Indwelling catheter (H0100A), external catheter (H0100B), or ostomy (H0100C)	
☐	• Parenteral/IV feeding (K0520A)	
☐	• Feeding tube (K0520B)	
☐	• Pressure ulcer/injury (M0210, M0300) or pressure ulcer/injury care (M1200E)	
☐	• Other skin ulcers, wounds, skin problems (M1040) or wound care (M1200F–M1200I)	
☐	• Oxygen therapy (O0110C1)	
☐	• Tracheostomy (O0110E1, clinical record)	
☐	• Ventilator or respirator (O0110F1)	
☐	• IV medications (O0110H1)	
☐	• Transfusions (O0110I1)	
☐	• Functional decline, decreased mobility (GG0130, GG0170)	
☐	• Alarm use (P0200)	
☐	• Other medical problem or equipment associated with restraint use (clinical record)	

✓	**Cognitive impairment/behavioral symptoms that may lead to restraint use** (also see Cognitive Loss and Behavior CAAs)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Inattention, easily distracted (C1310B)	
☐	• Disorganized thinking (C1310C)	
☐	• Fidgety, restless	
☐	• Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
☐	• Confusion (C0500, C0700–C1000)	
☐	• Psychosis (E0100A, E0100B)	
☐	• Physical symptoms directed toward others (E0200A)	
☐	• Verbal behavioral symptoms directed toward others (E0200B)	
☐	• Rejection of care (E0800)	
☐	• Wandering (E0900)	
☐	• Delirium (C1310), including side effects of medications	
☐	• Alzheimer's disease (I4200) or other dementia (I4800)	
☐	• Traumatic brain injury (I5500)	
☐	• Psychiatric disorder (I5700–I6100)	
✓	**Risk for falls that may lead to restraint use** (also see Falls CAA)	**Supporting Documentation**
☐	• Poor safety awareness, impulsivity	
☐	• Urinary urgency	
☐	• Incontinence of bowel and/or bladder (H0300, H0400)	
☐	• Side effect of medication, such as dizziness, postural/orthostatic hypotension (I0800), sedation, etc.	
☐	• Insomnia, fatigue (D0150C–D, D0500C–D)	
☐	• Need for assistance with mobility (GG0170)	
☐	• Balance problem	
☐	• Postural/orthostatic hypotension (I0800)	
☐	• Hip or other fracture (I3900, I4000)	
☐	• Hemiplegia/hemiparesis (I4900), paraplegia (I5000), quadriplegia (I5100)	
☐	• Other neurological disorder (for example, Cerebral Palsy (I4400), Multiple Sclerosis (I5200), Parkinson's Disease (I5300))	
☐	• Respiratory problems (J1100, I6200, I6300)	
	• History of falls (J1700–J1900)	

Draft

✓	Adverse reaction to restraint use	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Skin breakdown (M0300, M1030, M1040)	
☐	• Incontinence or increased incontinence (H0300, H0400)	
☐	• Moisture associated skin damage (M1040H)	
☐	• Constipation (H0600)	
☐	• Increased agitation behavior (E0200, clinical record) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
☐	• Depression, withdrawal, diminished dignity, social isolation (I5800, I5900)	
☐	• Loss of muscle mass, contractures, lessened mobility) and stamina (GG0170, GG0115)	
☐	• Infections, such as UTI or pneumonia (I1700–I2500)	
☐	• Frequent attempts to get out of the restraints (P0100), falls (J1700–J1900)	

Draft

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

Draft

19. PAIN

Review of Indicators of Pain

✓	**Diseases and conditions that may cause pain** (diagnosis OR signs/symptoms present)	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Cancer (I0100)	
☐	• Circulatory/heart — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Deep Vein Thrombosis (I0500) — Peripheral Vascular Disease (I0900)	
☐	• Skin/Wound — Pressure ulcer/injury (M0210, M0300) — Venous or arterial ulcers (M1030) — Other ulcers, wounds, and skin problems (M1040A–H)	
☐	• Infections — Urinary tract infection (I2300) — Pneumonia (I2000)	
☐	• Neurological (I4200–I5500) — Head trauma (clinical record) — Headache — Neuropathy — Post-stroke syndrome	
☐	• Gastrointestinal — Gastroesophageal Reflux Disease/Ulcer (I1200) — Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease (I1300) — Constipation (H0600, clinical record, resident interview)	
☐	• Hospice care (O0110K1)	
☐	• Terminal condition (J1400)	
☐	• Musculoskeletal — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Other fracture (I4000) — Back problems (I8000) — Amputation (GG0120D, O0500I) — Other (I8000)	
☐	• Dental problems (L0200)	

Draft

✓	Characteristics of the pain	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Location	
☐	• Type (constant, intermittent, varies over time, etc.)	
☐	• What makes it better	
☐	• What makes it worse	
☐	• Words that describe it (for example, aching, soreness, dull, throbbing, crushing) — Burning, pins and needles, shooting, numbness (neuropathic) — Cramping, crushing, throbbing, stabbing (musculoskeletal) — Cramping, tightness (visceral)	
✓	**Frequency and intensity of the pain** (J0410–J0600, J0850)	**Supporting Documentation**
☐	• How often it occurs	
☐	• Time or situation of onset	
☐	• How long it lasts	
✓	**Non-verbal indicators of pain** (particularly important if resident is stoic)	**Supporting Documentation**
☐	• Facial expression (frowning, grimacing, etc.) (J0800C)	
☐	• Vocal behaviors (sighing, moaning, groaning, crying, etc.) (J0800A, J0800B)	
☐	• Body position (guarding, distorted posture, restricted limb movement, etc.) (J0800D)	
☐	• Restlessness	
✓	**Pain effect on function**	**Supporting Documentation**
☐	• Disturbs sleep (J0510)	
☐	• Decreases appetite	
☐	• Adversely affects mood (D0150, D0500)	
☐	• Limits participation in rehabilitation therapy (J0520)	
☐	• Limits day-to-day activities (J0530) (social events, eating in dining room, etc.)	
☐	• Limits independence with at least some functional abilities (GG0130, GG0170)	

Draft

✓	Associated signs and symptoms	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Agitation or new or increased behavior problems (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
☐	• Delirium (C1310)	
☐	• Withdrawal	
✓	**Other Considerations**	**Supporting Documentation**
☐	• Improper positioning	
☐	• Contractures (GG0115)	
☐	• Immobility (GG0170)	
☐	• Use of restraints (P0100)	
☐	• Recent change in pain (characteristics, frequency, intensity, etc.) (J0410–J0850)	
☐	• Insufficient pain relief (J0300–J0850)	
☐	• Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain (J0300–J0850)	

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Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

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20. RETURN TO COMMUNITY REFERRAL

Review of Return to Community Referral

✓	Steps in the Process
☐	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B).
☐	2. Discuss with the individual and their family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual's smooth transition to community living. (Q0110)
☐	3. Other factors to consider regarding the individual's discharge assessment and planning for community supports include: • Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700–C1000) • Functional/mobility (GG0130, GG0170) or balance problems • Need for assistive devices and/or home modifications if considering a discharge home
☐	4. Inform the discharge planning team and other facility staff of the individual's choice.
☐	5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual's overall goals of care and discharge planning from previous items responses (Q0310 and Q0400A). Has the individual indicated that their goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility? (Q0310, Q0400A)
☐	6. Initiate contact with the State-designated local contact agency within approximately 10 business days, and document (Q0610). Follow-up is expected in a "reasonable" amount of time, 10 business days is a recommendation and not a requirement.
☐	7. If the local contact agency does not contact the individual by telephone or in person within approximately 10 business days, make another follow-up call to the designated local contact agency as necessary. The level and type of response needed by a particular individual is determined on a resident-by-resident basis, so timeframes for response may vary depending on the needs of the resident and the supports available within the community.
☐	8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan.
☐	9. Communicate findings and concerns with the facility discharge planning team, the individual's support circle, the individual's physician and the local contact agency in order to facilitate discharge/transition planning.

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Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		**Care Plan Considerations**
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

_____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes ☐ No

Signature/Title:_____ Date:_____

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CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

***NOTE**: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.*

- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: http://www.ahrq.gov/professionals/clinicians-providers/index.html;
- Academy of Nutrition and Dietetics – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version): https://www.eatrightpro.org/practice/position-and-practice-papers/position-papers/individualized-nutrition-approaches-adults-health-care-communities;
- Alzheimer's Association Resources: https://www.alz.org/;
- American Geriatrics Society Clinical Practice Guidelines and Tools: http://www.americangeriatrics.org/publications-tools;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: http://www.paltc.org/product-store;
- American Society of Consultant Pharmacists Practice Resources: https://www.ascp.com/page/prc;
- Association for Professionals in Infection Control and Epidemiology Practice Resources: http://www.apic.org/Resources/Overview;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/longtermcare/prevention/index.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf;
- Emerging Solutions in Pain Tools: http://www.emergingsolutionsinpain.com/;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools: https://consultgeri.org/tools;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: https://consultgeri.org/;
- Improving Nursing Home Culture (CMS Special Study): http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf;
  Institute for Safe Medication Practices: http://www.ismp.org/;
- Quality Improvement Organization (QIO) Program Nursing Home Resources: https://qioprogram.org/nursing-home-resources/;

CARE AREA GENERAL RESOURCES (cont.)

- Quality Improvement Organizations: https://qualitynet.cms.gov/;
- University of Missouri's Geriatric Examination Tool Kit: http://geriatrictoolkit.missouri.edu/; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: http://www.guideline.gov/.

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APPENDIX D: INTERVIEWING TO INCREASE RESIDENT VOICE IN MDS ASSESSMENTS

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. There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information (e.g., mood, preferences, pain). 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.

In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident's cognitive status. The majority of residents, even those with moderate to severe cognitive impairment, are able to answer some simple questions about these topics.

Even simple scripted interviews like those in MDS 3.0 involve a dynamic, collaborative process. There are some basic approaches that can make interviews simpler and more effective.

- **Introduce yourself** to the resident.
- **Be sure the resident can hear what you are saying.**
  - Do not mumble or rush. Articulate words clearly.
  - Ask the resident if they use or own a hearing aid or other communication device.
  - Help them get the aid or device in place before starting the interview.
  - The assessor may need to offer an assistive device (headphones).
  - If the resident is using a hearing aid or other communication device make sure that it is operational.
- **Ask whether the resident would like an interpreter (language or signing)** if the resident does not appear to be fluent in English or continues to have difficulty understanding. Interpreters are people who translate oral or written language from one language to another. If an interpreter is used during resident interviews, they should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the interviewee's responses. The resident should determine meaning based solely on their interpretation of what is being translated.
- **Find a quiet, private area where you are not likely to be interrupted or overheard.** This is important for several reasons:
  - Background noise should be minimized.
  - Some items are personal, and the resident will be more comfortable answering in private. The interviewer is in a better position to respond to issues that arise.
  - Decrease available distractions.

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- Sit where the resident can see you clearly and you can see their expressions.
  - Have your face well lighted.
  - Minimize glare.
  - Ask the resident where you should sit so that they can see you best. Some residents have decreased central vision or limited ability to turn their heads.
- Establish rapport and respect.
  - The steps you have already taken to ensure comfort go a long way toward establishing rapport and demonstrating respect.
  - You can also engage the resident in general conversation to help establish rapport.
  - If the resident asks a particular question or makes a request, try to address the request or question before proceeding with the interview.
- Explain the purpose of the questions to the resident.
  - Start by introducing the topic and explain that you are going to ask a series of questions.
  - You can tell the resident that these questions are designed to be asked of everyone to make sure that nothing is missed.
  - Highlight what you will ask.
  - End by explaining that their answers will help the care team develop a care plan that is appropriate for the resident.
  - Suggested explanations and introductions are included in specific item instructions.
- Say and show the item responses.
  - It is helpful to many older adults to both hear and read the response options.
  - As you verbally review the response options, show the resident the items written in large, clear print on a piece of paper or card.
  - Residents may respond to questions verbally, by pointing to their answers on the visual aid or by writing out their answers.
- **Ask the questions** as they appear in the questionnaire.
  - Use a nonjudgmental approach to questioning.
  - Don't be afraid of what the resident might say; you are there to hear it.
  - Actively listen; these questions can provide insights beyond the direct answer.
- **Break the question apart if necessary.** If the resident has difficulty understanding, requests clarification, or seems hesitant, you can employ unfolding or disentangling techniques. (Do not, however, use these techniques for the memory test).
  1. **Unfolding** refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present. This approach walks the resident through the steps needed to think through the question.

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Example: Read the item (or part of the item) to the resident, then ask, "Do you have this at all?" If yes, then ask, "Do you have it every day?" If no, then ask, "Did you have it at least half the days in the past 2 weeks?"

2. **Disentangling** refers to separating items with several parts into manageable pieces. The type of items that lend themselves to this approach are those that include a list and phrases such as "and" or "or." The resident is given a chance to respond to each piece separately. If a resident responds positively to more than one component of a complex item, obtain a frequency rating for each positive response and score that item using the frequency of the component that occurred most often.

   Example: An item asks about "Poor appetite or overeating." Disentangle this item by asking, "Poor appetite?"; pause for a response and then ask, "Or overeating?" If neither part is rated positively by the resident, mark no. If either or both are rated positively, then mark yes.

- **Clarify using echoing.** If the resident appears to understand but is having difficulty selecting an answer, try clarifying their response by first echoing what they told you and then repeating the related response options.
  - **Echoing** means simply restating part of the resident's response. This is often extremely helpful during clinical interviews. If the resident provides a related response but does not use the provided response scale or fails to directly answer the question, then help clarify the best response by repeating the resident's own comment and then asking the related response options again. This interview approach frequently helps the resident clarify which response option they prefer.
- **Repeat the response options** as needed. Some residents might need to have response choices repeated for each item on a given list.
- **Move on to another question** if the resident is unable to answer.
  - Even if the interview item cannot be completed the time spent is not wasted. The observation of resident behaviors and attention during the interview attempt provide important insights into delirium, cognition, mood, etc.
- **Break up the interview if the resident becomes tired or needs to leave for rehabilitation, etc.**
  - Try to complete the current item set and then offer to come back at another time to complete the remaining interview sections.
  - It is particularly important to complete the performance-based cognitive items in one sitting.
- **Do not try to talk a resident out of an answer.** If the resident expresses strong emotions, be nonjudgmental, and listen.
- **Record the resident's response,** not what you believe they should have said.
- **If the resident becomes deeply sorrowful or agitated,** sympathetically respond to their feelings.
  - Allowing emotional expression—even when it is uncomfortable for you as the interviewer—recognizes its validity and provides cathartic support to residents.

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- If the resident remains agitated or overly emotional and does not want to continue, respond to their needs. This is more important than finishing the interview at that moment. You can complete this and other sections at a later point in time.

- **Resident preferences may be influenced by many factors in a resident's physical, psychological and environmental state, and can be challenging to truly discern.**
  - Residents should be encouraged to articulate their desires and not be strictly limited by their physical limitations and perceived environmental restrictions.
  - When a resident is unable to communicate information about their preferences, a family member, close friend, or other representative must be used to complete preference questions. In this case, it is important to emphasize that this person should try to answer based on what the resident would prefer. The resident's preferences while in the nursing home and the resident's current responses when the particular item is offered or provided should form the basis for these responses.

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APPENDIX E: PATIENT HEALTH QUESTIONNAIRE (PHQ) SCORING RULES AND INSTRUCTION FOR BIMS (WHEN ADMINISTERED IN WRITING)

Scoring Rules: Resident Mood Interview Total Severity Score D0160

- Item D0160 is used to store the total severity score for the Resident Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the following nine items: D0150A2, D0150B2, D0150C2, D0150D2, D0150E2, D0150F2, D0150G2, D0150H2, D0150I2. These are referred to as the "items in Column 2", below.
- Scoring of items evaluated in D0150A–D0150I is dependent on the completion of these items following instructions for the PHQ-2 to 9©. Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions (D0150A and D0150B). If **both** D0150A1 and D0150B1 are coded 9, OR **both** D0150A2 and D0150B2 are coded 0 or 1, **end** the PHQ interview; otherwise continue. If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank**, then end the PHQ-2© and leave D0160, Total Severity Score blank. If **both** D0150A2 and D0150B2 are **coded 0 or 1**, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score. For all other scenarios, proceed to ask the remaining seven questions (D0150C to D0150I of the PHQ-9©) and complete D0160, Total Severity Score.
- The following rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2", which is the number of items in Column 2 that are blank (or skipped). An item in Column 2 could be blank if the corresponding item in Column 1 was equal to 9, No response or a dash (symptom not assessed).
- If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values.
- If any of the items in Column 2 are blank (or skipped), then omit their values when computing the sum.
- If the number of missing items in Column 2 is equal to **one**, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160.
- If the number of missing items in Column 2 is equal to **two,** then compute the simple sum of the seven items in Column 2 that have non-missing values, multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160.
- If the number of missing items in Column 2 is equal to **three or more**, then item D0160 must equal [99].

Scoring Rules: Resident Mood Interview Total Severity Score: D0160 (cont.)

Example 1: All Items in Column 2 Have Non-missing Values

The following example shows how to score the resident interview when all of the items in Column 2 have non-missing values:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	2
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	3
D0150I2	2
D0160	**14**

In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are blank). Therefore, the value of D0160 is equal to the simple sum of the values in Column 2, which is 14.

Example 2: One Missing Value in Column 2

The following example shows how to score the resident interview when one of the items in Column 2 has a missing value:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	3
D0150I2	1
D0160	**12**

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Scoring Rules: Resident Mood Interview Total Severity Score: D0160 (cont.)

In this example, one of the items in Column 2 (D0150C2) has a missing value (it is blank) and the other 8 items have non-missing values. D0160 is computed as follows:

1. Compute the sum of the 8 items with non-missing values. This sum is 11.
2. Multiply this sum by 1.125. In the example, 11 x 1.125 = 12.375.
3. Round the result to the nearest integer. In the example, 12.375 rounds to 12.
4. Place the rounded result in D0160.

Example 3: Two Missing Values in Column 2

The following example shows how to score the resident interview when two of the items in Column 2 are blank:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	0
D0150G2	1
D0150H2	1
D0150I2	
D0160	**10**

In this example, two of the items in Column 2 have missing values: both D0150C2 and D0150I2 are blank (or skipped). The other seven items have non-missing values. D0160 is computed as follows:

1. Compute the sum of the 7 items with non-missing values. This sum is 8.
2. Multiply this sum by 1.286. In the example, 8 x 1.286 = 10.288.
3. Round the result to the nearest integer. In the example, 10.288 rounds to 10.
4. Place the rounded result in D0160.

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Scoring Rules: Resident Mood Interview Total Severity Score: D0160 (cont.)

Example 4: Three or More Missing Values in Column 2

The following example shows how to score the resident interview when three or more of the items in Column 2 are blank:

Item	Value
D0150A2	1
D0150B2	2
D0150C2	
D0150D2	0
D0150E2	3
D0150F2	
D0150G2	
D0150H2	3
D0150I2	2
D0160	**99**

In this example, three of the items in Column 2 have missing values: D0150C2, D0150F2, and D0150G2 are blank (or skipped). The other 6 items have non-missing values. Because three or more items have missing values, D0160 is equal to 99.

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Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600

- Item D0600 is used to store the total severity score for the Staff Assessment of Resident Mood. The score in item D0600 is based upon the sum of the values that are contained in the following ten items: D0500A2, D0500B2, D0500C2, D0500D2, D0500E2, D0500F2, D0500G2, D0500H2, D0500I2, D0500J2. These are referred to as the "items in Column 2", below.
- The following rules explain how to compute the score that is placed in item D0600. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are equal to dash (an item could be equal to dash if it could not be assessed – for example, if the resident was unexpectedly discharged before the assessment could be completed).
- If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0600 is equal to the simple sum of those values.
- If any of the items in Column 2 are equal to dash, then omit their values when computing the sum.
- If the number of missing items in Column 2 is equal to one, then compute the simple sum of the nine items in Column 2 that have non-missing values, multiply the sum by 10/9 (1.111), and place the result rounded to the nearest integer in item D0600.
- If the number of missing items in Column 2 is equal to two, then compute the simple sum of the eight items in Column 2 that have non-missing values, multiply the sum by 10/8 (1.250), and place the result rounded to the nearest integer in item D0600.
- If the number of missing items in Column 2 is equal to three or more, then enter a dash in item D0600.

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Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600 (cont.)

Example 1: All Items in Column 2 Have Non-missing Values

The following example shows how to score the resident interview when all of the items in Column 2 have non-missing values:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	3
D0500F2	0
D0500G2	1
D0500H2	3
D0500I2	2
D0500J2	1
D0600	**15**

In this example, all of the items in Column 2 have non-missing values (i.e., none of the values are skipped or equal to dash). Therefore, the value of D0600 is equal to the simple sum of the values in Column 2, which is 15.

Example 2: One Missing Value in Column 2

The following example shows how to score the resident interview when one of the items in Column 2 has a missing value:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	—
D0500F2	0
D0500G2	1
D0500H2	3
D0500I2	2
D0500J2	1
D0600	**13**

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Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600 (cont.)

In this example, one of the items in Column 2 (D0500E2) has a missing value (it is equal to dash) and the other 9 items have non-missing values. D0600 is computed as follows:

1. Compute the sum of the 9 items with non-missing values. This sum is 12.
2. Multiply this sum by 1.111 (See bullet 5 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 12. Therefore, the calculation is: 12 x 1.111 = 13.332.
3. Round the result to the nearest integer. In the example, 13.332 rounds to 13.
4. Place the rounded result in D0600.

Example 3: Two Missing Values in Column 2

The following example shows how to score the resident interview when two of the items in Column 2 have missing values:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	—
D0500F2	0
D0500G2	1
D0500H2	—
D0500I2	2
D0500J2	1
D0600	**11**

In this example, two of the items in Column 2 have missing values: D0500E2 and D0500H2 are equal to dash. The other 8 items have non-missing values. D0600 is computed as follows:

1. Compute the sum of the 8 items with non-missing values. This sum is 9.
2. Multiply this sum by 1.250 (See bullet 6 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 9. Therefore, the calculation is: 9 x 1.250 = 11.250.
3. Round the result to the nearest integer. In the example, 11.250 rounds to 11.
4. Place the rounded result in D0600.

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Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600 (cont.)

Example 4: Three or More Missing Values in Column 2

The following example shows how to score the resident interview when three or more of the items in Column 2 have missing values:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	—
D0500F2	—
D0500G2	1
D0500H2	—
D0500I2	2
D0500J2	1
D0600	**—**

In this example, three of the items in Column 2 have missing values: D0500E2, D0500F2, and D0500H2 are equal to dash. Because three or more items have missing values, enter a dash in D0600 (enter a single dash in the leftmost space of D0600 and leave the second space blank).

Instructions for BIMS When Administered in Writing

When staff identify that the resident's primary method of communication is in written format, the Brief Interview for Mental Status (BIMS) and Category Cues can be administered in writing. **The administration of the BIMS in writing should be limited only to this circumstance.**

1. Interview any resident not screened out by the **Should Brief Interview for Mental Status Be Conducted?** item (C0100).
2. Conduct the interview in a private setting, if possible.
3. Residents with visual impairment should be tested using their usual visual aids.
4. Minimize glare by directing light sources away from the resident's face and from written materials.
5. Provide a written introduction before starting the interview.

   Suggested language: "I would like to ask you some questions, which I will show you in a moment. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult. We ask these questions of everyone so we can make sure that our care will meet your needs."

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Instructions for BIMS When Administered in Writing (cont.)

6. Directly provide the written questions for each item in C0200 through C0400 at one sitting and in the order provided.
   - For each BIMS question, show the resident a sheet of paper or card with the instruction for that question from the form clearly written in a large enough font to be easily seen.
   - The resident may respond to any of the BIMS questions in writing.
   - Show separate sheets or cards for each question or statement.
   - For C0200 items, instructions should be written as:
     - I have written 3 words for you to remember. Please read them. Then I will remove the card and ask you repeat or write down the words as you remember them.
     - Category cues should be provided to the resident in writing after the resident's first attempt to answer. Written category cues should state: "sock, something to wear; blue, a color; bed, a piece of furniture."
   - For C0300 items, instructions should be written as:
     - C0300A: "Please tell me what year it is right now."
     - C0300B: "What month are we in right now?"
     - C0300C: "What day of the week is today?"
   - For C0400 items, instructions should be written as:
     - "Let's go back to an earlier question. What were those three words that I asked you to repeat?"
     - If the resident is unable to remember a word, provide Category cues again, but without using the actual word. Therefore, Category cues for:
       - C0400A should be written as "something to wear,"
       - C0400B should be written as "a color," and
       - C0500C should be written as "a piece of furniture."
7. If the resident chooses not to answer a particular item, accept their refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect.
8. Rules for stopping the interview are the same as if for administering the BIMS verbally.

The following resources may be used, or the facility may develop their own. If the facility develops their own, they must use the exact language as in these resources.

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Written Introduction Card – BIMS – Items C0200 – C0400

I would like to ask you some questions, which I will show you in a moment.

We ask everyone these same questions.

This will help us provide you with better care.

Some of the questions may seem very easy, while others may be more difficult.

We ask these questions so that we can make sure that our care will meet your needs.

Written Instruction Cards – Item C0200 – Repetition of Three Words

I have written 3 words for you to remember.

Please read them.

Then, I will remove the card and ask you repeat or write down the words as you remember them.

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Word Card – Item C0200

SOCK

BLUE

BED

Category Cue Card – Item C0200

SOCK, something to wear

BLUE, a color

BED, a piece of furniture

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Written Instruction Cards – Item C0300 – Temporal Orientation

Statement Card – C0300A - Year

Please tell me what year it is right now.

Question Card – C0300B - Month

What month are we in right now?

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Question Card – Item C0300C - Day

What day of the week is today?

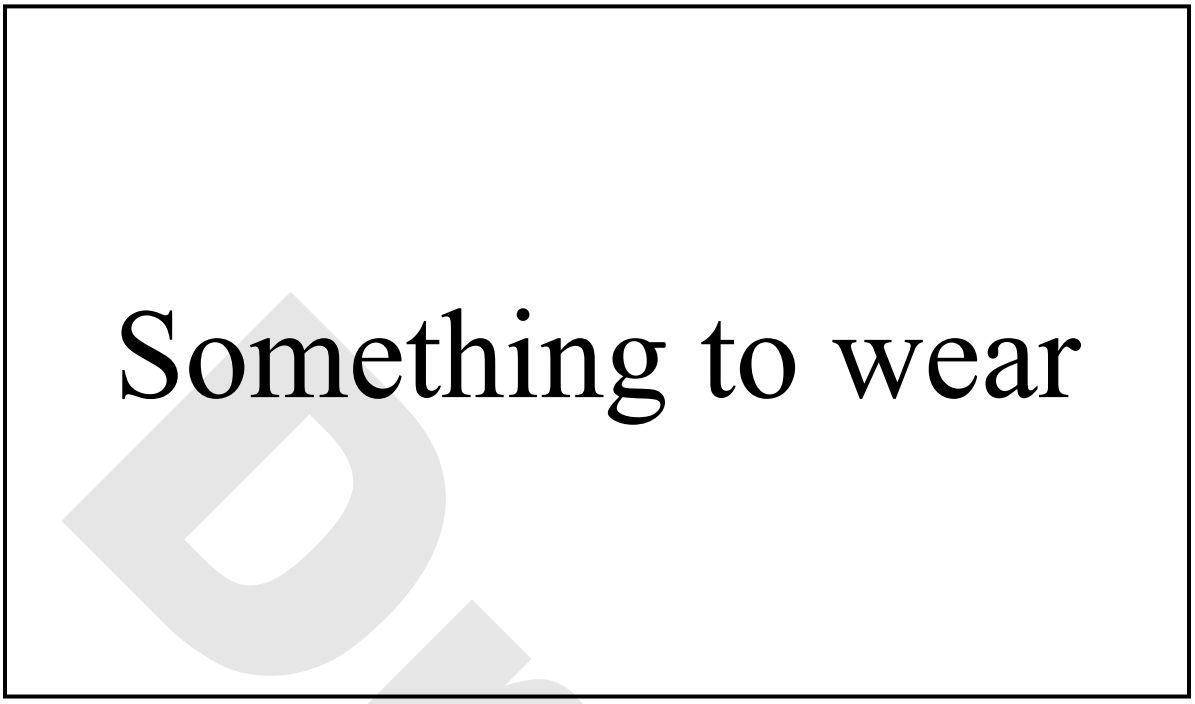
Written Instruction Card – Item C0400 - Recall

Let's go back to an earlier question.

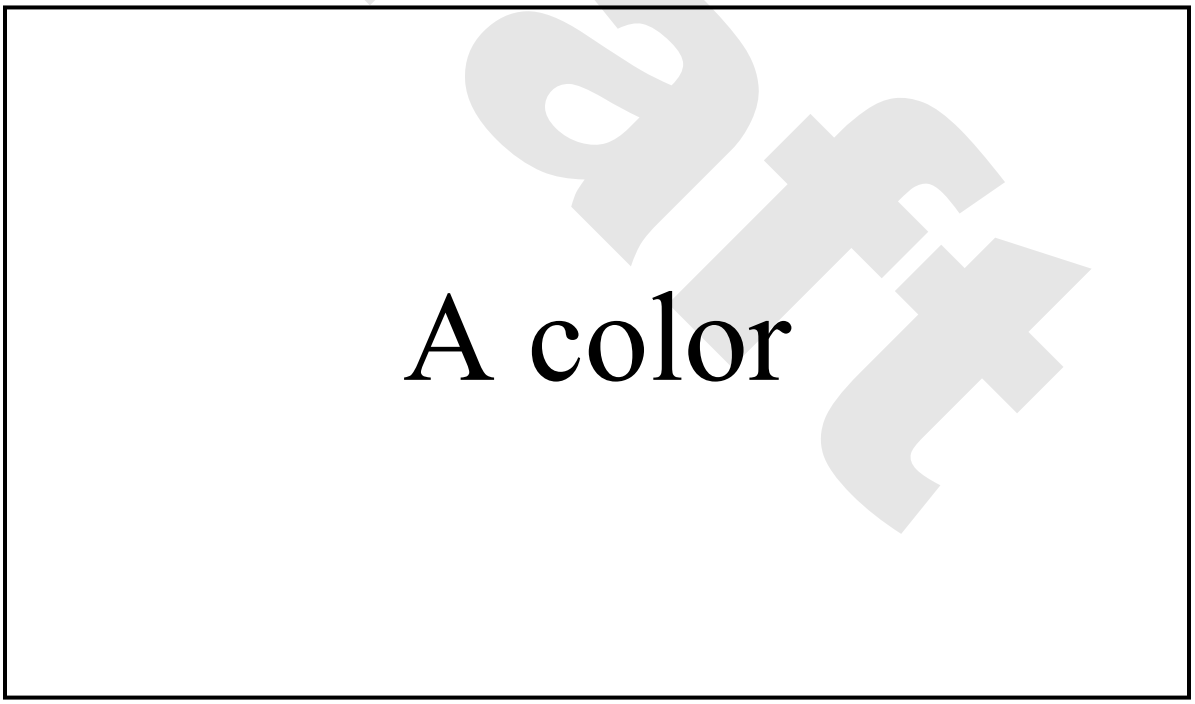
What were those three words that I asked you to repeat?

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Category Cue Card – Item C0400A - Sock



Category Cue Card – Item C0400B - Blue



Draft

Category Cue Card – Item C0400C

A piece of furniture

Draft

APPENDIX F
MDS ITEM MATRIX

The MDS Item Matrix is located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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APPENDIX H
MDS 3.0 FORMS

The MDS 3.0 Forms are located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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Track Changes
from Title Page v1.18.11
to Title Page v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
—	—	1	**Version 1.18~~.11~~9.1**
—	—	1	**October 202~~3~~24**
—	—	2	**October 202~~3~~24** **For Use Effective October 1, 202~~3~~24**

Draft

Track Changes
from TOC v1.18.11
to TOC v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
TOC	—	i	Section GG Functional Abilities ~~and Goals~~ GG-1

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Track Changes
from Chapter 1 v1.18.11
to Chapter 1 v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
1	1.2	1-3	• **Minimum Data Set (MDS).** A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The data elements (also referred to as "items") in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data elements for each MDS assessment and tracking document (e.g., Comprehensive, Quarterly, OBRA Discharge, Entry Tracking, PPS item sets) can be found ~~in Appendix H~~on CMS's website at https://www.cms.gov/Medicare/Quality/Nursing-Home-Improvement/Resident-Assessment-Instrument-Manual.
1	1.7	1-11	F — Preferences for Customary Routine and Activities — Obtain information regarding the resident's preferences for their daily routine and activities. GG — Functional Abilities~~ and Goals~~ — Assess the need for assistance with self-care and mobility activities, prior function, admission performance, ~~discharge goals,~~ discharge performance, functional limitations in range of motion, and current and prior device use. H — Bladder and Bowel — Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

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Track Changes
from Chapter 3 Intro v1.18.11
to Chapter 3 Intro v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	3.2	3-3	• As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section. • Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Functional Abilities ~~and Goals~~? • As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.

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Track Changes
from Chapter 3 Section B v1.18.11
to Chapter 3 Section B v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	B0100	B-1	• **Code 1, yes:** if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section GG, **Functional Abilities ~~and Goals~~**.
3	B1300	B-14	B1300. Health Literacy *Complete only if A0310B = 01* ***or*** *~~A0310G = 1 and~~ A0310H = 1.*
3	B1300	B-14	Replaced screenshot. OLD **B1300. Health Literacy** Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1 Enter Code ☐ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond *The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.* NEW **B1300. Health Literacy** Complete only if A0310B = 01 **or** A0310H = 1 Enter Code ☐ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy? 0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Resident declines to respond 8. Resident unable to respond *The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.*

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Track Changes
from Chapter 3 Section C v1.18.11
to Chapter 3 Section C v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	C0500	C-17	**Coding Tips** • Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, **BIMS Summary Score**, and complete the Staff Assessment for Mental Status. • If all of the BIMS items are coded with a dash, then C0500, BIMS Summary Score must also be coded with a dash.

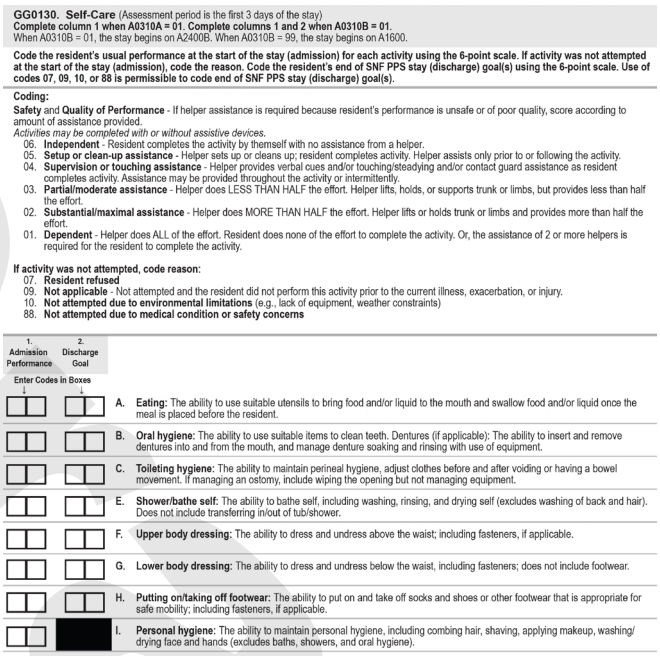
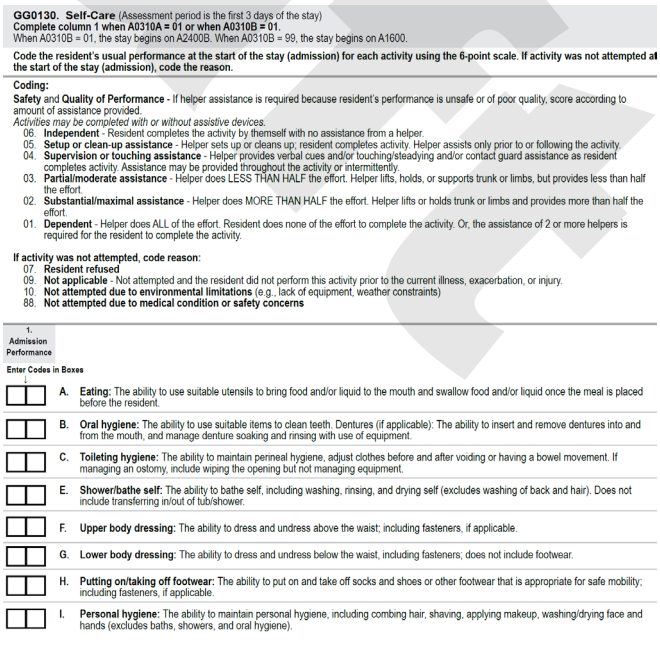
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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	—	GG-1	**SECTION GG: FUNCTIONAL ABILITIES ~~AND GOALS~~** **Intent:** This section includes items about functional abilities ~~and goals~~. It includes items focused on prior function, admission and discharge performance, ~~discharge goals,~~ performance throughout a resident's stay, mobility device use, and range of motion. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

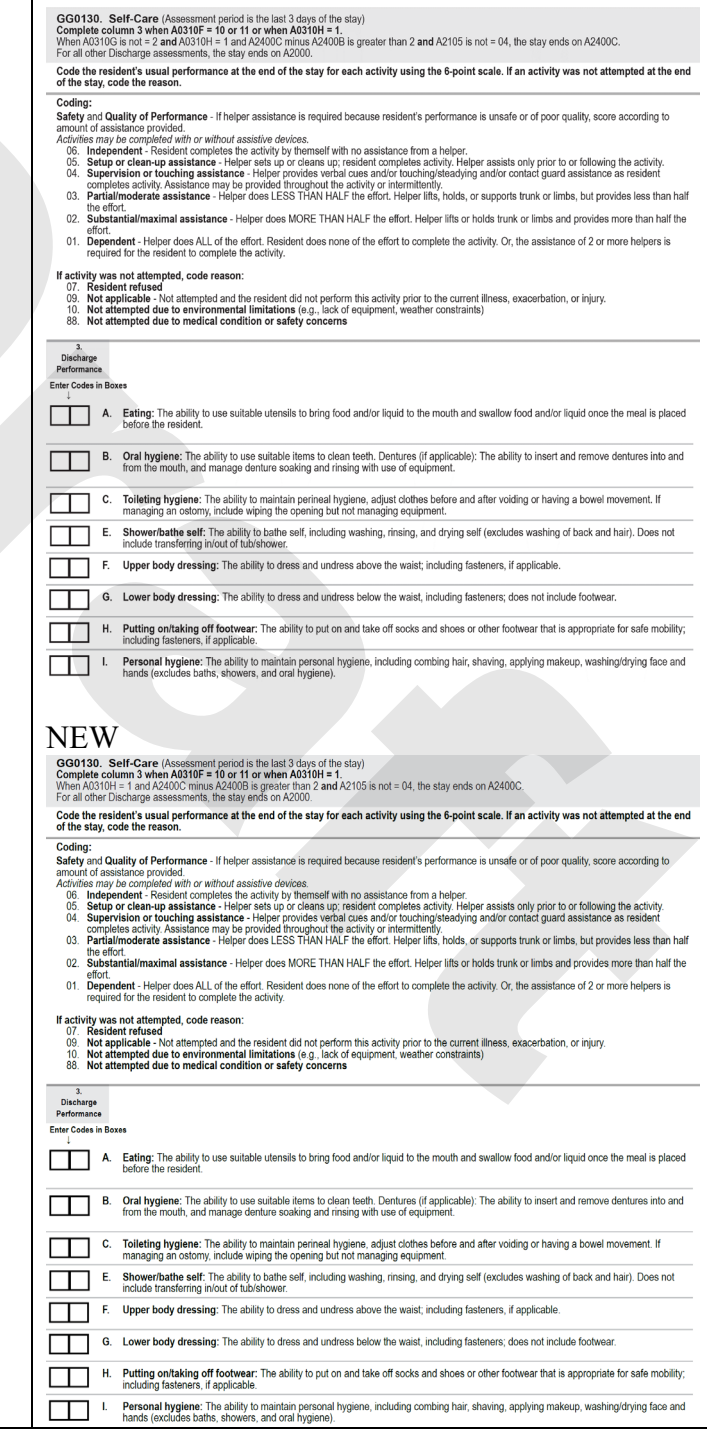
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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

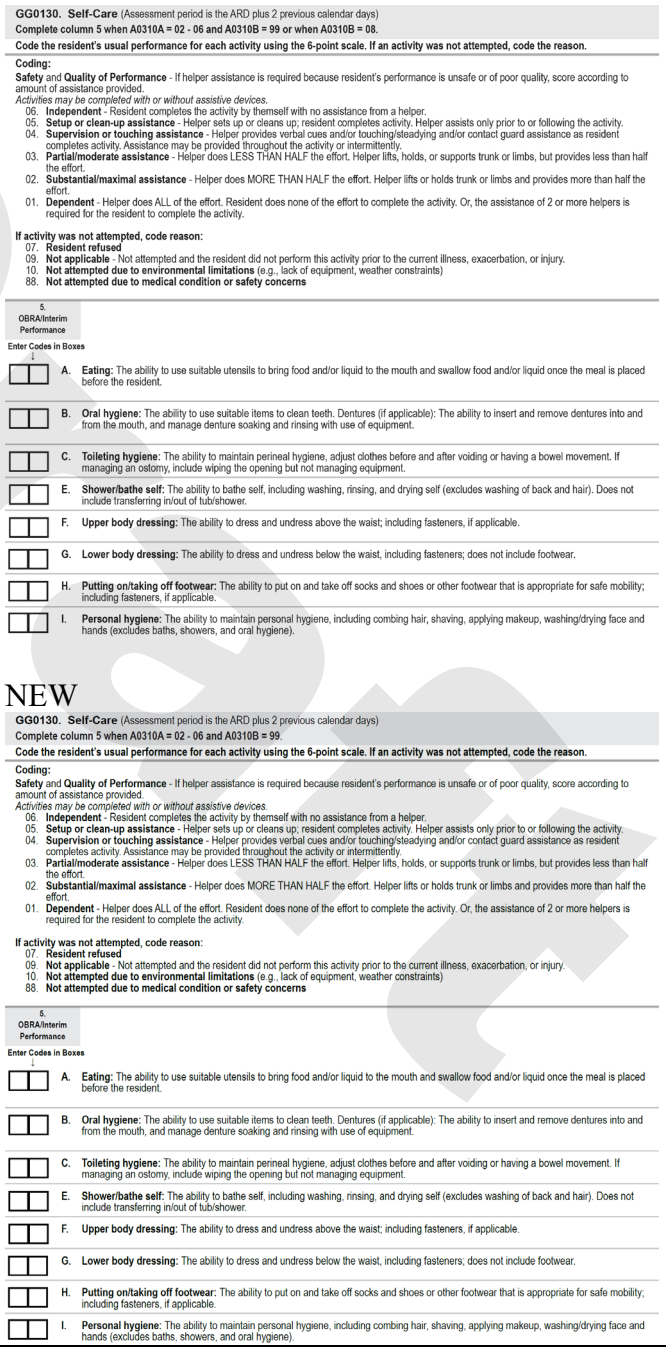
Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-11	Replaced screenshot. OLD  NEW 

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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-12	Replaced screenshot. OLD  **GG0130. Self-Care** (Assessment period is the last 3 days of the stay) **Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.** When A0310G is not = 2 **and** A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000. **Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. **If activity was not attempted, code reason:** 07. **Resident refused** 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns** 3. Discharge Performance Enter Codes in Boxes A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment. C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable. G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear. H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). NEW **GG0130. Self-Care** (Assessment period is the last 3 days of the stay) **Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.** When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C. For all other Discharge assessments, the stay ends on A2000. **Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. 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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-13	Replaced screenshot. OLD  **GG0130. Self-Care** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. 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I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). NEW **GG0130. Self-Care** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. 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C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment. E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower. F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable. G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear. H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. I. **Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

Draft

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-16	**Coding Instructions** • When coding the resident's usual performance ~~and discharge goal(s)~~, use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
3	GG0170	GG-34–GG-73	Page length changed due to revised content.
3	GG0130	GG-34	~~**Discharge Goals: Coding Tips**~~ ~~*Discharge goals are coded with each Admission assessment when A0310B = 01, indicating the start of a PPS stay. Discharge goals are not required with stand-alone OBRA assessments.*~~ ~~• For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. Identifying multiple goals helps to ensure that the assessment accurately reflects resident status and facilitates person-centered individualized care planning. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.~~

DRAFT

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-34	• ~~Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, practice standards, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.~~ • ~~If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a Discharge Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.~~
3	GG0130	GG-34	~~**Discharge Goal: Coding Examples**~~ ~~1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code~~ ~~If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.~~

Draft

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-34	~~2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code~~ ~~The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain their admission functional performance level. The qualified clinician discusses functional status goals with the resident and their family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident's admission performance code.~~ ~~**Oral Hygiene 5-Day PPS Assessment Admission Performance:** In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. Resident E has stated their preference for participation twice daily in their oral hygiene activity. Resident E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes Resident E's 5-Day PPS admission performance and discusses their usual performance with qualified clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Resident E's limb). The qualified clinician codes Resident E's 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding their limb.~~

Draft

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

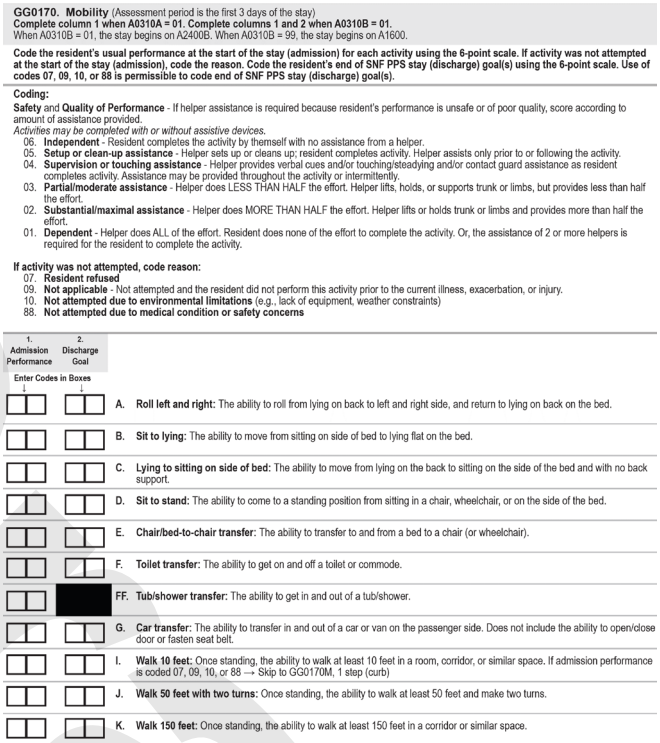
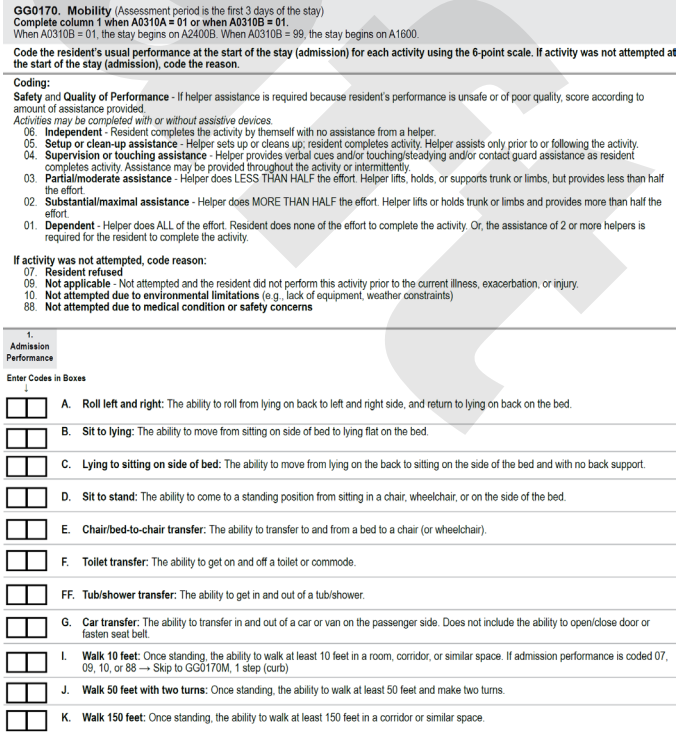
Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-34	~~**Oral Hygiene 5-Day PPS Assessment Discharge Goal:** The qualified clinician anticipates Resident E's discharge performance will remain 02, Substantial/maximal assistance. Due to Resident E's progressive and degenerative condition, the qualified clinician and resident feel that, while Resident E is not expected to make gains in oral hygiene performance, maintaining their function at this same level is desirable and achievable as a Discharge Goal.~~
3	GG0130	GG-34	~~3. Discharge Goal Code Is *Lower* than 5-Day PPS Assessment Admission Performance Code~~ ~~The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident's 5-Day PPS assessment admission performance code.~~ ~~**Toileting Hygiene:** Resident T's participation in skilled therapy is expected to slow down the pace of their anticipated functional deterioration. The resident's Discharge Goal code will be lower than the 5-Day PPS Admission Performance code.~~

Draft

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0130	GG-34	~~**Toileting Hygiene 5-Day PPS Assessment Admission Performance:** Resident T has a progressive neurological illness that affects their strength, coordination, and endurance. Resident T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Resident T while they are standing so that Resident T can release their hand from the grab bar (next to their bedside commode) and pull down their underwear before sitting onto the bedside commode. When Resident T has finished voiding, they wipe their perineal area. Resident T then requires the helper to support their trunk while Resident T pulls up their underwear. The qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Resident T's toileting hygiene.~~ ~~**Toileting Hygiene Discharge Goal:** By discharge, it is expected that Resident T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The qualified clinician codes their Discharge Goal as 02, Substantial/maximal assistance.~~

Draft

3	GG0170	GG-34	Replaced screenshot. OLD  NEW 

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

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

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes ↓	↓	
☐☐	☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	■	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

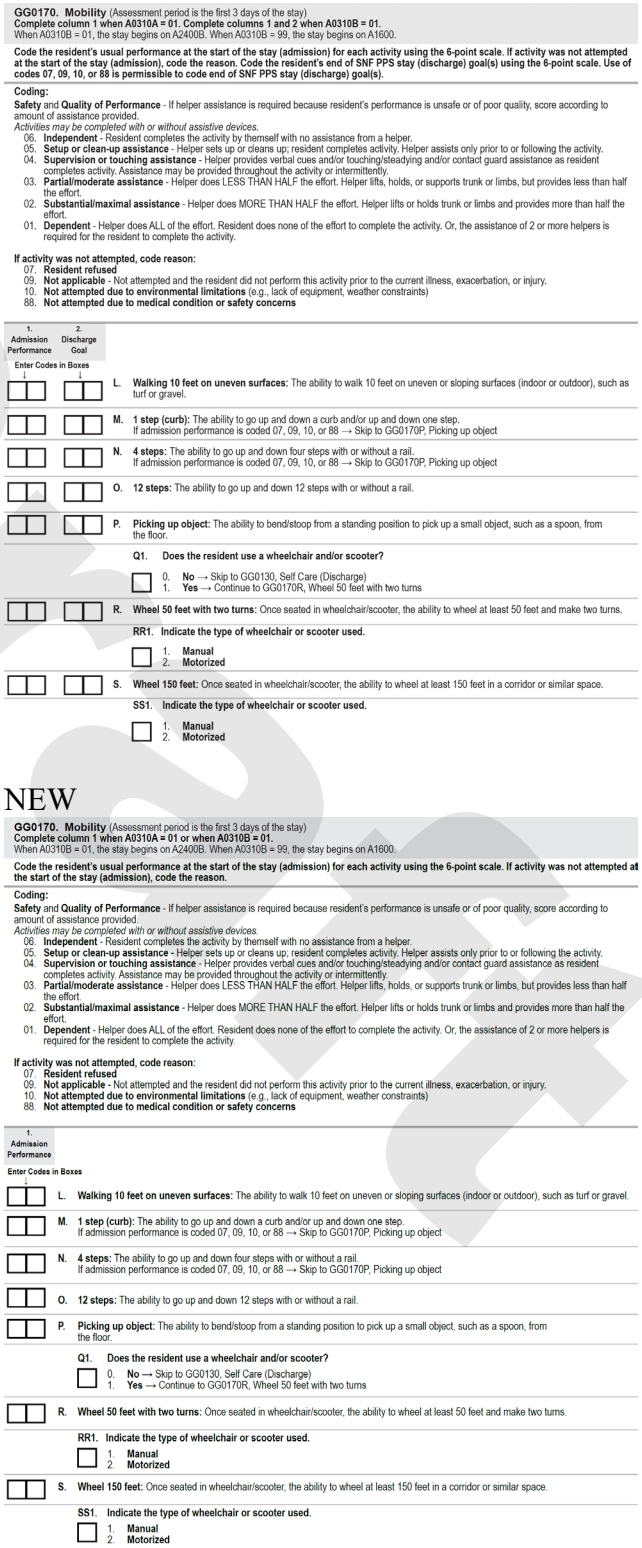
Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
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04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	
Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

3	GG0170	GG-35	Replaced screenshot.

OLD



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

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

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes ↓	↓	
☐☐	☐☐	**L.** **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M.** **1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N.** **4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O.** **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P.** **Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		Q1. Does the resident use a wheelchair and/or scooter? ☐ 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R.** **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**

NEW

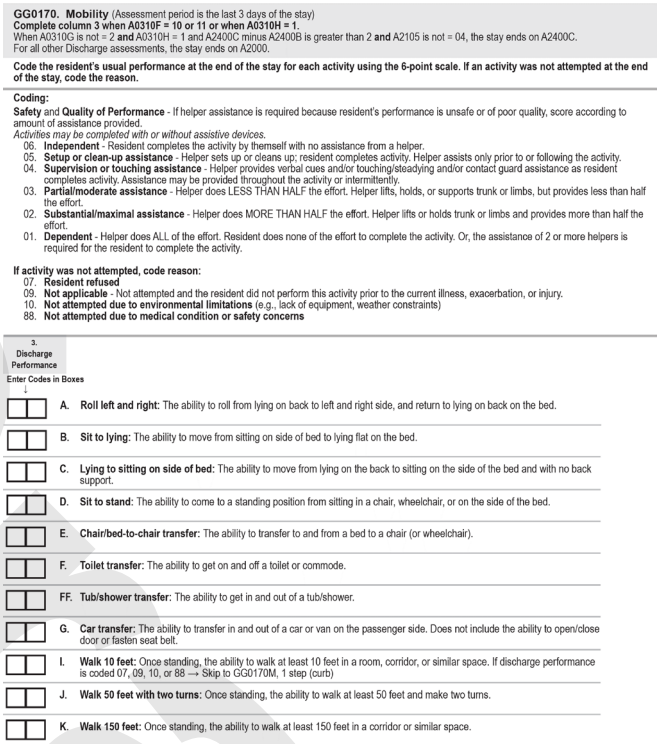
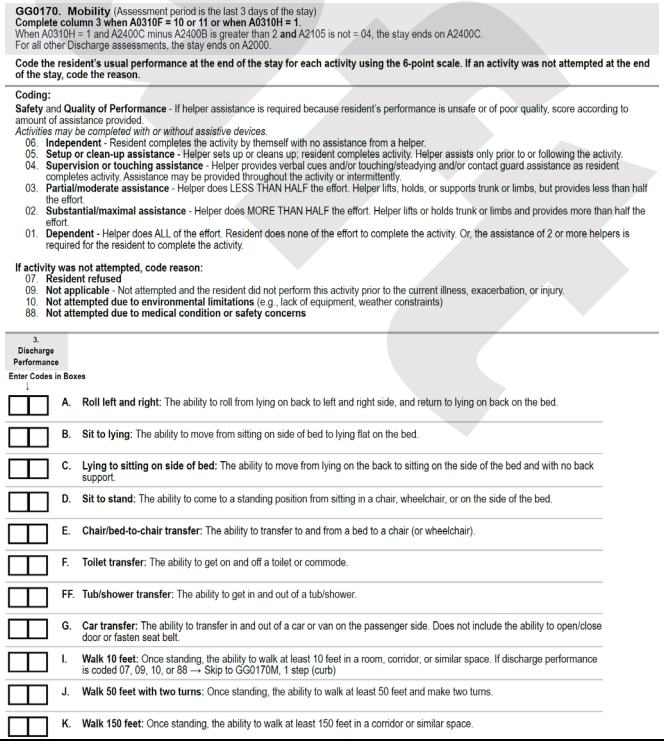
GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
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01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	
Enter Codes in Boxes ↓	
☐☐	**L.** **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M.** **1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N.** **4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O.** **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P.** **Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q1. Does the resident use a wheelchair and/or scooter? ☐ 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R.** **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**
☐☐	**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS1. Indicate the type of wheelchair or scooter used. ☐ 1. **Manual** 2. **Motorized**

3	GG0170	GG-36	Replaced screenshot. OLD  NEW 

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

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
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02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

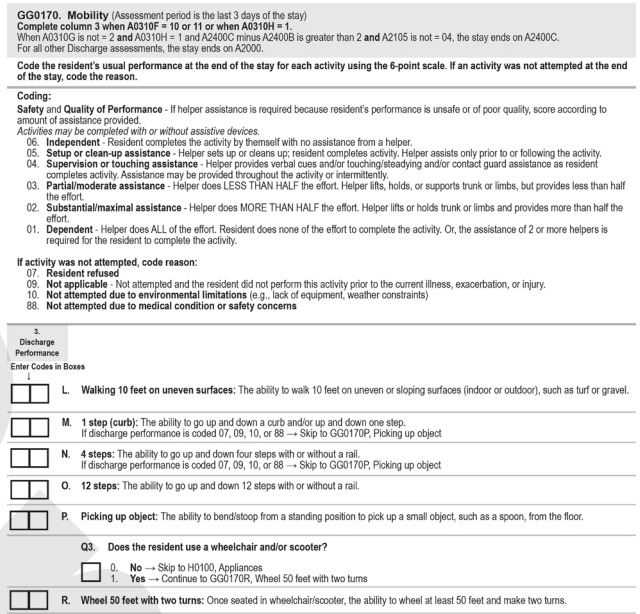
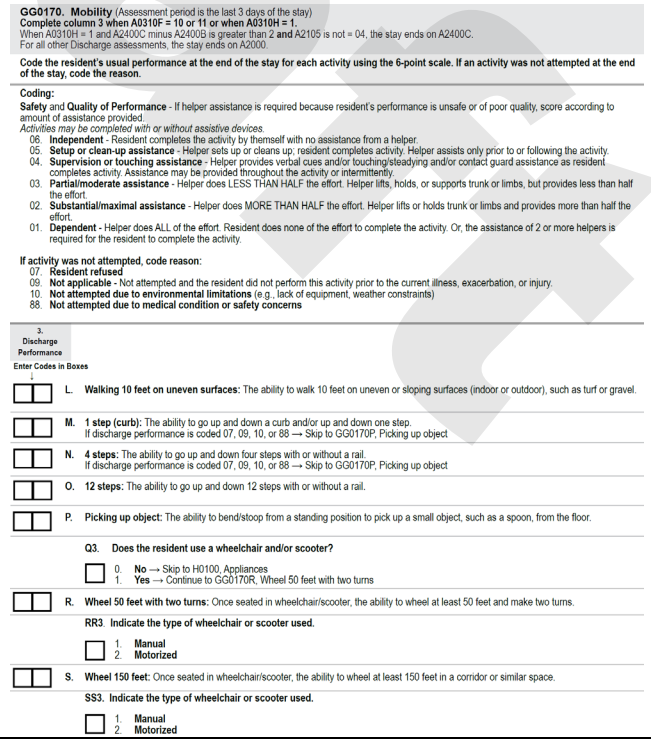
GG0170. Mobility (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

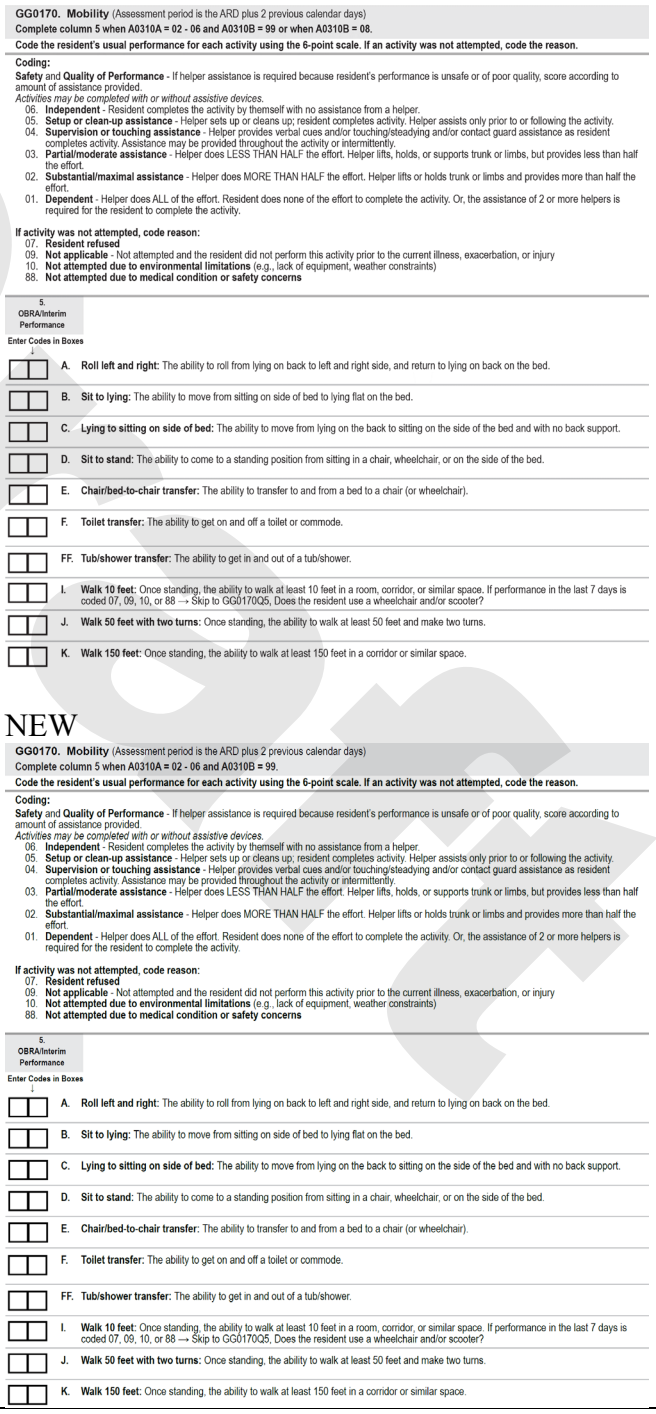
If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

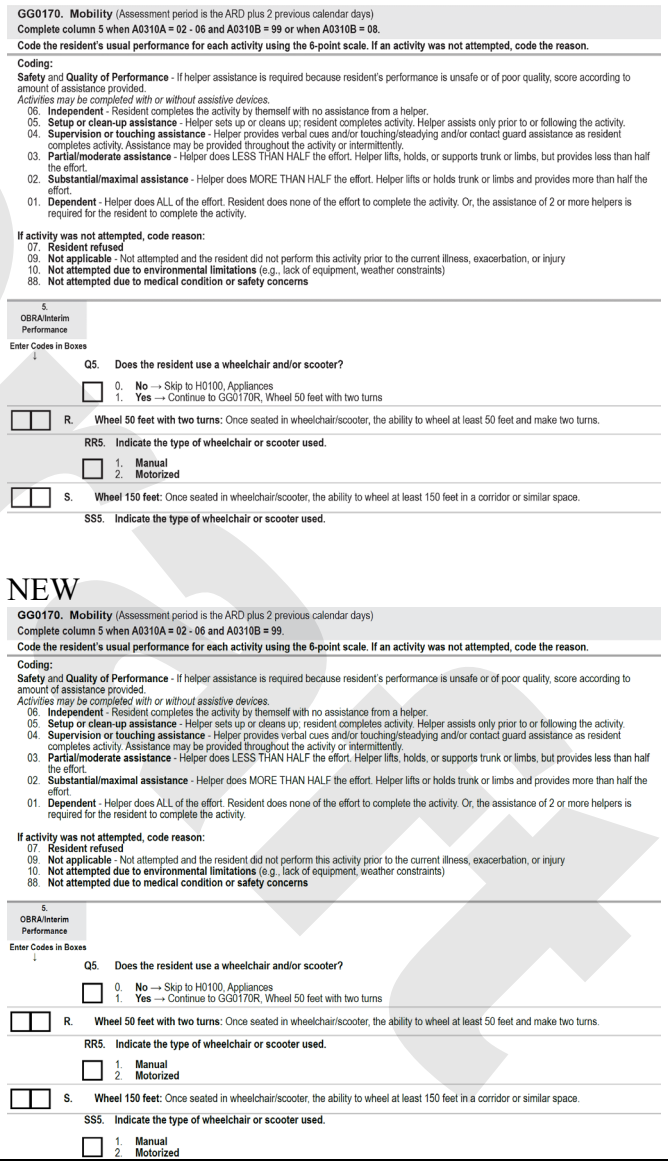
3	GG0170	GG-37	Replaced screenshot. OLD  NEW 

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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-38	Replaced screenshot. OLD  **GG0170. Mobility** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. 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Or, the assistance of 2 or more helpers is required for the resident to complete the activity. **If activity was not attempted, code reason:** 07. **Resident refused** 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns** 5. OBRA/Interim Performance Enter Codes in Boxes A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed. B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support. D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair). F. **Toilet transfer:** The ability to get on and off a toilet or commode. FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower. I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter? J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns. K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space. NEW **GG0170. Mobility** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. 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If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter? J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns. K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-39	Replaced screenshot. OLD  **GG0170. Mobility** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99 or when A0310B = 08.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. 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Or, the assistance of 2 or more helpers is required for the resident to complete the activity. **If activity was not attempted, code reason:** 07. **Resident refused** 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns** 5. OBRA/Interim Performance Enter Codes in Boxes **Q5. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. **RR5. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized** **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **SS5. Indicate the type of wheelchair or scooter used.** NEW **GG0170. Mobility** (Assessment period is the ARD plus 2 previous calendar days) **Complete column 5 when A0310A = 02 - 06 and A0310B = 99.** **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. 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Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. **SS5. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-41	**Coding Instructions** • When coding the resident's usual performance ~~and the resident's discharge goal(s)~~, use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.
3	GG0170	GG-58	2. **Walk 10 feet:** Resident L had bilateral amputations three years ago, and prior to the current admission they used a wheelchair and did not walk. Currently Resident L does not use prosthetic devices and uses only a wheelchair for mobility. Resident L's care plan includes fitting and use of bilateral lower extremity prostheses. **Coding:** GG0170I would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. **Rationale:** When assessing a resident for GG0170I, Walk 10 feet, consider the resident's status prior to the current episode of care and current assessment status. Use code 09, Not applicable, because Resident L did not walk prior to the current episode of care and did not walk during the assessment period. ~~Resident L's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the resident's care plan.~~

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Track Changes
from Chapter 3 Section GG v1.18.11
to Chapter 3 Section GG v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-60	2. **Walk 150 feet:** Resident R has endurance limitations due to heart failure and has only walked about 30 feet during the assessment period. They have not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Resident R. ~~The therapist speculates that Resident R could walk this distance in the future with additional assistance.~~ **Coding:** GG0170K would be coded 88, Not attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item GG0170I. **Rationale:** The activity was not attempted. The resident did not complete the activity, and a helper cannot complete the activity for the resident. A resident who walks less than 50 feet would be coded in item GG0170I, Walk 10 feet.
3	GG0170	GG-61	• If, at the time of the assessment, a resident is unable to complete the activity because of a physician-prescribed restriction ~~(for instance,~~ of no stair climbing ~~for two weeks) but could perform this activity prior to the current illness, exacerbation, or injury, code 88, Not attempted due to medical condition or safety concern~~, they may be able to complete the stair activities safely by some other means (e.g., stair lift, bumping/scooting on their buttocks). If so, code based on the type and amount of assistance required to complete the activity. If, at the time of assessment, a resident is unable to complete the stair activities because of a physician prescribed bedrest, code the stair activity using the appropriate "activity not attempted" code.
3	GG0170	GG-62	• While a resident may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means, without taking more than a brief rest break in order to consider the stair activity completed.

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Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-65	**Example for GG0170Q1, Does the resident use a wheelchair/scooter?** 1. **Does the resident use a wheelchair/scooter?** On admission, Resident T wheels themself using a manual wheelchair, but with difficulty due to their severe osteoarthritis and COPD. **Coding:** GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Resident T uses for GG0170RR1 is indicated as code 1, Manual. ~~If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.~~ **Rationale:** The resident currently uses a wheelchair. Coding the resident's performance and the type of wheelchair (manual) is indicated. ~~Wheeling goal(s) if clinically indicated may be coded.~~

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Chapter	Section	Page(s) in version 1.19.1	Change
3	GG0170	GG-74	~~**Discharge Goals: Coding Tips**~~ ~~*Discharge goals are coded with each Admission assessment when A0310B = 01, indicating the start of a PPS stay. Discharge goals are not required with stand-alone OBRA assessments.*~~ • ~~For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. Identifying multiple goals helps to ensure that the assessment accurately reflects resident status and facilitates person-centered individualized care planning. Use of "activity not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.~~ • ~~Licensed qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.~~ • ~~If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.~~

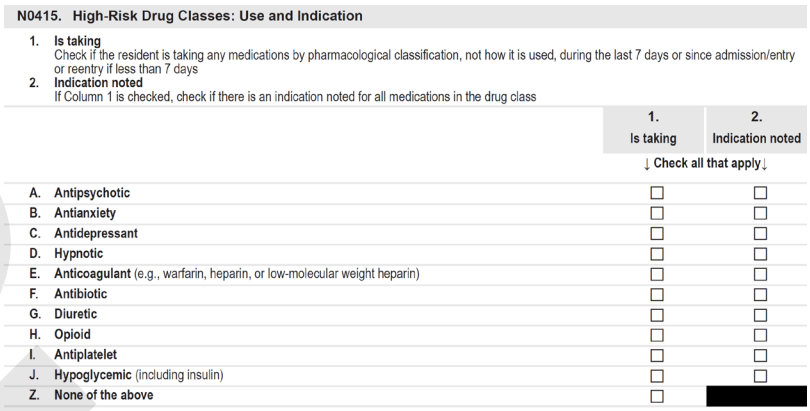
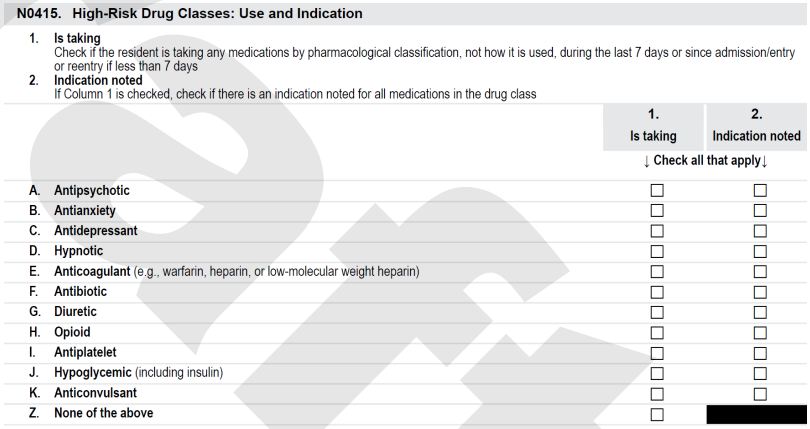
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Track Changes
from Chapter 3 Section K v1.18.11
to Chapter 3 Section K v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	K0520	K-10	
			DEFINITIONS **PARENTERAL/IV FEEDING** Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). **FEEDING TUBE** Presence of any type of tube that can deliver food/ nutritional substances/ fluids~~/ medications~~ directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes.
3	K0520	K-12	• Parenteral/IV feeding—The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and Federal Regulations and/or internal facility policy:** — IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently — IV fluids running at KVO (Keep Vein Open) — IV fluids contained in IV Piggybacks — Hypodermoclysis and subcutaneous ports in hydration therapy — IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and/or hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

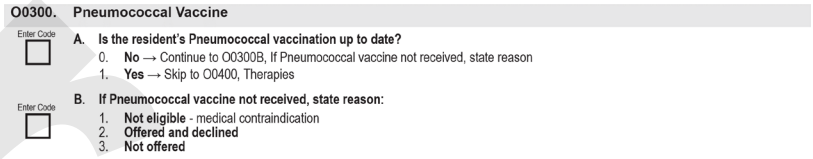
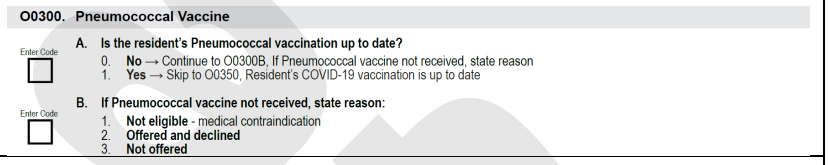
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Track Changes
from Chapter 3 Section N v1.18.11
to Chapter 3 Section N v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	N0415	N-4	Replaced screenshot. OLD  **N0415. High-Risk Drug Classes: Use and Indication** 1. **Is taking** — Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days 2. **Indication noted** — If Column 1 is checked, check if there is an indication noted for all medications in the drug class 1. Is taking / 2. Indication noted — ↓ Check all that apply ↓ A. Antipsychotic B. Antianxiety C. Antidepressant D. Hypnotic E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) F. Antibiotic G. Diuretic H. Opioid I. Antiplatelet J. Hypoglycemic (including insulin) Z. None of the above NEW  **N0415. High-Risk Drug Classes: Use and Indication** 1. **Is taking** — Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days 2. **Indication noted** — If Column 1 is checked, check if there is an indication noted for all medications in the drug class 1. Is taking / 2. Indication noted — ↓ Check all that apply ↓ A. Antipsychotic B. Antianxiety C. Antidepressant D. Hypnotic E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) F. Antibiotic G. Diuretic H. Opioid I. Antiplatelet J. Hypoglycemic (including insulin) K. Anticonvulsant Z. None of the above
3	N0415	N-8	• **N0415K1. Anticonvulsant:** Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). • **N0415K2. Anticonvulsant:** Check if there is an indication noted for all anticonvulsant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days).
3	N0415	N-9	• Do not code flushes to keep an IV access ~~port~~ patent.
3	N0415–N2005	N-8–N-28	Page length changed due to revised content.

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Track Changes
from Chapter 3 Section O v1.18.11R
to Chapter 3 Section O v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	O0110	O-9	• **O0110O1, IV Access** Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measurement of central venous pressure. An arteriovenous (AV) fistula does not meet the definition of IV Access for O0110O1.
3	O0300	O-16	Replaced screenshot. OLD  O0300. Pneumococcal Vaccine Enter Code A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies Enter Code B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered NEW  O0300. Pneumococcal Vaccine Enter Code A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0350, Resident's COVID-19 vaccination is up to date Enter Code B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered
3	O0350	O-19	O0350: Resident's COVID-19 vaccination is up to date  O0350. Resident's COVID-19 vaccination is up to date Enter Code 0. No, resident is not up to date 1. Yes, resident is up to date

Track Changes
from Chapter 3 Section O v1.18.11R
to Chapter 3 Section O v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	O0350	O-19	**Item Rationale** **Health-related Quality of Life** • The intent of this item is to report if a person is up to date with their COVID-19 vaccine status. • Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81 percent of U.S. COVID-19-related deaths. • Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, or ventilator support for breathing, or may even die.

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Track Changes
from Chapter 3 Section O v1.18.11R
to Chapter 3 Section O v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	O0350	O-19	**Planning for Care** • A strong infection prevention and control program is vital to protect both patients and healthcare personnel. • Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and patients from Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection. • COVID-19 vaccines currently approved or authorized by the U.S. Food & Drug Administration are effective in reducing the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death. • Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain an important strategy for preventing illnesses, hospitalizations, and deaths from COVID-19. • A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems from the COVID-19 vaccine are very rare. More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the CDC webpage "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States" at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications.

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Track Changes
from Chapter 3 Section O v1.18.11R
to Chapter 3 Section O v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	O0350	O-20	**Steps for Assessment** • Vaccination status may be determined based on information from any available source. o Review the patient's medical record or documentation of COVID-19 vaccination and/or interview the patient, family or other caregivers or healthcare providers to determine whether the patient is up to date with their COVID-19 vaccine. • If the patient is **not up to date**, and the facility has the vaccine available, ask the patient if they would like to receive the COVID-19 vaccine.
3	O0350	O-20	**DEFINITION** **UP TO DATE for COVID-19 Vaccine** For the definition of "up to date," providers should refer to the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.
3	O0350	O-20	**Coding Instructions** • Code 0, No, patient is not up to date if the patient does not meet the CDC's definition of up to date. o This includes patients who have not received one or more recommended COVID-19 vaccine doses **for any reason** including medical, religious, or other qualified exemptions. o This includes patients for whom vaccination status cannot be determined. • Code 1, Yes, patient is up to date if the patient meets the CDC's definition of up to date. • A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.

Track Changes
from Chapter 3 Section O v1.18.11R
to Chapter 3 Section O v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
3	O0350	O-20	**Coding Tip** • Current COVID-19 vaccine recommendations are available on the Centers for Disease Control and Prevention's (CDC's) webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.
3	O0350–O0500	O-19–O-57	Page length changed due to revised content.

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Track Changes
from Chapter 4 v1.18.11R
to Chapter 4 v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
4	4.4	4-5	Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline. For example, ~~Section GG captures the resident's goals on admission when they are in an SNF PPS stay,~~ Section F identifies the resident's preferences for customary routine and activities~~,~~ and Section Q captures information about the resident's desire to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community. These and other MDS items can help focus the assessment and care plan on what is most important to the resident and areas with the greatest potential for functional improvement.

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Track Changes
from Chapter 5 v1.18.11R
to Chapter 5 v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
5	5.7	5-12	The ~~10/01/2023~~ Cross-Over Rule • ~~A unique~~When item sets are updated, a situation may exist~~s~~ that will prevent providers from correcting the target date of any assessment crossing over from October 1~~, 2023~~ of a given year. That is, providers may not submit a modification to change a target date on an assessment completed prior to October 1~~, 2023~~ of a given year to a target date on or after October 1~~,~~ ~~2023~~ of the same year, nor can they submit a modification to change a target date on an assessment completed on or after October 1~~, 2023~~ of a given year to a target date prior to October 1~~, 2023~~ of a given year when the MDS item sets have had substantial changes. • When ~~T~~the MDS item sets ~~that are effective October 1, 2023~~have had significant changes, including the omission and addition of many items or significant changes to existing items, clinicians will be required to collect and code new items, may have different look-back periods, or may need to code the MDS according to changes in the coding requirements. It is the target date of the assessment that identifies the required version of the item set, and, because of the substantial changes ~~in~~that may exist between versions of the item sets, they are not interchangeable. Therefore, commonly when there are updates to item sets, providers may not change target dates on assessments crossing over October 1~~, 2023~~ of specific years.

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Track Changes
from Chapter 5 v1.18.11R
to Chapter 5 v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
5	5.8	5-13	**5.8 Special Manual Record Correction Request** A few types of errors in a record in iQIES cannot be corrected with an automated Modification or Inactivation request. These errors are: 1. The record is a test record inadvertently submitted as production. 2. The record has the wrong unit certification or licensure designation in Item A0410. 3. The record has the wrong state code or facility ID in the control Items STATE_CD or FAC_ID. 4. The record submitted was not for OBRA or Medicare Part A purposes.

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Track Changes
from Appendix A v1.18.11
to Appendix A v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change	
App. A	—	A-11	**Indication**	The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of a resident's condition and therapeutic goals.
App. A	—	A-25	**Up to Date (for COVID-19 Vaccine)**	For the definition of "up to date," providers should refer to the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html.

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Track Changes
from Appendix C v1.18.11
to Appendix C v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
App. C	—	C-34	✓ **Medications** ☐ • Antibiotics (N0415F) ☐ • Anticholinergics ☐ • Antihypertensives ☐ • Anticonvulsants (N0415K) ☐ • Antipsychotics (N0415A) ☐ • Cardiac medications ☐ • Cimetidine ☐ • Clonidine ☐ • Chemotherapeutic agents ☐ • Digitalis ☐ • Other ☐ • Glaucoma medications ☐ • Guanethidine ☐ • Immuno-suppressive medications ☐ • Methyldopa ☐ • Opioids (N0415H) ☐ • Nitrates ☐ • Propranolol ☐ • Reserpine ☐ • Steroids ☐ • Stimulants
App. C	—	C-63	✓ **Dry mouth** causing buildup of oral bacteria ☐ • Dehydration (see Dehydration/Fluid Maintenance CAA) ☐ • Medications — Antipsychotics (N0415A) — Antidepressants (N0415C) — Antianxiety agents (N0415B) — Sedatives/hypnotics (N0415D) — Diuretics (N0415G) — Antihypertensives — Antiparkinsonian medications — Opioids (N0415H) — Anticonvulsants (N0415K) — Antihistamines — Decongestants — Antiemetics ☐ • Antineoplastics

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Track Changes
from Appendix F v1.18.11
to Appendix F v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
App. F	—	F-1	The MDS Item Matrix is located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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Track Changes
from Appendix H v1.18.11
to Appendix H v1.19.1

Chapter	Section	Page(s) in version 1.19.1	Change
App. H	—	H-1	~~**PRA Disclosure Statement**~~ ~~According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. (Note: The RAI mandated by OBRA is exempt from this requirement.) The valid OMB control number for this information collection is **0938-1140 (Expires 11/30/2024)**. The time required to complete this information collection is estimated to be 51 minutes (for the Nursing Home Prospective Payment System (NP) item set), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. This estimate does not include time for training. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.~~ ~~******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Heidi Magladry at Heidi.magladry@cms.hhs.gov.**~~ The MDS 3.0 Forms are located in the "Downloads" section on CMS's MDS 3.0 RAI Manual Web page: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html