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Michael Stoltz

John Williams, Director—Division of National Systems

Cheryl Wiseman, MPH, MS

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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/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp).

resource usage categories for the purposes of reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals ([www.cms.gov/Manuals/IOM/list.asp](http://www.cms.gov/Manuals/IOM/list.asp)) for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing. (The Medicare Benefit Policy Manual is located at [www.cms.gov/Manuals/IOM/itemdetail.asp](http://www.cms.gov/Manuals/IOM/itemdetail.asp))

- **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) 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 usefulness of the QMs, which may be modified in the future to enhance their effectiveness.
- **Consumer Access to Nursing Home Information.** Consumers are also able to access information about every Medicare- and Medicaid-certified nursing home in the country. The Nursing Home Compare tool (<http://www.medicare.gov/NHCompare>) provides public access to nursing home characteristics, staffing 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
- (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

## **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 Medicare assessments in nursing homes and the mandated Medicare 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 nursing home 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 for Medicare payment (Prospective Payment System [PPS]) purposes under Medicare Part A (described in detail in Section 2.9).

It is important to note that when the OBRA and Medicare 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 Medicare PPS requirements. (Refer to Sections 2.11 and 2.12 for combining OBRA and Medicare assessments).

### **2.2 State 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 the State and approved by CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS 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. As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.

- CMS's approval of a State's 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's approval of a State's 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 authorized by States 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 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-approved State's 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 the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI).

Additional information about State specification of the RAI, variations in format and CMS approval of a State's RAI can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual (SOM). 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. A list of RAI Coordinators can be found in Appendix B.

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 patient'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, a 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 facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level of care in order to be reimbursed under the SNF PPS. In addition, effective October 1, 2010, CMS will begin to collect MDS data for quality monitoring purposes of swing bed facilities. Therefore, swing bed providers must also complete the Entry record, Discharge assessments, and Death in Facility record. Requirements for the Medicare-required PPS assessments, Entry record, Discharge assessments and Death in Facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.

**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 OBRA assessments are a requirement for long-term care facilities; therefore resident assessments are conducted prior to certification as if the beds were already certified.
- Then, 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.
- NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.
- For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. If a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1.
- 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 PPS assessments.
- **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 a bed until the facility has been notified that the bed has been certified.
- **Change In Ownership:** There are two types of change in ownership transactions:
  - The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case:
    - o The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - o **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 14-Day Medicare PPS assessment was combined with the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.
  - There are also situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - o The beds are no longer certified.
    - o There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, provider number, etc.

- o The previous owner would complete a Discharge assessment - return not anticipated, thus code A0310F=10, A2000=date of ownership change, and A2100=02 for those residents who will remain in the facility.
- o 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 A1800=02.
- o 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 Medicare-required PPS 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 Regional Office, State agency, and Medicare contractor 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 Regional Office, State agency, and Medicare contractor for guidance.

## 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. The 15-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 to 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 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.
- 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 long-term care 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 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.

- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a hand written **or** a computer-generated copy be maintained in the clinical record. Either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, long-term care 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 1<sup>st</sup> 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 prior to completion of the OBRA Admission assessment; 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 Medicare 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 Medicare PPS requirements. Sections 2.11 and 2.12 provide more detailed information on combining Medicare and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA

assessment requirements, such as Admission and Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.

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

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

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

**Assessment Reference Date (ARD)** refers to the last day of the observation (or “look back”) period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the appropriate timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.

Most 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 AM on June 25<sup>th</sup> and ending on July 1<sup>st</sup> at 11:59PM 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.

**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 Medicare-required 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 a 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.
- Early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.13).

**Assessment Transmission** refers to the electronic transmission of submission files to the QIES Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). 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 Care Area Assessment (CAA) process and care planning. Comprehensive MDSs include Admission, Annual, Significant Change in Status Assessment (SCSA), and Significant Correction to Prior Comprehensive Assessment (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. A Discharge assessment is not required.

**Discharge** refers to the date a resident leaves 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 two types of discharges – return anticipated and return not anticipated. A Discharge assessment is required with both types of discharges. Section 2.6 provides detailed instructions regarding both discharge types. 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.

**Discharge Assessment** refers to an assessment required on resident discharge. 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 or leave a nursing home. Entry/Discharge reporting includes Entry tracking record, Discharge assessments, and Death in Facility tracking record.

**Interdisciplinary Team (IDT<sup>1</sup>)** is a group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident.

**Item Set** refers to the MDS items that are active on a particular assessment type or tracking form. There are 10 different item subsets for nursing homes and 8 for swing bed providers as follows:

- **Nursing Home**
  - **Comprehensive (NC<sup>2</sup>) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone 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 Quarter Assessment). This item set is used for a stand-alone 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 scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day). This item set is used for a standalone.

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<sup>1</sup> 42 CFR 483.20(k)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative;"

<sup>2</sup> The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

- **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
- **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

Printed layouts for the item sets are available on the CMS website at:

[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage)

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, and A0310F). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2-15 of this chapter provides manual lookup tables for determining the item set, when automated software is unavailable.

**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 patient.

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

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.

**MDS Assessment Codes** are those values that correspond to the OBRA-required and Medicare- required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

**Medicare-Required 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. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA). They include:

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- Readmission/Return
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)

- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA
- Change of Therapy (COT) OMRA

**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 and Significant Correction to Prior Quarterly (SCQA) assessments.

**Observation (Look Back) 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.

**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)

**Reentry** refers to the situation when a resident was previously in this nursing home **and** had an OBRA admission assessment completed **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 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 day” 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 a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA admission.

## 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 (Discharge Assessment). Medicare 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.

## 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).
- If a resident goes to the hospital **prior** to completion of the OBRA admission assessment, when the resident returns, the nursing home must consider the resident as a new admission. 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 a 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 timeframe 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.<sup>3</sup> In closing the record, the nursing home should note why the RAI was not completed.

- 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.<sup>4</sup> 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 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 assessment except an Admission and a SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the MDS system, 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 a 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 the MDS database) 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 Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

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:

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<sup>3</sup> 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.

<sup>4</sup> 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 had been in this facility previously and was discharged prior to completion of the OBRA Admission assessment, 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 am or 11:59 pm, 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 a Discharge assessment **each time** the resident is discharged. The nursing home may combine the Admission assessment with the 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 a SCSA or a 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 Significant Correction to Prior Quarterly assessment (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 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 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, is not “self-limiting” (for declines only);
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 progress notes.
- A SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her 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 a Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from a Significant Change in Status Assessment during the intervening period, the staff must complete a 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).
- A SCSA may **not** be completed prior to an OBRA Admission assessment.
- A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) 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). A 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 his/her 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), the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by a SCSA is not required.
- A 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.

- The ARD must be within 14 days after the determination that the criteria are met for a SCSA (determination date + 14 calendar days) but no later than day 14 after the IDT's determination is made that the criteria for a SCSA are met.
- 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 a SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When a 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 a 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 a SCSA. This timeframe 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 a 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.
- A 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 a 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, a SCSA may be warranted.

- **If there is only one change**, staff may still decide that the resident would benefit from a 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 a SCSA. Nursing homes must document a rationale, in the resident’s medical record, for completing a SCSA that does not meet the criteria for completion.
- A 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).
- A 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 changes;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9<sup>®</sup>), 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);
  - Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
  - 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 II or higher or worsening in pressure ulcer status;
  - Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
  - Overall deterioration of resident’s condition.

### *Examples (SCSA):*

1. Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change, and a 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. Mr. T’s behavioral symptoms could have many causes, and a SCSA

will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

2. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.
  - **Improvement in two or more of the following:**
    - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
    - 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 changes for the better;
    - Resident's incontinence pattern changes for the better;
    - Overall improvement of resident's condition.
3. Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. A SCSA will permit the interdisciplinary team to review her 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 a 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 a significant change assessment).
- 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 a SCSA for Residents with Terminal Conditions:  
Note: this is not an exhaustive list*

The key in determining if a 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 a SCSA, a SCSA assessment 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. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia, diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.
2. Mrs. K came into the nursing home with identifiable problems and has steadily responded to treatment. Her condition has improved over time and has recently hit a plateau. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. 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 Mrs. K is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if she is not discharged, an assessment is required by the end of the allotted 14-day period.
3. Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her 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 a SCSA at this time. However, if her condition was to stabilize and her discharge was not imminent, a 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 a SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability (“mental retardation” in the regulation), or related condition (as defined by 42 CFR 483.102), a referral to the state mental health or ID/DD authority (SMH/MR/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<sup>5</sup>.
- 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 state MH/MR/DD authorities and the state Medicaid agency is available at <http://www.cms.gov/>.
- The nursing facility must provide the SMH/MR/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/MR/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.

*Referral for Level II Resident Review Evaluations are Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual 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.

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<sup>5</sup> 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.

- 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 a SCSA.)

*Examples (PASRR & SCSAs):*

1. Mr. L has a diagnosis of serious mental illness, but his primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and he becomes ambulatory, even if other conditions exist for which Mr. L receives medical care, he should be referred for a PASRR evaluation to determine whether a change in his placement or services is needed.
2. Ms. K has intellectual disability. She is normally cooperative, but after she had a fall and sustained a leg injury, she becomes agitated and combative with the physical therapist and with staff who try to assess her status. She does not understand why her normal routine has changed and why staff are touching a painful area of her body.

*Referral for Level II Resident Review Evaluations are Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual 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.

#### **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
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.*

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).

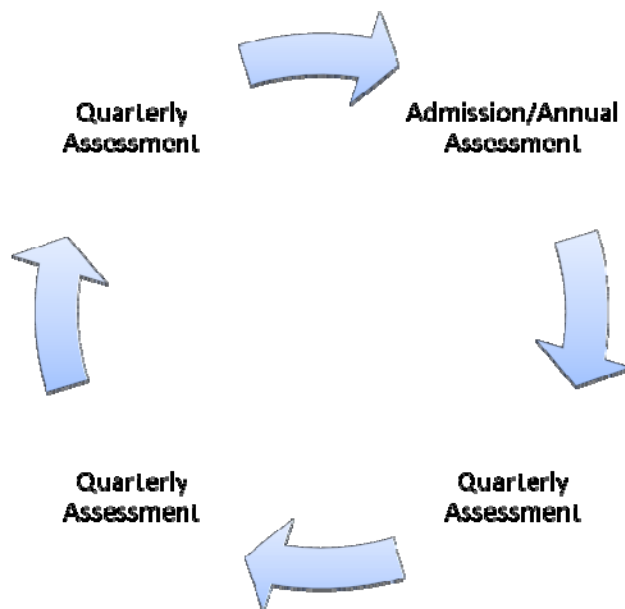
If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA.

For example:

- Resident A has a Quarterly assessment with an ARD of March 20<sup>th</sup>. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23<sup>rd</sup> and returns on March 25<sup>th</sup>. 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 continue with the assessment that was not fully completed before discharge and complete the assessment by April 3<sup>rd</sup> (which is day 14 after the ARD).
- Resident B also has a Quarterly assessment with an ARD of March 20<sup>th</sup>. She goes to the hospital on March 20<sup>th</sup> and returns March 30<sup>th</sup>. While there is no significant change the facility decides to start a new assessment and sets the ARD for April 2<sup>nd</sup> 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.<sup>6</sup> 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.<sup>5</sup> 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 assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.

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<sup>6</sup> 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.



- 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, SCQA, SCPA, 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).

#### 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 progress notes.
- A SCQA is appropriate when:
  - the erroneous Quarterly assessment has been completed (MDS completion date, Item Z0500B) and transmitted/submitted into the MDS system; 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 Quarterly assessment has occurred (determination date + 14 calendar days) and no later than 14 days after determining that the significant error occurred.
- 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 Swing Bed residents and respite residents.

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

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 prior to completion of the OBRA Admission assessment; 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.
- For swing bed facilities, the Entry tracking record will always be coded 1, Admission, since these providers do not complete an OBRA Admission assessment.

#### *Example (Admission):*

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He 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 a nursing home when the resident was previously admitted to this nursing home (i.e., an OBRA Admission was completed), **and** was discharged return anticipated from this nursing home, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

#### *Example (Reentry):*

1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital. On May 18, 2011, Mr. 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

#### *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).
- 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 14<sup>th</sup> 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 stand-alone 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. Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

A0310F = 12  
A2000 = 11-13-2011  
A2100 = 08

### Discharge Assessments (A0310F)

Discharge assessments consist of discharge return anticipated and discharge return not anticipated. These are OBRA required assessments.

### 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 PPS schedule starts with a

Medicare-required 5-day scheduled assessment or combination of the Admission and 5-day PPS assessment.

*Example (Discharge-return not anticipated):*

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

A0310F = 10

A2000 = 03-29-2011

A2100 = 01

## **10. 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 he or she will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and a 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).
- 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 a SCSA (only when the OBRA Admission assessment was completed prior to discharge).
  - If criteria are met, complete a Significant Change in Status assessment.
  - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If a 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 Discharge assessment completed indicating that the resident was expected to return (A0310E=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 Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

## 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 can either date be later than the established timeframes 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. In many cases, interventions 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 preliminary care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14<sup>th</sup> 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.

## 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, PPS assessments, Discharge assessments, or Tracking records.
- 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 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 can either date be later than the established timeframes 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.
- Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and modify the care plan on an ongoing basis, if appropriate.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

## 2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

Skilled nursing facilities (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 Medicare-required assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the Medicare-required assessments, such as completion and submission time frames.

### Assessment Window

Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 5. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS

(including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in Chapter 2 of this manual and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software the coding of Item 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 2.15).

### ***PPS Scheduled Assessment and Start of Therapy OMRA***

- ARD (Item A2300) must be set within the ARD window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
  - A0310A = 99
  - A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  - A0310C = 1
  - A0310D = 0 (Swing Beds only)

***PPS Scheduled Assessment and End of Therapy OMRA***

- ARD (Item A2300) must be set within the window for the Medicare scheduled assessment **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). If both ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:  
A0310A = 99  
A0310B = 01, 02, 03, 04, 05, or 06 as appropriate  
A0310C = 2  
A0310D = 0 (Swing Beds only)

***PPS Scheduled Assessment and Start and End of Therapy OMRA***

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments **MUST** be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:  
A0310A = 99  
A0310B = 01, 02, 03, 04, 05, or 06 as appropriate  
A0310C = 3  
A0310D = 0 (Swing Beds only)

***PPS Scheduled Assessment and Change of Therapy OMRA***

- If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS Assessment, and the ARD of the scheduled PPS assessment has not been set for a day that is prior to Day 7 of the COT observation period, and a COT OMRA is deemed necessary upon completion of the change of therapy evaluation, then the SNF must combine the COT OMRA and the scheduled assessment.
- Must complete the scheduled PPS assessment item set.
- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current

### ***Swing Bed Clinical Change Assessment and End of Therapy OMRA***

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:  
A0310A = 99  
A0310B = 07  
A0310C = 2  
A0310D = 1

### ***Swing Bed Clinical Change Assessment and Start and End of Therapy OMRA***

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:  
A0310A = 99  
A0310B = 07  
A0310C = 3  
A0310D = 1

## **2.11 Combining Medicare Assessments and OBRA Assessments<sup>7</sup>**

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 Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, and Item A0310C, **PPS Other Medicare Required Assessment - OMRA** and are required for resident's whose stay is covered by Medicare Part A.

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<sup>7</sup> OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare 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 14-day Medicare assessment. For the OBRA admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 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/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

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 Medicare 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.

### Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly/ PPS* Item Sets	Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities
Stand-alone Assessment Types	<ul style="list-style-type: none"> <li>OBRA Admission</li> <li>Annual</li> <li>Significant Change in Status (SCSA)</li> <li>Significant Correction to Prior Comprehensive (SCPA)</li> </ul>	<ul style="list-style-type: none"> <li>Quarterly</li> <li>Significant Correction to Prior Quarterly</li> <li>PPS 5-Day (5-Day)</li> <li>PPS 14-Day (14-Day)</li> <li>PPS 30-Day (30-Day)</li> <li>PPS 60-Day (60-Day)</li> <li>PPS 90-Day (90-Day)</li> <li>PPS Readmission/Return</li> </ul>	<ul style="list-style-type: none"> <li>Entry Tracking Record</li> <li>Discharge assessments</li> <li>Death in Facility Tracking Record</li> <li>Start of Therapy OMRA</li> <li>Start of Therapy OMRA and Discharge</li> <li>Change of Therapy OMRA</li> <li>OMRA</li> <li>OMRA and Discharge</li> </ul>

(continued)

completed in combination with another assessment type, an item set that contains all items required for both assessments must be selected.

## 2.12 Medicare and OBRA Assessment Combinations

Below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. The coding of Item 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 2.15).

### ***Medicare-required 5-Day and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Medicare-required 14-Day and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on days 13 or 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 18 (i.e., grace days may not be used).
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Medicare-required Scheduled Assessment and OBRA Quarterly Assessment***

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Quarterly assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Quarterly ARD is met.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

### ***Medicare-required Scheduled Assessment and Annual Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Annual assessment in Section 2.6.

- ARD may be extended to grace days as long as the requirement for the Annual ARD is met.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Medicare-required Scheduled Assessment and Significant Change in Status Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- 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 for requirements for CAA process and care plan completion.

### ***Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- 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 for requirements for CAA process and care plan completion.

### ***Medicare-required Scheduled Assessment and Significant Correction to Prior Quarterly Assessment***

- See Medicare-required Scheduled Assessment and OBRA Quarterly Assessment.

### ***Medicare-required Scheduled Assessment and Discharge Assessment***

- PPS item set.
- ARD (Item A2300) must be set on a day of discharge (Item A2000) **and** the date of discharge falls within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

### ***Start of Therapy OMRA and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).

### ***Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after determination that an uncorrected significant error in a comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in a comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment***

- See SOT OMRA and OBRA Quarterly Assessment

### ***Start of Therapy OMRA and Discharge Assessment***

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set on day of discharge (Item A2000) **and** the date of discharge falls within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) within 14 days after the ARD.

### ***End of Therapy OMRA and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1-3 days after the last day therapy was furnished (difference is 3 or less for Item A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment***

- See EOT OMRA and OBRA Quarterly Assessment.

### ***End of Therapy OMRA and Discharge Assessment***

- OMRA and Discharge item set.
- ARD (Item A2300) must be set on day of discharge (Item A2000) **and** the date of discharge falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

### ***Start and End of Therapy OMRA and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when

- ARD (A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Z0500B) within 14 days after the ARD and within 14 days after the determination that criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Start and End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Start and End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment***

- See Start and End of Therapy OMRA and OBRA Quarterly Assessment.

### ***Start and End of Therapy OMRA and Discharge Assessment***

- OMRA-Start of Therapy and Discharge item set.

- ARD (Item A2300) must be set on the day of discharge (Item A2000) and the date of discharge falls within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing..
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

### ***Change of Therapy OMRA and OBRA Admission Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier after admission **and** be on the last day of a COT 7-day observation period. Must be completed (Item Z0500B) by day 14 after admission (admission date plus 13 calendar days).
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change).
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Change of Therapy OMRA and OBRA Quarterly Assessment***

- Quarterly item set as required by the State.
- ARD (Item A2300) must meet the requirements for an OBRA Quarterly assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder

of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.

- See Section 2.6 for OBRA Quarterly assessment completion requirements.

### ***Change of Therapy OMRA and Annual Assessment***

- Comprehensive item set.
- ARD (Item A2300) must meet the requirements for an OBRA Annual assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

### ***Change of Therapy OMRA and Significant Change in Status Assessment***

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

## 2.13 Factors Impacting the SNF Medicare Assessment Schedule<sup>8</sup>

### *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 Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

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

If the beneficiary is discharged from the SNF or transferred to another payer source before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). When the beneficiary is discharged from the SNF, the provider must also complete a Discharge assessment (see Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a discharge assessment).

### *Short Stay*

If the beneficiary dies, is discharged from the SNF, or discharged from Part A level of care on or before the eighth day of covered SNF stay, the resident may be a candidate for the short stay policy. The short stay policy allows the assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident received rehabilitation therapy and was not able to have received 5 days of therapy due to discharge from Medicare Part A. See Chapter 6, Section 6.4 for greater detail.

### *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 (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted. The type of entry on the Entry Tracking record (as described in Section 2.6) completed by the provider determines whether a Medicare-required 5-day or a Medicare Readmission/Return assessment should be completed.

When the Medicare resident returns to the SNF and the entry type on the Entry Tracking record is a Reentry (Item A1700=2), the first required Medicare assessment is the Medicare Readmission/Return assessment (Item A0310B = 06) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

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<sup>8</sup> These requirements/policies also apply to swing bed providers.

record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C = 0 and A0310F = 99, then no row matches these entries, and the record is invalid and would be rejected.

There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. 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 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, and A0310F. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, and A0310F 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, A0310C, A0310D, and A0310F 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 the QIES ASAP system.

**Swing Bed Item Set Code (ISC) Reference Table**

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	ISC	Description
99	01 thru 06	0,1,2,3,4	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3,4	1	10,11,99	SP	PPS
99	07	1	0	99	SS	SOT OMRA
99	07	1	0	10,11	SSD	SOT OMRA and Discharge
99	07	2,3	0	99	SO	EOT , EOT-R or COT OMRA
99	07	2,3	0	10,11	SOD	EOT , EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	SD	Discharge
99	99	0	0	01,12	ST	Tracking

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

## 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.
- 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/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp).
- If you require further assistance, submit your question to your State RAI Coordinator listed in **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website:  
[http://www.cms.gov/NursingHomeQualityInits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp).

### 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 responses, 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? Does your facility processes require updating to comply with MDS requirements?
- 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 ADLs?
- 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 Regional Office RAI/MDS Contacts** available on CMS' website: [http://www.cms.gov/NursingHomeQuality/Inits/45\\_NHQIMDS30TrainingMaterials.asp](http://www.cms.gov/NursingHomeQuality/Inits/45_NHQIMDS30TrainingMaterials.asp))

#### 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.

- Unlike the MDS 2.0, the standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.
- **With the exception of certain items in Sections K and O, the look-back period generally does not include a hospital stay.**
- 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**, directs the assessor to skip to item G0110, **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes**. The intervening items from B0200-F0800 would not be coded (i.e. left blank). If B0100 was recorded as **code 0, no**, then the assessor would continue to code the MDS at the next item, B0200).
- Use a check mark for boxes with where the instructions state to “check all that apply,” if specified condition is met; otherwise these boxes remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).

## SECTION A: IDENTIFICATION INFORMATION

**Intent:** The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

### A0050: Type of Record

A0050. Type of Record	
Enter Code <input type="checkbox"/>	1. <b>Add new record</b> → Continue to A0100, Facility Provider Numbers 2. <b>Modify existing record</b> → Continue to A0100, Facility Provider Numbers 3. <b>Inactivate existing record</b> → 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 the QIES ASAP system. 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 the QIES ASAP system 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 QIES ASAP system.  
If this item is coded as 2, continue to A0100, Facility Provider Numbers.  
When a modification request is submitted, the QIES ASAP System will take the following steps:
  - The system will attempt to locate the existing record in the QIES ASAP database for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.
  - If the existing record is not found, the submitted modification record will be rejected and not accepted in the QIES ASAP system. A “fatal” error will be reported to the facility on the Final Validation Report.
  - 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 the QIES ASAP system. The “fatal” error(s) will be reported to the facility on the Final Validation Report.
  - If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP database. The prior record will be moved to a history file in the QIES ASAP database.

## 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 the QIES ASAP system.

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

When an inactivation request is submitted, the QIES ASAP system will take the following steps:

1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.
2. If the existing record is not found in the QIES ASAP database, 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 the QIES ASAP system.
4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file.

### Identification of Record to be Modified/Inactivated

The Section X items from X0200 through X0700 identify the existing QIES ASAP database 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 the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record. When the encoder “data entered” the prior assessment for Joan L Smith, he typed “John” by mistake. 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, the QIES ASAP system 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 the QIES ASAP system which causes the desired correction to be made.

## A0100: Facility Provider Numbers

A0100. Facility Provider Numbers																																																							
	<p>A. National Provider Identifier (NPI):</p> <table border="1" style="width: 100%;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p>B. CMS Certification Number (CCN):</p> <table border="1" style="width: 100%;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> <p>C. State Provider Number:</p> <table border="1" style="width: 100%;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																																																						

### Item Rationale

- Allows the identification of the nursing home submitting assessment.

### Coding Instructions

- Nursing homes must have a National Provider Number (NPI) and a CMS Certified Number (CCN).
- Enter the nursing home provider numbers:
  - National Provider Identifier (NPI)
  - CMS Certified Number (CCN)
  - State Provider Number (optional)

### 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	<p>Type of provider</p> <ol style="list-style-type: none"> <li>Nursing home (SNF/NF)</li> <li>Swing Bed</li> </ol>

### 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 hospital with swing bed approval.

### DEFINITION

**SWING BED** A rural 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.

## A0310: Type of Assessment

*For Comprehensive, Quarterly, and PPS Assessments, Entry and Discharge Records.*

A0310. Type of Assessment	
Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 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 <input type="text"/>	<b>B. PPS Assessment</b> <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above
Enter Code <input type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="text"/>	<b>D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2</b> 0. No 1. Yes
Enter Code <input type="text"/>	<b>E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</b> 0. No 1. Yes
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 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 <input type="text"/>	<b>G. Type of discharge - Complete only if A0310F = 10 or 11</b> 1. Planned 2. Unplanned

### Item Rationale

- Allows identification of needed assessment content.

### 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 and A0310C) all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.

## A0310: Type of Assessment (cont.)

### 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. The nursing home is required to complete a SCSA when they come off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
- It is a CMS requirement to have a significant change in status assessment 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.

### 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 01-07, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded as 01-07, enter code “99”.
- See Chapter 2 on assessment schedules for detailed information on the scheduling and timing of the assessments.

#### PPS Scheduled Assessments for a Medicare Part A Stay

01. 5-day scheduled assessment
02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
06. Readmission/return assessment

#### DEFINITION

PROSPECTIVE  
PAYMENT SYSTEM  
(PPS)

Method of reimbursement in which Medicare payment is made based on the classification system of that service (e.g., resource utilization groups, RUGs, for skilled nursing facilities).

## A0310: Type of Assessment (cont.)

### PPS Unscheduled Assessments for Medicare Part A Stay

- 07. Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)
- 99. None of the above

### Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA

- Code 0, no: if this assessment is not an OMRA.
- Code 1, Start of therapy assessment (OPTIONAL): with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a short stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.
- Code 2, End of therapy assessment: with an ARD that is 1 to 3 days after the last day therapy services were provided.
- Code 3, both the Start and End of therapy assessment: with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a short stay assessment, see Chapter 6).
- Code 4, Change of therapy assessment: with an ARD that is Day 7 of the COT observation period.

### Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?

- Code 0, no: if this assessment is not a swing bed clinical change assessment.
- Code 1, yes: if this assessment is a swing bed clinical change assessment.

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

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

### Coding Tips and Special Populations

- A0310E = 0 for any tracking record (entry or death in facility) because tracking records are not considered assessments.

## 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

- Code 1: if type of discharge is a planned discharge.
- Code 2: if type of discharge is an unplanned discharge.

## A0410: Submission Requirement

A0410. Submission Requirement	
Enter Code <input type="checkbox"/>	1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission

### Item Rationale

- There must be a federal and/or state authority to submit MDS assessment data to the MDS National Repository.
- Nursing homes must be certain they are submitting MDS assessments under the appropriate authority. With this item, the nursing home indicates the submission authority.

### Steps for Assessment

- Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, if any, and which units are Medicaid certified, if any.
- Identify all units in the nursing home that are not certified, if any.
  - If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative whether the State has authority to collect MDS information for residents on units that are neither Medicare nor Medicaid certified.

## A0410: Submission Requirement (cont.)

### Coding Instructions

- Code 1, neither federal nor state required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the state does not have authority to collect MDS information for residents on this unit. If the record is submitted, it will be rejected and all information from that record will be purged.
- Code 2, State but not federal required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the state has authority, under state licensure or other requirements, to collect MDS information for these residents.
- Code 3, Federal required submission: if the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.

## A0500: Legal Name of Resident

A0500. Legal Name of Resident	
<b>A. First name:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>B. Middle initial:</b> <input type="text"/>
<b>C. Last name:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>D. Suffix:</b> <input type="text"/> <input type="text"/> <input type="text"/>

### 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, guardian, or legally authorized representative.
2. Check the resident's name on his or her 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.)

#### 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.

## A0600: Social Security and Medicare Numbers

A0600. Social Security and Medicare Numbers	
	<p><b>A. Social Security Number:</b></p> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">-</span> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div>
	<p><b>B. Medicare number (or comparable railroad insurance number):</b></p> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div>

### 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 social security number is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank.
- Enter Medicare number in A0600B exactly as it appears on the resident's documents.
- If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the leftmost space followed by one letter/digit per space. If no Medicare number or RRB number is known or available, the item may be left blank.
- For PPS assessments (A0310B = 01, 02, 03, 04, 05, 06, and 07), either the SSN (A0600A) or Medicare number/RRB number (A0600B) must be present and both may not be blank.
- A0600B can only be a Medicare (HIC) number or a Railroad Retirement Board 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 (OR COMPARABLE RAILROAD INSURANCE NUMBER)

An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may be different from the resident's social security number (SSN), and may contain both letters and numbers. For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.

## A0700: Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient	
	<div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; display: inline-block; width: 30px; height: 20px; margin-right: 5px;"></div>

### Item Rationale

- Assists in correct resident identification.

## A0700: Medicaid Number (cont.)

### Coding Instructions

- Record this number if the resident is a Medicaid recipient.
- Enter one number 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 <input type="checkbox"/>	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 should match what is in the Social Security system.

## A0900: Birth Date

A0900. Birth Date	
<div> <div><input type="text"/></div> <div><input type="text"/></div> <div>–</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>–</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>	

## A0900: Birth Date (cont.)

### 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.

## A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓ Check all that apply	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

### Item Rationale

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Provides demographic race/ethnicity specific health trend information.
- These categories are NOT used to determine eligibility for participation in any Federal program.

## A1000: Race/Ethnicity (cont.)

### Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to his or her race/ethnicity from the list in A1000.
  - Individuals may be more comfortable if this and the preceding question are introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and 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).
2. If the resident is unable to respond, ask a family member or significant other.
3. Category definitions are provided to resident or family only if requested by them in order to answer the item.
4. Respondents should be offered the option of selecting one or more racial designations.
5. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used.

### Coding Instructions

*Check all that apply.*

- Enter the race or ethnic category or categories the resident, family or significant other uses to identify him or her.

#### DEFINITIONS

##### RACE/ETHNICITY

##### AMERICAN INDIAN OR ALASKA 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."

##### HISPANIC OR LATINO

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."

##### 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.

## A1100: Language

A1100. Language																
Enter Code <input type="checkbox"/>	<p><b>A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?</b></p> <p>0. No</p> <p>1. Yes → Specify in A1100B, Preferred language</p> <p>9. Unable to determine</p> <p><b>B. Preferred language:</b></p> <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>															

### 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 result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.

#### Planning for Care

- When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a 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 the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the resident is unable to respond, a family member or significant other should be asked.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, ask for preferred language.
5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

### Coding Instructions for A1100A

- Code 0, no: if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff.
- Code 1, yes: if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.
- Code 9, unable to determine: if no source can identify whether the resident wants or needs an interpreter.

## A1100: Language (cont.)

### Coding Instructions for A1100B

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.

### 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.

## A1200: Marital Status

A1200. Marital Status	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"><li>1. Never married</li><li>2. Married</li><li>3. Widowed</li><li>4. Separated</li><li>5. Divorced</li></ol>

### 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 his or her marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither source 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

## A1300: Optional Resident Items

A1300. Optional Resident Items	
A. Medical record number:	<input type="text"/>
B. Room number:	<input type="text"/>
C. Name by which resident prefers to be addressed:	<input type="text"/>
D. Lifetime occupation(s) - put "/" between two occupations:	<input type="text"/>

### 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."
- 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.

## A1300: Optional Resident Items (cont.)

### 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 a mentally retarded/developmentally delayed adult resident who has never had an occupation, record as "none."

## A1500: Preadmission Screening and Resident Review (PASRR)

<b>A1500. Preadmission Screening and Resident Review (PASRR)</b>	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code <input type="checkbox"/>	<p>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?</p> <p>0. No → Skip to A1550, Conditions Related to ID/DD Status</p> <p>1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</p> <p>9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status</p>

### Item Rationale

#### Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI/ID 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 must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a significant change in status MDS assessment is completed for a resident with MI or ID, the nursing home is required to notify the State mental health authority, intellectual disability or developmental delay 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.<sup>1</sup>

<sup>1</sup> 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.)

- 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.cms.gov/PASRR/01\\_Overview.asp](https://www.cms.gov/PASRR/01_Overview.asp) for CMS information on PASRR.

### 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/ID. 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, significant change in status assessment, 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 O, 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 mental illness and/or intellectual disability or related condition, 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 he or she 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.

## 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 intellectual disability 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	
<input type="checkbox"/>	A. Serious mental illness
<input type="checkbox"/>	B. Intellectual Disability ("mental retardation" in federal regulation)
<input type="checkbox"/>	C. Other related conditions

### Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (admission assessment, annual assessment, significant change in status assessment, 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 ("mental retardation" in federal regulation): if resident has been diagnosed with intellectual disability (or "mental retardation").
- Code C, Other related conditions: if resident has been diagnosed with other related conditions.

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

<b>A1550. Conditions Related to ID/DD Status</b>	
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	
	<b>ID/DD With Organic Condition</b>
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
	<b>ID/DD Without Organic Condition</b>
<input type="checkbox"/>	E. ID/DD with no organic condition
	<b>No ID/DD</b>
<input type="checkbox"/>	Z. None of the above

### Item Rationale

- To document conditions associated with intellectual or developmental delay disabilities.

### Steps for Assessment

- If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (admission assessment).
- If resident is 21 years of age or younger on the assessment reference date, complete if A0310A = 01, 03, 04, or 05 (admission assessment, annual assessment, significant change in status assessment, 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.

## A1550: Conditions Related to Intellectual Disability/Developmental Delay (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, macrocephaly, meningocele, congenital hydrocephalus, etc.

## A1600: Entry Date (date of this admission/entry or reentry into the facility)

A1600. Entry Date (date of this admission/entry or reentry into the facility)									
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>	
Month		Day		Year					

### Item Rationale

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

### Coding Instructions

- Enter the most recent date of admission/entry or reentry to this nursing home. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

### DEFINITION

#### ENTRY DATE

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

## A1700: Type of Entry

A1700. Type of Entry	
Enter Code <input type="checkbox"/>	1. Admission 2. Reentry

### Item Rationale

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

### Coding Instructions

- Code 1, admission/entry: when one of the following occurs:

## A1700: Type of Entry (cont.)

1. resident has never been admitted to this facility before; OR
  2. resident has been in this facility previously and was discharged prior to completion of the OBRA admission assessment; OR
  3. resident has been in this facility previously and was discharged return not anticipated; OR
  4. 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 3 of the following occurred prior to the this entry, the resident was:
    1. admitted to this nursing home (i.e., OBRA admission assessment was completed ), AND
    2. discharged return anticipated, AND
    3. returned to facility within 30 days of discharge.

## Coding Tips and Special Populations

- Swing bed facilities will always code the resident's entry as an admission, '1', since an OBRA Admission assessment must have been completed to code as a reentry. OBRA Admission assessments are not completed for swing bed residents.
- In determining if a 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 is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 day" requirement.

## A1800: Entered From

A1800. Entered From	
Enter Code <input type="text"/>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other

## Item Rationale

- Understanding the setting that the individual was in immediately prior to nursing home admission informs care planning and may also inform discharge planning and discussions.
- Demographic information.

## Steps for Assessment

1. Review transfer and admission records.
2. Ask the resident and/or family or significant others.

## A1800: Entered From (cont.)

### Coding Instructions

*Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission.*

- Code 01, community (private home/apt, board/care, assisted living, group home): if the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
- Code 02, another nursing home or swing bed: if the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- Code 04, psychiatric hospital: if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility (IRF): if the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: 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 who have intellectual or developmental delay disabilities.
- Code 07, hospice: if the resident was admitted from a 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. Includes community-based or inpatient hospice programs.
- Code 09, long term care hospital (LTCH): if the patient was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare

#### 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.

## A1800: Entered From (cont.)

payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

- Code 99, other: 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 07, Hospice, instead of 01, Community.

## A2000: Discharge Date

<b>A2000. Discharge Date</b>			
Complete only if A0310F = 10, 11, or 12			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month	Day	Year	

## Item Rationale

- Closes case in system.

## 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 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

- If a resident was receiving services under SNF Part A PPS, the discharge date may be later than the end of Medicare stay date (A2400C).

## A2100: Discharge Status

<b>A2100. Discharge Status</b>	
Complete only if A0310F = 10, 11, or 12	
Enter Code <input type="text"/>	<ul style="list-style-type: none"> <li>01. Community (private home/apt., board/care, assisted living, group home)</li> <li>02. Another nursing home or swing bed</li> <li>03. Acute hospital</li> <li>04. Psychiatric hospital</li> <li>05. Inpatient rehabilitation facility</li> <li>06. ID/DD facility</li> <li>07. Hospice</li> <li>08. Deceased</li> <li>09. Long Term Care Hospital (LTCH)</li> <li>99. Other</li> </ul>

## A2100: Discharge Status (cont.)

### Item Rationale

- 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 2-digit code that corresponds to the resident's discharge status.*

- Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
- Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- Code 04, psychiatric hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- Code 05, inpatient rehabilitation facility: if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- Code 06, ID/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental delay disabilities.
- Code 07, hospice: if discharge location is a 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. Includes community-based (e.g., home) or inpatient hospice programs.
- Code 08, deceased: if resident is deceased.
- Code 09, long term care hospital (LTCH): if the patient was discharged from a hospital that is certified under Medicare as a short-term, acute-care hospital which has

## A2100: Discharge Status (cont.)

been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

- Code 99, other: if discharge location is none of the above.

## 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 or quarterly assessment (A0310A = 05 or 06) 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 look-back period so that all assessment items refer to the resident's status during the same period of time.

As the last day of the look-back 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 a MDS item with a 7-day look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period. For an item with a 14-day look-back period, the information is collected for a 14-day period ending on and including the ARD. The look-back period includes observations and events through the end of the day (midnight) of the ARD.

## 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 look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back 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 look-back period, the 2 leave days are still considered part of the look-back 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 the physician during the leave, the visit would be counted in Item O0600, **Physician Examination** (if criteria are otherwise met).

This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

### DEFINITIONS

#### ASSESSMENT REFERENCE DATE (ARD)

The specific end-point for look-back 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 look-back period, also called the observation or assessment period, is a 7-day period ending on the ARD. Look-back periods may cover the 7 days ending on this date, 14 days ending on this date, etc.

## A2400: Medicare Stay

A2400. Medicare Stay	
Enter Code <input type="checkbox"/>	<p><b>A. Has the resident had a Medicare-covered stay since the most recent entry?</b></p> <p>0. <b>No</b> → Skip to B0100, Comatose</p> <p>1. <b>Yes</b> → Continue to A2400B, Start date of most recent Medicare stay</p> <p><b>B. Start date of most recent Medicare stay:</b></p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  Month Day Year </p> <p><b>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</b></p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>  Month Day Year </p>

## A2400: Medicare Stay (cont.)

### 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.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.

### 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 covered 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.
- 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 100<sup>th</sup> day of the benefit); or
  - Date of last day covered as recorded on the effective date from the Generic Notice 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).

#### 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

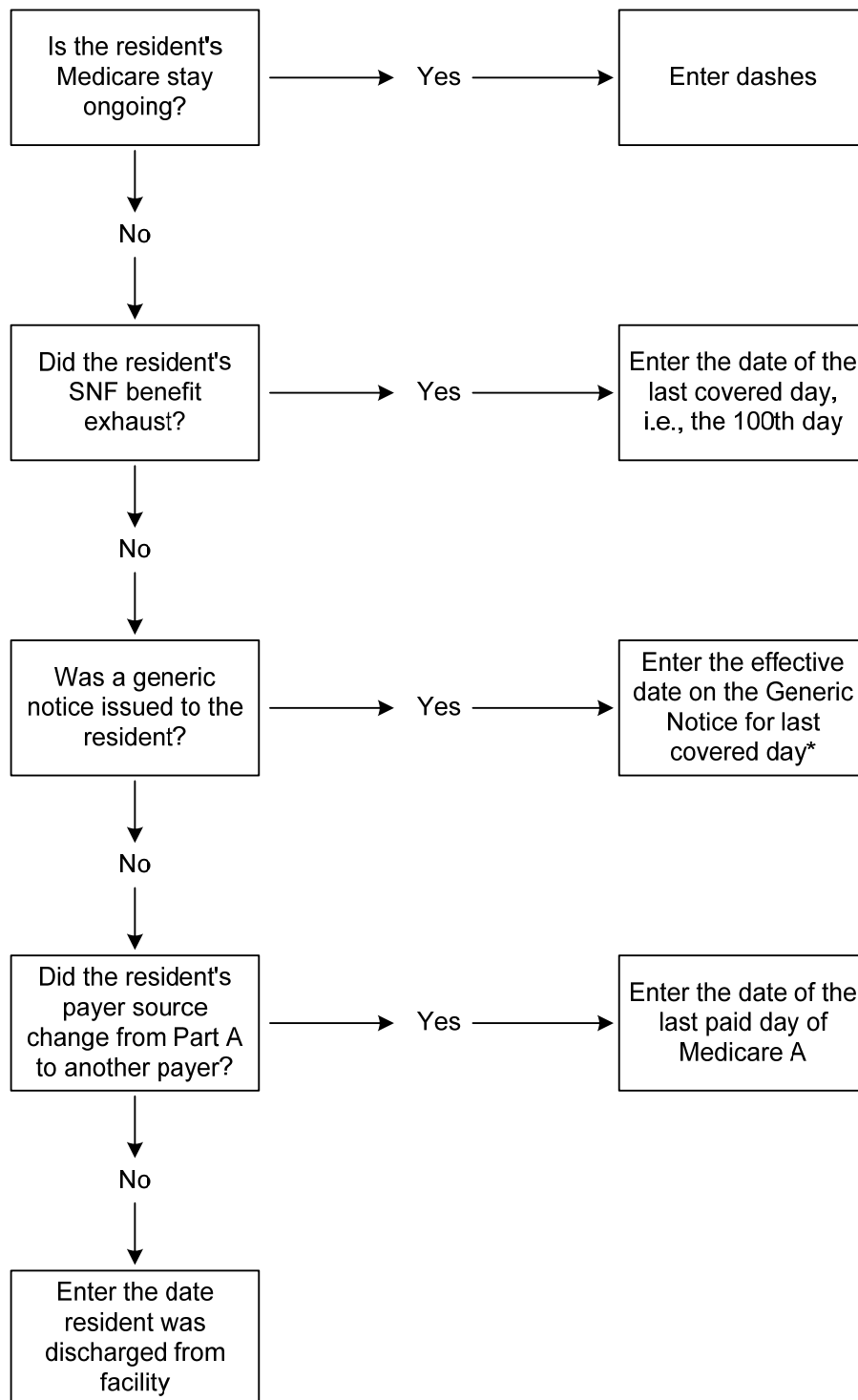
##### NEW ADMISSION:

Day 1 of Medicare Part A stay.

##### READMISSION:

Day 1 of Medicare Part A coverage after readmission following a discharge.

### 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.

## A2400: Medicare Stay (cont.)

### 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.
- The end date of the Medicare stay may be earlier than actual discharge date from the facility (Item A2000).

### Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an ABN with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her discharge assessment:
  - A2000 = 11-24-2010
  - A2400A = 1
  - A2400B = 10-14-2010
  - A2400C = 11-23-2010
2. Mr. N began receiving services under Medicare Part A on December 11, 2010. He was sent to the ER on December 19, 2010 at 8:30pm and was not admitted to the hospital. He returned to the facility on December 20, 2010, at 11:00 am. The facility completed his 14-day PPS assessment with an ARD of December 23, 2010. Code the following on his 14-day PPS assessment:
  - A2400A = 1
  - A2400B = 12-11-2010
  - A2400C = -----
3. Mr. R. began receiving services under Medicare Part A on October 15, 2010. He was discharged return anticipated on October 20, 2010, to the hospital. Code the following on his discharge assessment:
  - A2000 = 10-20-2010
  - A2400A = 1
  - A2400B = 10-15-2010
  - A2400C = 10-20-2010

## 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. 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

- This information identifies if the interview will be attempted.
- Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
- 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 his or her 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 (C1300).

### Steps for Assessment

1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 – C1000, Staff Assessment of Mental Status.
2. Review **Language** item (A1100), to determine if the resident needs or wants an interpreter.
  - If the resident needs or wants an interpreter, complete the interview with an interpreter.

### Coding Instructions

*Record whether the cognitive interview should be attempted with the resident.*

- Code 0, no: if the interview should not be attempted because the resident is rarely/never understood or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
- Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

## 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 himself or herself. 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 his or her 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., "Mr. A. doesn't really mean to hurt anyone. He's 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	
<input type="checkbox"/>	A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)
<input type="checkbox"/>	B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
<input type="checkbox"/>	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.

## 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. 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	
Enter Code <input type="checkbox"/>	<p>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.</p> <p>0. Behavior not exhibited</p> <p>1. Behavior of this type occurred 1 to 3 days</p> <p>2. Behavior of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behavior of this type occurred daily</p>

### 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 his or her 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.

## 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 his pajamas at 3 a.m. When staff members talk to him, he insists he is looking for his wife. This elopement behavior had occurred when he was living at home, and on one occasion he became lost and was missing for 3 days, leading his family to choose nursing home admission for his 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 him crossing a busy street against a red light. When staff try to persuade him to return, he becomes angry and says, "My boss called, and I have to get to the office." When staff remind him that he has been retired for many years, he continues to insist that he 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 himself in his 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 Behavioral or Other Symptoms

<b>E1100. Change in Behavior or Other Symptoms</b>	
Consider all of the symptoms assessed in items E0100 through E1000	
Enter Code <input type="checkbox"/>	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

### 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.

## SECTION G: FUNCTIONAL STATUS

**Intent:** Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

### G0110: Activities of Daily Living (ADL) Assistance

G0110. Activities of Daily Living (ADL) Assistance		
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding		
<b>Instructions for Rule of 3</b> ■ When an activity occurs three times at any one given level, code that level. ■ When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3). ■ When an activity occurs at various levels, but not three times at any given level, apply the following: ◦ When there is a combination of full staff performance, and extensive assistance, code extensive assistance. ◦ When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2). <b>If none of the above are met, code supervision.</b>		
<b>1. ADL Self-Performance</b> Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time <b>Coding:</b> <u>Activity Occurred 3 or More Times</u> 0. <b>Independent</b> - no help or staff oversight at any time 1. <b>Supervision</b> - oversight, encouragement or cueing 2. <b>Limited assistance</b> - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance 3. <b>Extensive assistance</b> - resident involved in activity, staff provide weight-bearing support 4. <b>Total dependence</b> - full staff performance every time during entire 7-day period <u>Activity Occurred 2 or Fewer Times</u> 7. <b>Activity occurred only once or twice</b> - activity did occur but only once or twice 8. <b>Activity did not occur</b> - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period	<b>2. ADL Support Provided</b> Code for most support provided over all shifts; code regardless of resident's self-performance classification <b>Coding:</b> 0. <b>No setup or physical help from staff</b> 1. <b>Setup help only</b> 2. <b>One person physical assist</b> 3. <b>Two+ persons physical assist</b> 8. <b>ADL activity itself did not occur</b> or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period	
	<b>1. Self-Performance</b> ↓ Enter Codes in Boxes ↓	<b>2. Support</b> ↓ Enter Codes in Boxes ↓
A. <b>Bed mobility</b> - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	<input type="text"/>	<input type="text"/>
B. <b>Transfer</b> - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position ( <b>excludes</b> to/from bath/toilet)	<input type="text"/>	<input type="text"/>
C. <b>Walk in room</b> - how resident walks between locations in his/her room	<input type="text"/>	<input type="text"/>
D. <b>Walk in corridor</b> - how resident walks in corridor on unit	<input type="text"/>	<input type="text"/>
E. <b>Locomotion on unit</b> - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	<input type="text"/>	<input type="text"/>
F. <b>Locomotion off unit</b> - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	<input type="text"/>	<input type="text"/>
G. <b>Dressing</b> - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	<input type="text"/>	<input type="text"/>
H. <b>Eating</b> - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	<input type="text"/>	<input type="text"/>
I. <b>Toilet use</b> - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	<input type="text"/>	<input type="text"/>
J. <b>Personal hygiene</b> - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands ( <b>excludes</b> baths and showers)	<input type="text"/>	<input type="text"/>

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.

- A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).
- The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common. Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code.
- Although it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.
- Because this section involves a two-part evaluation (ADL Self-Performance and ADL Support), each using its own scale, it is recommended that the Self-Performance evaluation be completed for all ADL activities before beginning the ADL Support evaluation.
- **Instructions for the Rule of Three:**
  - When an activity occurs three times at any one given level, code that level.
  - When an activity occurs three times at multiple levels, **code the most dependent**.
    - o Example, three times extensive assistance (3) and three times limited assistance (2)—code extensive assistance (3).
  - Exceptions are as follows:
    - o Total dependence (4)—activity must require full assist every time, and
    - o Activity did not occur (8)—activity must not have occurred at all or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period.
  - When an activity occurs at more than one level, but not three times at any one level, apply the following:
    - o Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance—this is total dependence).
    - o When there are three or more episodes of a combination of full staff performance and weight-bearing assistance—code extensive assistance (3)

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

- o When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and non-weight-bearing assistance—code limited assistance (2).
- **If none of the above are met, code supervision.**

### Coding Instructions for G0110, Column 1, ADL-Self Performance

- Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period.
- Code 1, supervision: if oversight, encouragement, or cueing was provided **three** or more times during the last 7 days.
- Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three** or more times during the last 7 days.
- Code 3, extensive assistance: if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:
  - Weight-bearing support provided three or more times.
  - Full staff performance of activity during part but not all of the last 7 days.
- Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- Code 7, activity occurred only once or twice: if the activity occurred but **not** three times or more.
- Code 8, activity did not occur: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

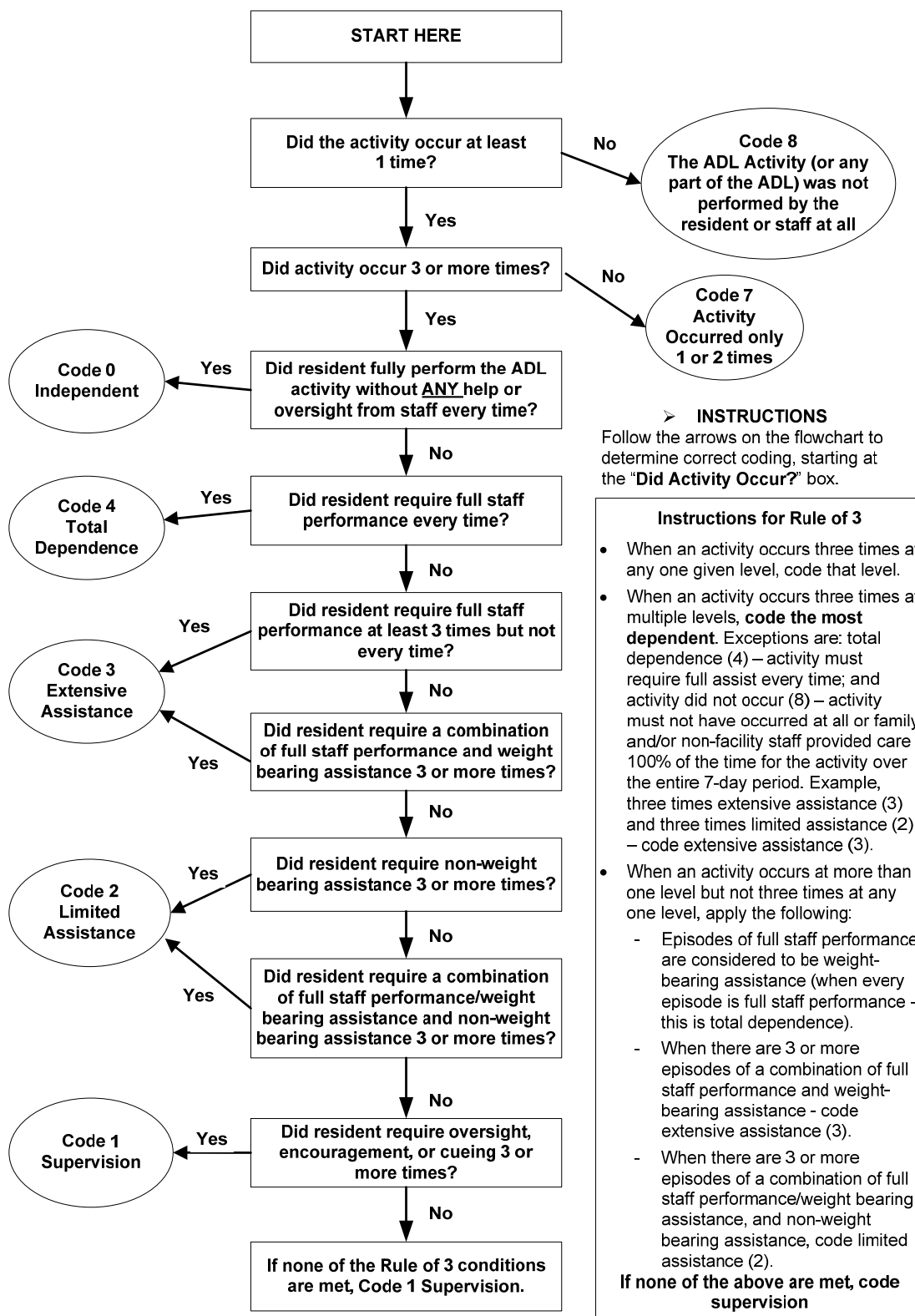
### Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts; code regardless of resident's self-performance classification.*

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

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

## ADL Self Performance Algorithm



## G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Coding activity did not occur, 8:**
  - **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
  - **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period.
  - **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.
- **Coding activity occurred only once or twice, 7:**
  - Walk in corridor would be **coded 7, activity occurred only once or twice**: if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the 7-day look-back period.
  - Locomotion off unit would be **coded 7, activity occurred only once or twice**: if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building.
- **Residents with tube feeding, TPN, or IV fluids**
  - **Code extensive assistance (1 or 2 persons)**: if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
  - **Code totally dependent in eating**: only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

### Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"

NA: "She can lay down and sit up by herself, but I help her turn on her side."

RN: "She lays down and sits up without any verbal instructions or physical help?"

NA: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

RN: "How do you help her turn side to side?"

NA: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

RN: "Do you lift her by yourself or does someone help you?"

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

NA: "I do it by myself."

RN: "How many times during the last 7 days did you give this type of help?"

NA: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of actual assistance Mrs. L. received. Because accurate coding is important as a basis for reporting on the type and amount of care provided, be sure to consider each activity definition fully.

Coding: Bed Mobility ADL assistance would be coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.

### Examples for G0110A, Bed Mobility

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. She requires use of a single side rail that staff place in the up position when she is in bed.

Coding: G0110A1 would be coded 0, independent.

G0110A2 would be coded 1, setup help only.

Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must verbally remind her to reposition off her right side daily during the 7-day look-back period.

Coding: G0110A1 would be coded 1, supervision.

G0110A2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place her hands on the side rail and encourage her to change her position when in bed daily over the 7-day look-back period.

Coding: G0110A1 would be coded 2, limited assistance.

G0110A2 would be coded 2, one person physical assist.

Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

4. Mr. Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition him toward the head of the bed. Mr. Q. was able to assist by bending his knees and pushing with legs when reminded by staff.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110A1 would be coded 3, extensive assistance.

G0110A2 would be coded 3, two+ persons physical assist.

Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She must be physically assisted to a seated position in bed when reading.

Coding: G0110A1 would be coded 4, total dependence.

G0110A2 would be coded 3, two+ persons physical assist.

Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position her in bed.

### Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

Coding: G0110B1 would be coded 0, independent.

G0110B2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is independent each and every time she transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as she transfers from her bed to wheelchair daily. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

Coding: G0110B1 would be coded 1, supervision.

G0110B2 would be coded 1, setup help only.

Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then assist the resident with guided maneuvering as she transfers. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

Coding: G0110B1 would be coded 2, limited assistance.

G0110B2 would be coded 2, one person physical assist.

Rationale: Resident requires staff to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

4. Mrs. B. requires weight-bearing assistance of one staff member to partially lift and support her when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110B1 would be coded 3, extensive assistance.

G0110B2 would be coded 2, one person physical assist.

Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

5. Mr. T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. T. is unable to assist or participate in any way.

Coding: G0110B1 would be coded 4, total dependence.

G0110B2 would be coded 3, two+ persons physical assist.

Rationale: Resident did not participate and required two staff to transfer him out of his bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

6. Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

Coding: G0110B1 would be coded 8, activity did not occur.

G0110B2 would be coded 8, ADL activity itself did not occur during entire period.

Rationale: Activity did not occur.

7. Mr. M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

Coding: G0110B1 would be coded 7, activity occurred only once or twice.

G0110B2 would be coded 3, two+ persons physical assist.

Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

## Examples for G0110C, Walk in Room

1. Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff at all during the entire 7-day look-back period.

Coding: G0110C1 would be coded 0, independent.

G0110C2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is independent.

2. Mr. B. was able to walk in his room daily, but a staff member needed to cue and stand by during ambulation because the resident has had a history of an unsteady gait.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding: G0110C1 would be coded 1, supervision.

G0110C2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires staff supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from staff.

3. Mr. K. is able to walk in his room, and, with hand-held assist from one staff member, the resident was noted to ambulate daily during the 7-day look-back period.

Coding: G0110C1 would be coded 2, limited assistance.

G0110C2 would be coded 2, one person physical assist.

Rationale: Resident requires hand-held (non-weight-bearing) assistance of one staff member daily for ambulation in his room.

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to help support him when he selects clothing from his closet. During the 7-day look-back period the resident was able to ambulate with weight-bearing assistance from one staff member in his room four times.

Coding: G0110C1 would be coded 3, extensive assistance.

G0110C2 would be coded 2, one person physical assist.

Rationale: The resident was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one staff member.

5. Mr. J. is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance to stand pivot to a commode next to his bed.

Coding: G0110C1 would be coded 8, activity did not occur.

G0110C2 would be coded 8, ADL activity itself did not occur during entire period.

Rationale: Activity did not occur.

### Examples for G0110D, Walk in Corridor

1. Mr. X. ambulated daily up and down the hallway on his unit with a cane and did not require any setup or physical help from staff at any time during the 7-day look-back period.

Coding: G0110D1 would be coded 0, independent.

G0110D2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires no setup or help from the staff at any time during the entire 7-day look-back period.

2. Staff members provided verbal cueing while resident was walking in the hallway every day during the 7-day look-back period to ensure that the resident walked slowly and safely.

Coding: G0110D1 would be coded 1, supervision.

G0110D2 would be coded 0, no setup or physical help from staff.

Rationale: Resident requires staff supervision, cueing, and reminders daily while ambulating in the hallway during the 7-day look-back period.

## G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and personal hygiene needs several times each day.

Coding: G0110I1 would be coded 4, total dependence.

G0110I2 would be coded 2, one person physical assist.

Rationale: Resident did not participate and required one staff person to provide total care for toileting and personal hygiene each time during the entire 7-day look-back period.

### Examples for G0110J, Personal Hygiene

- The nurse assistant takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

Coding: G0110J1 would be coded 1, supervision.

G0110J2 would be coded 1, setup help only.

Rationale: Staff placed grooming devices at sink for his use, and during the 7-day look-back period staff provided cueing three times.

- Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.

Coding: G0110J1 would be coded 3, extensive assistance.

G0110J2 would be coded 2, one person physical assist.

Rationale: A staff member had to complete part of the activity for the resident 3 days during the look-back period; the assistance was non-weight-bearing.

## G0120: Bathing

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support	
Enter Code <input type="checkbox"/>	<b>A. Self-performance</b> 0. Independent - no help provided 1. Supervision - oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code <input type="checkbox"/>	<b>B. Support provided</b> (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)

## G0120: Bathing (cont.)

### Item Rationale

#### Health-related Quality of Life

- The resident's choices regarding his or her bathing schedule should be accommodated when possible so that facility routine does not conflict with resident's desired routine.

#### Planning for Care

- The care plan should include interventions to address the resident's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

### DEFINITIONS

#### BATHING

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

### Coding Instructions for G0120A, Self Performance

*Code for the maximum amount of assistance the resident received during the bathing episodes.*

- Code 0, independent: if the resident required no help from staff.
- Code 1, supervision: if the resident required oversight help only.
- Code 2, physical help limited to transfer only: if the resident is able to perform the bathing activity, but required help with the transfer only.
- Code 3, physical help in part of bathing activity: if the resident required assistance with some aspect of bathing.
- Code 4, total dependence: if the resident is unable to participate in any of the bathing activity.
- Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

### Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

### Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance)**, do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADL's in the 7-day look-back period.
- If a nursing home has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the resident self-performance as supervision, even if the supervision is precautionary because the resident is still being individually supervised. Support for bathing in this instance would be coded according to whether or not the staff had to actually assist the resident during the bathing activity.

## G0120: Bathing (cont.)

### Examples

1. Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

Coding: G0120A would be coded 1, supervision.

G0120B would be coded 0, no setup or physical help from staff.

Rationale: Resident needed only supervision to perform the bathing activity with no setup or physical help from staff.

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

Coding: G0120A would be coded 4, total dependence.

G0120B would be coded 2, one person physical assist.

Rationale: Coding directions for bathing state, "code for most dependent in self performance and support." Resident's most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.

3. On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, the resident had physical help of one person to get into tub but washed himself completely.

Coding: G0120A would be coded 3, physical help in part of bathing activity.

G0120B would be coded 2, one person physical assist.

Rationale: Resident's most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one staff person.

## G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking	
After observing the resident, code the following walking and transition items for most dependent	
	↓ Enter Codes in Boxes
Coding: 0. Steady at all times 1. Not steady, but <u>able</u> to stabilize without staff assistance 2. Not steady, <u>only able</u> to stabilize with staff assistance 8. Activity did not occur	<input type="checkbox"/> A. Moving from seated to standing position
	<input type="checkbox"/> B. Walking (with assistive device if used)
	<input type="checkbox"/> C. Turning around and facing the opposite direction while walking
	<input type="checkbox"/> D. Moving on and off toilet
	<input type="checkbox"/> E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

## G0300: Balance During Transitions and Walking (cont.)

### Examples for G0300D, Moving on and off Toilet

1. A resident sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

Coding: G0300D would be coded 0, steady at all times.

Rationale: This resident's use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The resident was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. A resident wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

Rationale: The resident was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. A resident wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, and then is able to steady himself with the grab bar.

Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

Rationale: The resident was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

### Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

*Code for the least steady episode.*

- Code 0, steady at all times:
  - If all of the observed transfers during the 7-day look-back period are steady without assistance of a staff.
  - If the resident is stable when transferring using an assistive device identified for this purpose.
  - If an assistive device or equipment is used, the resident uses it independently and appropriately plans and integrates the use of the device into the transition activity.
  - Residents **coded 0** should not appear to be at risk of a fall during a transition.

## G0300: Balance During Transitions and Walking (cont.)

- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transfers during the look-back period are not steady, but the resident stabilizes without assistance from a staff.
  - If the resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transfers during the 7-day look-back period are not steady, and the resident can only stabilize with assistance from a staff.
  - If the resident fell during a surface-to-surface transfer during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the resident requires staff assistance to stabilize, **code 2**.
- Code 8, activity did not occur:
  - If the resident did not transfer from bed and chair or wheelchair during the 7-day look-back period.

### Examples for G0300E, Surface-to-Surface Transfer (Transfer Between Bed and Chair or Wheelchair)

1. A resident who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.  
Coding: G0300E would be coded 0, steady at all times.  
Rationale: The resident was steady when transferring from bed to wheelchair and did not require staff assistance to make a steady transfer.
2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.  
Coding: G0300E would be coded 2, not steady, only able to stabilize with staff assistance.  
Rationale: The resident was unsteady when transferring from bed to wheelchair and required staff assistance to make a steady transfer.
3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.  
Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

## H0600: Bowel Patterns (cont.)

### 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.

### Coding Instructions

- Code 0, no: if the resident shows no signs of constipation during the 7-day look-back-period.
- Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period.

### Coding Tips and Special Populations

- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

#### DEFINITIONS

##### 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.

## 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.

### 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	
<input type="checkbox"/>	<b>Cancer</b>
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
<input type="checkbox"/>	<b>Heart/Circulation</b>
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	<b>Gastrointestinal</b>
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
<input type="checkbox"/>	<b>Genitourinary</b>
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
<input type="checkbox"/>	<b>Infections</b>
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
<input type="checkbox"/>	<b>Metabolic</b>
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	<b>Musculoskeletal</b>
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	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)
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	<b>Neurological</b>
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	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	

## 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											
<b>Neurological - Continued</b>											
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis										
<input type="checkbox"/>	I5000. Paraplegia										
<input type="checkbox"/>	I5100. Quadriplegia										
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)										
<input type="checkbox"/>	I5250. Huntington's Disease										
<input type="checkbox"/>	I5300. Parkinson's Disease										
<input type="checkbox"/>	I5350. Tourette's Syndrome										
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy										
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)										
<b>Nutritional</b>											
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition										
<b>Psychiatric/Mood Disorder</b>											
<input type="checkbox"/>	I5700. Anxiety Disorder										
<input type="checkbox"/>	I5800. Depression (other than bipolar)										
<input type="checkbox"/>	I5900. Manic Depression (bipolar disease)										
<input type="checkbox"/>	I5950. Psychotic Disorder (other than schizophrenia)										
<input type="checkbox"/>	I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)										
<input type="checkbox"/>	I6100. Post Traumatic Stress Disorder (PTSD)										
<b>Pulmonary</b>											
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)										
<input type="checkbox"/>	I6300. Respiratory Failure										
<b>Vision</b>											
<input type="checkbox"/>	I6500. Cataracts, Glaucoma, or Macular Degeneration										
<b>None of Above</b>											
<input type="checkbox"/>	I7900. None of the above active diagnoses within the last 7 days										
<b>Other</b>											
I8000. Additional active diagnoses											
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.											
A. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
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G. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
H. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
I. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										
J. _____	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>										

## I: Active Diagnoses in the Last 7 Days (cont)

### Item Rationale

#### Health-Related Quality of Life

- Disease processes can have a significant adverse affect 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. Do not include conditions that have been resolved or have no **longer** affected the resident's current functioning or plan of care, or that the resident has adjusted to as their "new normal," during the last 7 days. Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300 UTI.

### 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.).

## I: Active Diagnoses in the Last 7 Days (cont)

- **Active** diagnoses have a **direct** relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.
- 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-8 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, check the "Other" box (I8000) and write in the ICD code and name for that diagnosis.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to insure 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 and on the left.)
- If a diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000.

### Cancer

- I0100, cancer (with or without metastasis)

### Heart/Circulation

- I0200, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- I0300, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- I0400, coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])

## I: Active Diagnoses in the Last 7 Days (cont.)

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

## 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 he or she takes 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 <input type="checkbox"/>	A. Did the resident have a fall any time in the <b>last month</b> prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the <b>last 2-6 months</b> prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine
Enter Code <input type="checkbox"/>	C. Did the resident have any <b>fracture related to a fall in the 6 months</b> 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.

## J1700: Fall History on Admission (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.

### DEFINITIONS

#### 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 he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

## J1700: Fall History on Admission (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.

#### DEFINITIONS

##### 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, Mrs. J. is asked about falls and says she has "not really fallen." However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she 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 (cont.)

2. On admission interview a resident denies a history of falling. However, her daughter says that she found her mother on the floor near her 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, Mr. M. and his family deny any history of falling. However, nursing notes in the transferring hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his 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 Mr. M. was found on a mat on the floor. This is defined as a fall.
4. Medical records note that Miss K. had hip surgery 5 months prior to admission to the nursing home. Miss K.'s daughter 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: Miss K. had a fall related fracture 1-6 months prior to nursing home entry.
5. Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.  
Coding: J1700C would be coded 0, no.  
Rationale: The fractures were not related to a fall.
6. Ms. P. has a history of a "Colles' fracture" of her left wrist about 3 weeks before nursing home admission. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.  
Coding: Both J1700A and J1700C would be coded 1, yes.  
Rationale: Ms. P. had a fall-related fracture less than 1 month prior to entry.

## 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?
<input type="checkbox"/>	0. No → Skip to K0100, Swallowing Disorder
	1. Yes → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

### 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.

#### DEFINITIONS

##### PRIOR ASSESSMENT

Most recent MDS assessment that reported on falls.

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

### 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 (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.
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.

### Coding Instructions

- Code 0, no: if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100).
- 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.

### Examples

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

Coding: J1800 would be coded 1, yes.

Rationale: An intercepted fall is considered a fall.

## 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	
	↓ Enter Codes in Boxes
<b>Coding:</b> 0. None 1. One 2. Two or more	<input type="checkbox"/> <b>A. No injury</b> - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/> <b>B. Injury (except major)</b> - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/> <b>C. Major injury</b> - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

### 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.

### Steps for Assessment

- If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
- 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.

#### DEFINITIONS

##### 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.

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

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.

### 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).
- 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).

## 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 major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

### Examples

1. A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, an assessment was completed that indicated 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 Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she fell in the bathroom. No injury was noted when she 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 his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. He was 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).

4. A resident fell, lacerated his 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.

## 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	
<input type="checkbox"/>	A. Loss of liquids/solids from mouth when eating or drinking
<input type="checkbox"/>	B. Holding food in mouth/cheeks or residual food in mouth after meals
<input type="checkbox"/>	C. Coughing or choking during meals or when swallowing medications
<input type="checkbox"/>	D. Complaints of difficulty or pain with swallowing
<input type="checkbox"/>	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 he or she has 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 he or she is eating, drinking, or swallowing to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
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.



## 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.

## 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 his or her 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 his or her 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.

### 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**.

#### 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. When a physician has ordered diuretics and weight loss is expected to occur it is included under this definition. 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](http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html)

## 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. Mrs. J has been on a physician ordered calorie-restricted diet for the past year. She and her physician agreed to a plan of weight reduction. Her current weight is 169 lbs. Her weight 30 days ago was 172 lbs. Her weight 180 days ago was 192 lbs.

Coding: K0300 would be coded 1, yes, on physician-prescribed weight-loss regimen.

Rationale:

- 30-day calculation:  $172 \times 0.95 = 163.4$ . Since the resident's current weight of 169 lbs is more than 163.4 lbs, which is the 5% point, she **has not** lost 5% body weight in the last 30 days.
- 180-day calculation:  $192 \times .90 = 172.8$ . Since the resident's current weight of 169 lbs **is** less than 172.8 lbs, which is the 10% point, she **has** lost 10% or more of body weight in the last 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 <input type="checkbox"/>	<b>Gain of 5% or more in the last month or gain of 10% or more in last 6 months</b> 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., steroids), or changed fluid volume status.
- Weight gain 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 his or her 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.

## 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 his or her 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 his or her 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.

## 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.

## K0510: Nutritional Approaches

K0510. Nutritional Approaches		
Check all of the following nutritional approaches that were performed during the last 7 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank	1. While NOT a Resident	2. While a Resident
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

### 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.

#### Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

### 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.

## K0510: Nutritional Approaches (cont.)

### Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

### Coding Instructions for Column 1

Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.

### Coding Instructions for Column 2

Check all nutritional approaches performed **after** admission/entry or reentry to the facility and within the 7-day look-back period.

*Check all that apply. If none apply, check K0510Z, None of the above*

- K0510A, parenteral/IV feeding
- K0510B, feeding tube – nasogastric or abdominal (PEG)
- K0510C, mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- K0510D, therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- K0510Z, none of the above

### Coding Tips for K0510A

*K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days 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/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

#### 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 ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).

## K0510: Nutritional Approaches (cont.)

- IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and 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 K0510A:**
  - IV Medications—**Code these when appropriate in O0100H, 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.
- Guidelines on basic fluid and electrolyte replacement can be found online at <http://guidelines.gov/content.aspx?id=15590&search=fluid+and+electrolyte+replacement+amda>.
- Enteral feeding formulas:
  - Should not be coded as a mechanically altered diet.
  - Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

## Coding Tips for K0510D

- 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 K0510D, 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).

## Examples

1. Mrs. H is receiving an antibiotic in 100 cc of normal saline via IV. She has a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. She is placed on the nursing home's hydration plan to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

## K0510: Nutritional Approaches (cont.)

Coding: K0510A would be checked. The IV medication would be coded at **IV Medications** item (O0100H).

Rationale: The resident received 100 cc of IV fluid **and** there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

- Mr. J is receiving an antibiotic in 100 cc of normal saline via IV. He has a UTI, no fever, and documented adequate fluid intake. He is placed on the nursing home's hydration plan to ensure adequate hydration.

Coding: K0510A would NOT be checked. The IV medication would be coded at **IV Medications** item (O0100H).

Rationale: Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

## K0700: Percent Intake by Artificial Route

*Complete K0700 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B.*

K0700. Percent Intake by Artificial Route - Complete K0700 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B	
Enter Code <input type="checkbox"/>	<b>A. Proportion of total calories the resident received through parenteral or tube feeding</b> 1. 25% or less 2. 26-50% 3. 51% or more
Enter Code <input type="checkbox"/>	<b>B. Average fluid intake per day by IV or tube feeding</b> 1. 500 cc/day or less 2. 501 cc/day or more

### 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.

### K0700A, Proportion of Total Calories the Resident Received through Parental or Tube Feedings in the Last 7 Days

#### Steps for Assessment

- Review intake records to determine actual intake through parenteral or tube feeding routes.
- 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 this, consult with the dietician.

## K0700: Percent Intake by Artificial Route (cont.)

### Coding Instructions

- Select the best response:
  1. 25% or less
  2. 26% to 50%
  3. 51% or more

### Example

#### 1. Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. The dietitian has totaled his 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: K0700A 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:

$$15,000/17,450 = .859 \times 100 = 85.9\%$$

Mr. H received 85.9% of his calories by tube feeding, therefore K0700A code **3, 51% or more** is correct.

### K0700B, Average Fluid Intake per Day by IV or Tube Feeding in the Last 7 Days.

#### 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.

## K0700: Percent Intake by Artificial Route (cont.)

### Coding Instructions

*Code for the average number of cc's of fluid the resident received per day by 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

### Examples

#### 1. Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during 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: K0700B 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.

#### 2. Calculation for Average Daily Fluid Intake

Mrs. G. received 1 liter of IV fluids during the 7-day assessment period. She received no other intake via IV or tube feeding during the assessment period.

IV Fluid Intake	
Sun.	0 cc
Mon.	0 cc
Tues.	1,000 cc
Wed.	0 cc
Thurs.	0 cc
Fri.	0 cc
Sat.	0 cc
Total	1,000 cc

## K0700: Percent Intake by Artificial Route (cont.)

Coding: K0500b would be coded **1, 500 cc/day or less**.

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc  
1000 cc divided by 7 days = 142.9 cc/day  
142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.

## M0300A: Number of Stage 1 Pressure Ulcers (cont.)

### Coding Tips

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

## M0300B: Stage 2 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p><b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. <b>Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3</p> <p>2. <b>Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</p> <p>3. <b>Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown:</p> <table border="1"> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td>-</td> <td><input type="text"/></td> <td><input type="text"/></td> <td>-</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td colspan="2">Month</td> <td></td> <td colspan="2">Day</td> <td></td> <td colspan="4">Year</td> </tr> </table>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month			Day			Year			
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### 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).
- 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.

#### DEFINITIONS

##### STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough**.

May also present as an intact or open/ruptured blister.

### 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.

## M0300B: Stage 2 Pressure Ulcers (cont.)

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 suspected deep tissue injury 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-6).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

### Coding Instructions for M0300B

- 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 **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C).
- Enter the number of 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.
- Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. 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, 2011, should be entered as 01-02-2011.

### Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.
- Do NOT code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here.
- When a lesion that is related to pressure presents with 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.

## M0300C: Stage 3 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>C. <b>Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</p> <p>1. <b>Number of Stage 3 pressure ulcers</b> - If 0 → Skip to M0300D, Stage 4</p> <p>2. <b>Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</p>
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### 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.

#### DEFINITIONS

##### 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.

### Steps for Assessment

- Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
- 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.
- Identify all Stage 3 pressure ulcers currently present.
- Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

### Coding Instructions for M0300C

- 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 **Current Number of Unhealed Pressures Ulcers at Each Stage** item (M0300D).

## M0300C: Stage 3 Pressure Ulcers (cont.)

- Enter the number of 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.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

### 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, thus it is now a Stage 3 pressure ulcer.

Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 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 worsened to a deeper anatomical stage. This pressure ulcer worsened after admission.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry.

Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because it worsened to a Stage 3 during hospitalization it should be coded as a Stage 3, present on admission/entry or reentry.

## M0300C: Stage 3 Pressure Ulcers (cont.)

3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has worsened to a Stage 3 pressure ulcer.

Coding: 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: 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; the one that increased to a Stage 3 has increased in stage since admission and hence cannot be coded in M0300C2 as present on admission/entry or reentry.

4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns 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: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.

Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.

## M0300D: Stage 4 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p><b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</p> <p>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</p>
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### 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.

## 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.

### DEFINITIONS

**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.

### 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.

### Coding Instructions for M0300D

- 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 **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E).
- Enter the number of 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.

**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.

## 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.

## M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device

Enter Number <input type="text"/> Enter Number <input type="text"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device  <b>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable:</b> Slough and/or eschar  <b>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</b>
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### 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 and may be painful.

#### Planning for Care

- Although the pressure ulcer 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.

#### DEFINITIONS

**NON-REMOVABLE DRESSING/ DEVICE**  
Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

### Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing.
2. Determine the number of pressure ulcers unstageable related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

## M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

### Coding Instructions for M0300E

- Enter the number of pressure ulcers that are unstageable related to non-removable dressing/device.
- Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300F).
- Enter the number of unstageable pressure ulcers 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 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 related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

### 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.

## M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

Enter Number <input type="text"/> Enter Number <input type="text"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar  <b>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</b>  <b>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</b>
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### 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.

## M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

- 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 the necrotic tissue is removed.

### DEFINITIONS

#### FLUCTUANCE

Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

### Steps for Assessment

- Determine the number of pressure ulcers that are unstageable due to slough/eschar.
- Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

### Coding Instructions for M0300F

- 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 **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300G).
- Enter the number of 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

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true depth (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the depth of the tissue layers 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 tissues 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.

## 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 it is covered with eschar so it is unstageable. It 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 it can be observed to be a Stage 4 pressure ulcer and should be coded at M0300D. This pressure ulcer's dimensions would also be entered at M0610 if this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident.

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 at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry.

Rationale: The pressure ulcer is coded as unstageable due to coverage of the wound bed by slough but not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

## M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

Enter Number <input type="text"/> Enter Number <input type="text"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution  <b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</b>  <b>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</b>
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## M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

### 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. Deep tissue injuries may sometimes indicate severe damage. Identification and management of Suspected Deep Tissue Injury (sDTI) is imperative.

#### Planning for Care

- Suspected deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

#### DEFINITIONS

##### SUSPECTED 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.

### 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, boggiess or firmness, warmth or coolness), do NOT code as a suspected 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 ulcers that are unstageable related to suspected Deep Tissue Injury.
6. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for instructions).
7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

## M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

### Coding Instructions for M0300G

- Enter the number of unstageable pressure ulcer related to suspected 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 suspected deep tissue injury.
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).
- Enter the number of unstageable pressure ulcers related to suspected 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 ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or reentry.

### Coding Tips

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- 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.

## M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar

<b>M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</b>	
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<input type="text"/> <input type="text"/> . <input type="text"/> cm	<b>A. Pressure ulcer length:</b> Longest length from head to toe
<input type="text"/> <input type="text"/> . <input type="text"/> cm	<b>B. Pressure ulcer width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> <input type="text"/> . <input type="text"/> cm	<b>C. Pressure ulcer depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

## M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar (cont.)

7. Considering **only** the largest Stage 3 or 4 pressure ulcer due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Classify the stage and measure each pressure ulcer separately.

### Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough or Eschar

- Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough or eschar. Record the width in centimeters to one decimal point.
- Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough or eschar. If a pressure ulcer covered with slough or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

### Coding Tips

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- 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.

## M0700: Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="checkbox"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance 3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. <b>None of the Above</b>

## M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

### Item Rationale

#### Health-related Quality of Life

- The presence of a 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.
- Identify tissue type.

#### Planning for Care

- 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.

### Steps for Assessment

1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).

### Coding Instructions for M0700

- Code 1, epithelial tissue: if the wound is superficial and is re-epithelializing.
- Code 2, granulation tissue: if the wound is clean (e.g., free of slough and necrotic tissue) and contains granulation tissue.
- Code 3, slough: if there is any amount of slough present and necrotic tissue is absent.
- Code 4, necrotic tissue (eschar): if there is any necrotic tissue (eschar) present.
- Code 9, None of the above: if none of the above apply.

### Coding Tips and Special Populations

- Stage 2 pressure ulcers should **not** be coded as having granulation, slough, or necrotic tissue as by definition they do not have this extent of tissue damage. All Stage 2 pressure ulcers should be **coded as 1** for this item.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar) and slough is present, code for necrotic tissue (eschar).

### DEFINITIONS

#### EPITHELIAL TISSUE

New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and 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.

#### 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.

#### NECROTIC TISSUE (ESCHAR)

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.

## M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

- Code this item with **Code 9, None of the above**, in the following situations
  - Stage 1 pressure ulcer
  - Stage 2 pressure ulcer with intact blister
  - Unstageable pressure ulcer related to non-removable dressing /device
  - Unstageable pressure ulcer related to suspected deep tissue injury

Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.

### Examples

- A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

Coding: Code M0700 as 2, granulation tissue.

Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.

- A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

Coding: Code M0700 as 1, epithelial tissue.

Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.

- A resident has a pressure ulcer on the left trochanter that has 25% black necrotic tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

Coding: Code M0700 as 4, necrotic tissue.

Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, (Necrotic tissue).

## M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present</b> or <b>were at a lesser stage</b> on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4

## M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

### Item Rationale

#### Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have worsened to a higher (deeper) stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

#### Planning for Care

- Pressure ulcers that degenerate or worsen to a higher (deeper) stage require a reevaluation of the interdisciplinary care plan.

### Steps for Assessment

*Look-back period for this item is back to the ARD of the prior assessment. If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.*

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at a higher (deeper) stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.
2. For each current stage, count the number of current pressure ulcers that are new or have worsened since the last MDS assessment was completed.

### Coding Instructions for M0800

- Enter the number of pressure ulcers that were not present OR were at a lesser stage on prior assessment.
- Code 0: if no pressure ulcers have worsened OR there are no new pressure ulcers.

### Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a pressure ulcer is acquired during a hospital admission, it is coded as present on admission/entry or reentry and not included in a count of worsening pressure ulcers.

### DEFINITION

#### PRESSURE ULCER “WORSENING”

Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment determinations assigned to each stage; starting at the stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

## M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

- If a pressure ulcer worsens to a more severe stage during a hospital admission, it should also be coded as present on admission/entry or reentry and not included in counts of worsening pressure ulcers. While not included in counts of worsening pressure ulcers, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates (worsens) to a higher (deeper) stage on subsequent MDS assessments, it would then be included in counts of worsening pressure ulcers.
- Coding unstageable pressure ulcers:
  - If an ulcer was unstageable on admission/entry or reentry, do not consider it to be worse on the first assessment. However, if it worsens after that assessment, it should be included.
  - If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.
  - If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable. If the pressure ulcer's stage has worsened, code it as such in this item.

### Examples

1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now deteriorated (worsened) to a Stage 3 pressure ulcer.

Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0.

Rationale: The pressure ulcer was at a lesser stage on the prior assessment.

2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.

Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.

Rationale: The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it was a Stage 4. This is the first staging since debridement and should not be counted as worsening on the MDS assessment.

3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, and a Stage 2 pressure ulcer on the left trochanter.

Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1.

Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and

## M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

M0800C would be coded 1 for the worsening in pressure ulcer status (i.e. increased severity) of the sacrum and right heel pressure ulcers.

4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable. After debridement, the wound bed is clean and the pressure ulcer is coded as a Stage 3.

Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.

Rationale: M0800B would be coded 0 because the current Stage 3 pressure ulcer is the same stage as it was prior to the period it became unstageable.

## M0900: Healed Pressure Ulcers

M0900. Healed Pressure Ulcers	
Complete only if A0310E = 0	
Enter Code <input type="checkbox"/>	<b>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</b> 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input type="checkbox"/>	<b>B. Stage 2</b>
Enter Number <input type="checkbox"/>	<b>C. Stage 3</b>
Enter Number <input type="checkbox"/>	<b>D. Stage 4</b>

### Item Rationale

#### Health-related Quality of Life

- 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 the pressure ulcer development. Replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.

#### Planning for Care

- Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.
- Most Stage 2** pressure ulcers should heal in a reasonable timeframe (e.g. 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.

#### DEFINITIONS

##### 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.

## M0900: Healed Pressure Ulcers (cont.)

- Current clinical standards do not support reverse staging or backstaging. For example, over time, a Stage 4 pressure ulcer has been healing such that it is less deep, wide, and long. Previous standards using reverse or backstaging would have permitted identification of the pressure ulcer as a Stage 2 pressure ulcer when it reached a depth consistent with Stage 2 pressure ulcers. Current standards require that it continue to be documented as a Stage 4 pressure ulcer until it has completely healed. For care planning purposes, a healed Stage 4 pressure ulcer will remain at increased risk for future breakdown or injury and will require continued monitoring.

### Steps for Assessment

*Complete on all residents, including those without a current pressure ulcer.*

*Look-back period for this item is the ARD of the prior assessment. **If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have completely closed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each resurfaced (or healed) pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

### Coding Instructions for M0900A

*Complete on all residents (even if M0210 = 0)*

- Enter 0: if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).
- Enter 1: if there were pressure ulcers noted on the prior assessment.

### Coding Instructions for M0900B, C, and D.

- Enter the number of pressure ulcers that have healed since the last assessment for each Stage 2 through 4.
- Enter 0: if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

### Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same location, do not consider the first pressure ulcer to have healed, and do NOT record the pressure ulcer as healed.

## M1030: Number of Venous and Arterial Ulcers (cont.)

### Coding Instructions

*Check all that apply in the last 7 days.*

*Pressure ulcers coded in M0210 through M0900 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 her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

Coding: Code M1030 as 3.

Rationale: Ischemic changes point to the ulcer being vascular.

## M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present

## M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- M1040D, open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- M1040E, surgical wound(s)
- M1040F, burn(s)(second or third degree)
- M1040G, skin tear(s)
- M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage)
- M1040Z, none of the above were present

### 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 his other foot.
- Do NOT include pressure ulcers 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 Other than Ulcers, Rashes, Cuts

- Do NOT code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

#### 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.
- Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers.
- This coding is appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.

## 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.

### M1040H Moisture Associated Skin Damage (MASD)

- Moisture associated skin damage is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. MASD is also referred to as incontinence dermatitis.

## Examples

- 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-M0900).**

Rationale: Persons with diabetes can still develop pressure ulcers.

- A resident is readmitted from the hospital after flap surgery to repair a sacral pressure ulcer.

Coding: Check M1040E, (Surgical Wound(s)).

Rationale: A surgical flap procedure to repair pressure ulcers changes the coding to a surgical wound.

## M1200: Skin and Ulcer Treatments

M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

## M1200: Skin and Ulcer Treatments (cont.)

### 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 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.

#### DEFINITIONS

##### **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.

### 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 care
- M1200F, surgical wound care

## M1200: Skin and Ulcer Treatments (cont.)

- 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

### 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. The appropriate reducing (redistribution) 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.

## M1200: Skin and Ulcer 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. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, i.e. 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,” (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

### M1200E Pressure Ulcer Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300). Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

### M1200F Surgical Wound Care

- Do not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer continues to be coded as a 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.

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

- Do NOT code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **Pressure Ulcer Care** item (M1200E).
- 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 Band-Aids.

## M1200: Skin and Ulcer Treatments (cont.)

### 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 **Pressure Ulcer Care**, item (M1200E).
- 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 definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

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

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

## 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 (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-hour turning/repositioning program that is organized, planned, documented, monitored and evaluated based on an individualized assessment of her needs. The physician documents that 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 undernutrition. 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 (redistribution) mattresses.

Coding: Check items M1200A, M1200B, M1200C, M1200D, and M1200E.

Rationale: Interventions include pressure reducing (redistribution) pad in the wheelchair (M1200A) and pressure reducing (redistribution) 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 past 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 redistributing mattress and pad for the wheelchair.

## M1200: Skin and Ulcer Treatments (cont.)

Coding: Check items M1200A, M1200B, and M1200G.

Rationale: Treatments include pressure reducing (redistribution) mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression bandaging system (M1200G).

3. Mrs. S. has a diagnosis of right-sided hemiplegia from a previous stroke. As part of her assessment, it was noted that while in bed Mrs. S. is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every 3 hours while in bed. When she is in her wheelchair, it is difficult for her to offload the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when she is sitting, and therefore, Mrs. 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.

4. Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is 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

### Examples M0300, M0610, M0700 and M0800

1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.

Admission Assessment:

Coding:

— M0300A (Number of Stage 1 pressure ulcers), Code 0.

## Scenarios for Pressure Ulcer Coding (cont.)

- M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
- M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3  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  3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

Quarterly Assessment #1:

Coding:

- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
- M0300B2 (Number of these Stage 2 pressure ulcers present upon admission/entry or reentry), Code 1.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: On the quarterly assessment the Stage 2 pressure ulcer is still present and date was unknown. Therefore, M0300B3 is still coded with dashes.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3  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  3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> <div style="border: 1px solid black; padding: 2px;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>

## Scenarios for Pressure Ulcer Coding (cont.)

Quarterly Assessment #2:

Coding:

- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 0 and skip to M0300C, Stage 3 pressure ulcers.
- M0300C1 (Number of Stage 3 pressure ulcers). Code 1.
- M0300C2 (Number of these Stage 3 pressure ulcers that were present upon admission//entry or reentry). Code 0.
- M0300D1, M0300E1, M0300F1, and M0300G1 Code 0's and proceed to code M0610 (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.
- M0610A (Pressure ulcer length), Code 03.0, M0610B (Pressure ulcer width), Code 02.4, M0610C (Pressure ulcer depth) Code 00.2.
- M0700 (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.
- M0800 (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled PPS or Last Admission/Entry or Reentry) – M0800A (Stage 2) Code 0, M0800B (Stage 3) Code 1, M0800C (Stage 4) Code 0.

Rationale:

- M0300B1 is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to M0300C (Stage 3 pressure ulcer).
- M0300C1 is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.
- M0300C2 is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.
- M0300D1, M0300E1, M0300F1, and M0300G1 are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code M0610 with the dimensions of the Stage 3 ulcer.
- M0610A is coded, 03.0 for length, M0610B is coded 02.4 for width, and M0610C is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.
- M0700 is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.
- M0800A is coded as 0, M0800B is coded as 1, and M0800C is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

## Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <input type="text" value="0"/>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <input type="text"/>	<b>1. Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3
	<b>2. Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
	<b>3. Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown: <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 10px;">-</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 10px;">-</div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
Enter Number <input type="text" value="1"/>	<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling
Enter Number <input type="text" value="0"/>	<b>1. Number of Stage 3 pressure ulcers</b> - If 0 → Skip to M0300D, Stage 4
	<b>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
Enter Number <input type="text" value="0"/>	<b>1. Number of Stage 4 pressure ulcers</b> - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
Enter Number <input type="text"/>	<b>2. Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page

## Scenarios for Pressure Ulcer Coding (cont.)

<b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued</b>	
Enter Number <input type="text" value="0"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device  1. Number of unstageable pressure ulcers 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 that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar  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  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
Enter Number <input type="text" value="0"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution  1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  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
<b>M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</b> Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0 If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<input type="text" value="0"/> <input type="text" value="3"/> . <input type="text" value="0"/> cm	<b>A. Pressure ulcer length:</b> Longest length from head to toe
<input type="text" value="0"/> <input type="text" value="2"/> . <input type="text" value="4"/> cm	<b>B. Pressure ulcer width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text" value="0"/> <input type="text" value="0"/> . <input type="text" value="2"/> cm	<b>C. Pressure ulcer depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)
<b>M0700. Most Severe Tissue Type for Any Pressure Ulcer</b>	
Enter Code <input type="text" value="2"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance 3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. <b>None of the Above</b>
<b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry</b> Complete only if A0310E = 0 Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text" value="0"/>	<b>A. Stage 2</b>
Enter Number <input type="text" value="1"/>	<b>B. Stage 3</b>
Enter Number <input type="text" value="0"/>	<b>C. Stage 4</b>

## Scenarios for Pressure Ulcer Coding (cont.)

### Example M0100-M1200

1. Mrs. P is admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin break down. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. 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. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure redistribution devices on both her bed and chair, and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/2010. Upon reentry the 5-day PPS ARD was set at 11/19/2010. In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx, however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth. It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.

5-Day PPS #1:

Coding:

- M0100B (Formal assessment instrument), Check box.
- M0100C (Clinical assessment), Check box.
- M0150 (Risk of Pressure Ulcers), Code 1.
- M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 0 and skip to M0900 (Healed pressure ulcers).
- M0900 (Healed pressure ulcers). Skip to M1030 since this item is only completed if AO310E=0. The 5-Day PPS Assessment is the first assessment since the most recent admission/entry or reentry, therefore, AO310E=1.
- 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).

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, M0900 was skipped because the 5-Day PPS is the first assessment. 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.

## Scenarios for Pressure Ulcer Coding (cont.)

<b>M1030. Number of Venous and Arterial Ulcers</b>	
Enter Number	Enter the total number of venous and arterial ulcers present
<input type="text" value="0"/>	
<b>M1040. Other Ulcers, Wounds and Skin Problems</b>	
↓ Check all that apply	
<b>Foot Problems</b>	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
<b>Other Problems</b>	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
<b>None of the Above</b>	
<input checked="" type="checkbox"/>	Z. None of the above were present
<b>M1200. Skin and Ulcer Treatments</b>	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input checked="" type="checkbox"/>	Z. None of the above were provided

## Scenarios for Pressure Ulcer Coding (cont.)

### 14-Day PPS:

#### Coding:

- M0100A (Resident has a Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device), Check box.
- M0100B (Formal assessment instrument), Check box.
- M0100C (Clinical assessment), Check box.
- M0150 (Risk of Pressure Ulcers), Code 1.
- M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 1.
- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- 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.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), Enter 11-01-2010.
- 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).
- M0300E1 (Unstageable: Non-removable dressing), 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).
- M0300G1 (Unstageable: Deep tissue), Code 0 and skip to M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar).
- M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is NOT completed, as the resident has a Stage 2 pressure ulcer.
- M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).
- M0800 (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because the 14-Day PPS is NOT the first assessment since the most recent admission/entry or reentry. Therefore, A0310E=0. M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.
- M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is NOT the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.
- M1030 (Number of Venous and Arterial ulcers), Code 0.
- M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).

## Scenarios for Pressure Ulcer Coding (cont.)

- M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (Pressure ulcer care) are all checked.

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. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at A0310E. This is because the 14-Day PPS is NOT the first assessment since the most recent admission/entry or reentry. Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings – with or without topical medications) would **NOT** be coded here because **any** intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer care).

## Scenarios for Pressure Ulcer Coding (cont.)

<b>M0100. Determination of Pressure Ulcer Risk</b>	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input checked="" type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above
<b>M0150. Risk of Pressure Ulcers</b>	
Enter Code <b>1</b>	Is this resident at risk of developing pressure ulcers? 0. No 1. Yes
<b>M0210. Unhealed Pressure Ulcer(s)</b>	
Enter Code <b>1</b>	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
<b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b>	
Enter Number <b>0</b>	<b>A. Number of Stage 1 pressure ulcers</b> 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 <b>1</b>	<b>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</b>
Enter Number <b>0</b>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3
	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
	3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; padding: 2px 5px;">1</div> <div style="border: 1px solid black; padding: 2px 5px;">1</div> <div style="border: 1px solid black; padding: 2px 5px;">-</div> <div style="border: 1px solid black; padding: 2px 5px;">0</div> <div style="border: 1px solid black; padding: 2px 5px;">1</div> <div style="border: 1px solid black; padding: 2px 5px;">-</div> <div style="border: 1px solid black; padding: 2px 5px;">2</div> <div style="border: 1px solid black; padding: 2px 5px;">0</div> <div style="border: 1px solid black; padding: 2px 5px;">1</div> <div style="border: 1px solid black; padding: 2px 5px;">0</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
Enter Number <b>0</b>	<b>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</b>
Enter Number <b></b>	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
Enter Number <b>0</b>	<b>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</b>
Enter Number <b></b>	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
	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
M0300 continued on next page	

## Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input type="text" value="0"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device  <b>1. Number of unstageable pressure ulcers due to non-removable dressing/device</b> - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar  <b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> - If 0 → Skip to M0300G, Unstageable: Deep tissue  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution  <b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="text" value="1"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed  1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance 3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. <b>None of the Above</b>

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text" value="1"/>	<b>A. Stage 2</b>
Enter Number <input type="text" value="0"/>	<b>B. Stage 3</b>
Enter Number <input type="text" value="0"/>	<b>C. Stage 4</b>

## Scenarios for Pressure Ulcer Coding (cont.)

<b>M0900. Healed Pressure Ulcers</b>	
Complete only if A0310E = 0	
Enter Code <input type="text" value="0"/>	<b>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</b> 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Enter Number <input type="text"/>	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input type="text"/>	<b>B. Stage 2</b>
Enter Number <input type="text"/>	<b>C. Stage 3</b>
Enter Number <input type="text"/>	<b>D. Stage 4</b>
<b>M1030. Number of Venous and Arterial Ulcers</b>	
Enter Number <input type="text" value="0"/>	Enter the total number of venous and arterial ulcers present
<b>M1040. Other Ulcers, Wounds and Skin Problems</b>	
↓ Check all that apply	
<input type="checkbox"/>	<b>Foot Problems</b>
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
<input type="checkbox"/>	<b>Other Problems</b>
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
<input type="checkbox"/>	None of the Above
<input checked="" type="checkbox"/>	Z. None of the above were present
<b>M1200. Skin and Ulcer Treatments</b>	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Pressure reducing device for chair
<input checked="" type="checkbox"/>	B. Pressure reducing device for bed
<input checked="" type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input checked="" type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

## 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/reentry if less than 7 days) that any type of injection (subcutaneous, intramuscular or intradermal), insulin, and/or select medications were received by the resident.

### N0300: Injections

N0300. Injections	
Enter Days <input type="checkbox"/>	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 N0410, Medications Received

### 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.

### 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 subcutaneous, intramuscular, or intradermal 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 (subcutaneous, intramuscular, or intradermal) while a resident of the nursing home.
- Record the number of days that any type of injection (subcutaneous, intramuscular, or intradermal) was received in Item N0300.

## N0300: Injections (cont.)

### 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 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, Mr. T. received an influenza shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B<sub>12</sub> 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, Miss C. received both an influenza shot and her vitamin B<sub>12</sub> injection on Thursday.

Coding: N0300 would be coded 1.

Rationale: The resident received injections on one day during the 7-day look-back period.

## N0350: Insulin

N0350. Insulin	
Enter Days <input type="checkbox"/>	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 <input type="checkbox"/>	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.

## N0350: Insulin (cont.)

### 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 and Medicare) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or 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 and Medicare) changed the resident's insulin orders.

### Coding Tips and Special Populations

- 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.

## N0410: Medications Received

N0410. Medications Received	
Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days	
Enter Days <input type="text"/>	A. Antipsychotic
Enter Days <input type="text"/>	B. Antianxiety
Enter Days <input type="text"/>	C. Antidepressant
Enter Days <input type="text"/>	D. Hypnotic
Enter Days <input type="text"/>	E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
Enter Days <input type="text"/>	F. Antibiotic
Enter Days <input type="text"/>	G. Diuretic

### 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 drug 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 reduce the need for or maximize the effectiveness of medications for all residents. Therefore, 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.

## N0410: Medications Received (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 drugs in each of these drug groups 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 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

- Check A, antipsychotic: if antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)
- Check B, antianxiety: if anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Check C, antidepressant: if antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

### DEFINITIONS

#### 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 of the treatments; and support decisions about adding, modifying, continuing, or discontinuing, any interventions.

## N0410: Medications Received (cont.)

- Check D, hypnotic: if hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Check E, anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): if anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.
- Check F, antibiotic: if antibiotics were received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Check G, diuretic: if diuretics were received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Check Z, none of the above were received: if none of the medications in Item N0410 were received during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

### Coding Tips and Special Populations

- Code medications according to a drug's pharmacological classification, not how it is used. For example, oxazepam may be used as a hypnotic, but it is classified as an antianxiety medication. It would be coded as an antianxiety medication.
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- 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).
- Combination medications should be coded in all categories 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 should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not classified as hypnotic drugs.
- 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.

#### DEFINITIONS

##### SLEEP HYGIENE

Practices, habits and environmental factors that promote and/or improve sleep patterns.

## N0410: Medications Received (cont.)

- 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.
- 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.
- Doses of psychopharmacologic drugs 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.
- During the first year in which a resident on a psychopharmacological medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically 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** (the **State Operations Manual** can be found at <http://www.cms.gov/Manuals/IOM/list.asp>).
- Prior to discontinuing a psychoactive drug, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs]).

### 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.

### 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.

## N0410: Medications Received (cont.)

- 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.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring 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 <http://www.cms.gov/Manuals/IOM/list.asp>]), which may
    - o significantly increase PT/INR results to levels associated with life-threatening bleeding, or
    - o decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They 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. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the medical record and to monitor their potential effects as they can interact with other medications. For more information consult the FDA website <http://www.fda.gov/Food/DietarySupplements/ConsumerInformation/ucm110417.htm#what>.

### Example

1. The Medication Administration Record for Mrs. P. reflects the following:
  - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
  - Lorazepam 1 mg PO QAM: Received every day.
  - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

Coding: Medications in N0410, would be checked as follows: A. antipsychotic, risperidone is an antipsychotic drug, B. antianxiety, lorazepam is an antianxiety drug, and D. hypnotic, temazepam is a hypnotic drug. Please note: if a resident is receiving drugs in all three classes simultaneously there must be a clear clinical indication for the use of these drugs. Administration of these types of drugs, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

## N0410: Medications Received (cont.)

Additional information on psychopharmacologic medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)** (or subsequent editions) (<http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1>), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (<http://www.cms.gov/Manuals/IOM/list.asp>)].

Additional information on medications can be found in:

The Orange Book, <http://www.fda.gov/cder/ob/default.htm>

The National Drug Code Directory, <http://www.fda.gov/cder/ndc/database/Default.htm>

## O0250: Influenza Vaccine (cont.)

### Coding Instructions for O0250B, Date Vaccine Received

- Enter date vaccine 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 7, 2010 should be entered as 01-07-2010. If the day only contains a single digit, then fill the first box of the day with the “0”. For example, May 6, 2009 should be entered as 05-06-2009. A full 8 character date is required. If the date is unknown or the information is not available, 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 season (i.e., O250A=0), code the reason from the following list:*

- Code 1, resident not in facility during this year's Influenza season: Resident not in the facility during this year's Influenza 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 season.
- Code 3, not eligible—medical contraindication: if vaccination not received due to medical contraindications, including allergic reaction to eggs or other vaccine component(s), a physician order not to immunize, or an acute febrile illness is present. However, the resident should be vaccinated if contraindications end.
- Code 4, offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine.
- Code 5, not offered: resident or responsible party/legal guardian not offered the vaccine.
- Code 6, inability to obtain vaccine due to a declared shortage: vaccine unavailable at the facility due to declared vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.
- Code 9, none of the above: if none of the listed reasons describe why the vaccination was not administered. This code is also used if the answer is unknown.

### Coding Tips and Special Populations

- The Influenza season varies annually. Information about 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 their local Influenza surveillance information. The Influenza season ends when Influenza is no longer active in your geographic area.
- 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.

## O0400: Therapies

O0400. Therapies	
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>A. Speech-Language Pathology and Audiology Services</b>
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days
Enter Number of Days <input type="text"/>	3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group</b> of residents in the last 7 days
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date
	4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days
	5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
	6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>B. Occupational Therapy</b>
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days
Enter Number of Days <input type="text"/>	3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group</b> of residents in the last 7 days
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date
	4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days
	5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
	6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>C. Physical Therapy</b>
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days
Enter Number of Days <input type="text"/>	3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group</b> of residents in the last 7 days
	If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date
	4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days
	5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
	6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <div style="display: flex; justify-content: space-around; align-items: center;"> <div><input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/></div> <div>Month      Day      Year</div> </div>
O0400 continued on next page	

## O0400: Therapies (cont.)

O0400. Therapies - Continued	
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>D. Respiratory Therapy</b> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy 2. <b>Days</b> - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Days <input type="text"/>	
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>E. Psychological Therapy (by any licensed mental health professional)</b> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy 2. <b>Days</b> - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Days <input type="text"/>	
Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>F. Recreational Therapy (includes recreational and music therapy)</b> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0450, Resumption of Therapy 2. <b>Days</b> - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days
Enter Number of Days <input type="text"/>	

### 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, 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.**

## O0400: Therapies (cont.)

- **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.

### 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.
- 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.

## O0400: Therapies (cont.)

- 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.
- Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives 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;
  - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,

## O0400: Therapies (cont.)

- 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 he or she is 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.
- 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.
- Nursing homes may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.

## O0400: Therapies (cont.)

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.

- Once the qualified therapist has designed a 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 four 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 his/her 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.

## 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.

## 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. (Please also see the section on group therapy for limited exceptions related to group size.) 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** he/she is able to immediately intervene/assist the student as needed.

Example:

- A speech therapy graduate student treats Mr. A for 30 minutes. Mr. 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 Mr. A. Mr. 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.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of concurrent therapy, the minutes will be divided by 2.

## 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 Mrs. Q and Mrs. R at the same time, for 30 minutes. Mrs. Q's stay is covered under the Medicare SNF PPS Part A benefit. Mrs. 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:
  - Mrs. Q. received concurrent therapy for 30 minutes.
  - Mrs. R received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar, to Mrs. S. and Mrs. T. at the same time, for 30 minutes. Mrs. S.'s stay is covered under the Medicare SNF PPS Part A benefit. Mr. 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:
  - Mrs. S. received concurrent therapy for 30 minutes.
  - Mr. 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.)
- An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. 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:
  - Mr. K. received concurrent therapy for 60 minutes.
  - Mr. R. received concurrent therapy for 60 minutes.

## O0400: Therapies (cont.)

### **Group Therapy**

#### **Medicare Part A**

The treatment of 4 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.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of group therapy, the minutes will be divided by 4.

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.

Examples:

- A Physical Therapist provides similar therapies to Mr. W, Mr. X, Mrs. Y. and Mr. Z. at the same time, for 30 minutes. Mr. W. and Mr. X.'s stays are covered under the Medicare SNF PPS Part A benefit. Mrs. Y.'s therapy is covered under Medicare Part B, and Mr. 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:
  - Mr W. received group therapy for 30 minutes.
  - Mr. X. received group therapy for 30 minutes.
  - Mrs. 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.)
  - Mr. Z. received group therapy for 30 minutes.

## O0400: Therapies (cont.)

- Mrs. 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 Mr. S., whose therapy is covered by Medicare Part B, while Mrs. V. continues with her skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to Mrs. V. and Mr. S. for 24 minutes who are not performing the same or similar activities, at which time Mrs. V.'s therapy session ends. The therapist continues to treat Mr. 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:
  - Mrs. V. received individual therapy for 13 minutes and concurrent therapy for 24.
  - Mr. 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.)
- Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B. are joined by Mr. T. and Mr. 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, Mr. 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:
  - Mr. A. received concurrent therapy for 30 minutes and group therapy for 15 minutes.
  - Mr. B. received concurrent therapy for 30 minutes and group therapy for 30 minutes.
  - Mr. T. received group therapy for 30 minutes.
  - Mr. E. received group therapy for 30 minutes.

### **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, see page O-17) 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 patient's plan of care.

## O0400: Therapies (cont.)

### **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. When a resident's Medicare Part A stay is eight days or less, 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, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November 2011. Occupational and Physical therapy started December 3, 2011. His physical therapy ended January 27, 2012 and occupational therapy ended January 29, 2012. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, 2012 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, 2012.

Coding values for his MDS are:

- Item O0400A5 (SLP start date) is 02102012,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112012,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032011, and
- O0400C6 (PT end date) is 01272012.

NOTE: When an EOT-R is completed, the Therapy start date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the date of the Resumption of therapy on the EOT-R (O0450B). If therapy is ongoing, the Therapy end date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

### **General Coding Example:**

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

## O0400: Therapies (cont.)

- 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 10062011; and O0400A6 would be coded with dashes.

Rationale:

Individual minutes totaled 190 over the 7-day look-back period  $[(30 \times 5) + (20 \times 2) = 190]$ ; concurrent minutes totaled 70 over the 7-day look-back period  $(35 \times 2 = 70)$ ; and group minutes totaled 75 over the 7-day look-back period  $(25 \times 3 = 75)$ . Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2011, 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, O0400B4 would be coded 5, O0400B5 would be coded 10092011, and O0400B6 would be coded with dashes.

Rationale:

Individual minutes totaled 113 over the 7-day look-back period  $[(30 \times 2) + 23 + 18 + 12 = 113]$ ; concurrent minutes totaled 0 over the 7-day look-back period  $(0 \times 0 = 0)$ ; and group minutes totaled 80 over the 7-day look-back period  $(20 \times 4 = 80)$ . Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2011 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

## O0400: Therapies (cont.)

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, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes.

Rationale:

Individual minutes totaled 287 over the 7-day look-back period  $[(30 \times 2) + (35 \times 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]$ ; concurrent minutes totaled 100 over the 7-day look-back period  $(20 \times 5 = 100)$ ; and group minutes totaled 0 over the 7-day look-back period  $(0 \times 0 = 0)$ . Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, 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  $(10 \times 5 = 50)$ . 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**.

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 coded 0.

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.

## O0400: Therapies (cont.)

Coding:

O0400F1 would be coded 90, O0400F2 would be coded 3.

Rationale:

Total minutes were 90 over the 7-day look-back period ( $30 \times 3 = 90$ ). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

O0400. Therapies	
<b>Enter Number of Minutes</b> <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="0"/> <b>Enter Number of Minutes</b> <input type="text" value="7"/> <input type="text" value="0"/> <b>Enter Number of Minutes</b> <input type="text" value="7"/> <input type="text" value="5"/> <b>Enter Number of Days</b> <input type="text" value="5"/>	<b>A. Speech-Language Pathology and Audiology Services</b> <ol style="list-style-type: none"> <li><b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li><b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li><b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <ol style="list-style-type: none"> <li><b>Days</b> - record the number of days this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li><b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="6"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/>  Month Day Year</li> <li><b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/>  Month Day Year</li> </ol>
<b>Enter Number of Minutes</b> <input type="text" value="1"/> <input type="text" value="1"/> <input type="text" value="3"/> <b>Enter Number of Minutes</b> <input type="text" value="0"/> <b>Enter Number of Minutes</b> <input type="text" value="8"/> <input type="text" value="0"/> <b>Enter Number of Days</b> <input type="text" value="5"/>	<b>B. Occupational Therapy</b> <ol style="list-style-type: none"> <li><b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li><b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li><b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</p> <ol style="list-style-type: none"> <li><b>Days</b> - record the number of days this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li><b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="9"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/>  Month Day Year</li> <li><b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/>  Month Day Year</li> </ol>
<b>Enter Number of Minutes</b> <input type="text" value="2"/> <input type="text" value="8"/> <input type="text" value="7"/> <b>Enter Number of Minutes</b> <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="0"/> <b>Enter Number of Minutes</b> <input type="text" value="0"/> <b>Enter Number of Days</b> <input type="text" value="5"/>	<b>C. Physical Therapy</b> <ol style="list-style-type: none"> <li><b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li><b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li><b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <ol style="list-style-type: none"> <li><b>Days</b> - record the number of days this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li><b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="7"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/>  Month Day Year</li> <li><b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/>  Month Day Year</li> </ol>

O0400 continued on next page

## O0400: Therapies (cont.)

O0400. Therapies - Continued	
Enter Number of Minutes <input type="text"/> <input type="text"/> 5 <input type="text"/> 0 Enter Number of Days <input type="text"/> 0 Enter Number of Minutes <input type="text"/> <input type="text"/> <input type="text"/> 0 Enter Number of Days <input type="text"/> Enter Number of Minutes <input type="text"/> <input type="text"/> 9 <input type="text"/> 0 Enter Number of Days <input type="text"/> 3	<b>D. Respiratory Therapy</b> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days <b>E. Psychological Therapy</b> (by any licensed mental health professional) 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days <b>F. Recreational Therapy</b> (includes recreational and music therapy) 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0450, Resumption of Therapy 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days

## O0450: Resumption of Therapy

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99	
Enter Code <input type="text"/>	<b>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</b> 0. No → Skip to O0500, Restorative Nursing Programs 1. Yes <b>B. Date on which therapy regimen resumed:</b> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year

### Item Rationale

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

### Coding Instructions:

When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same RUG-IV classification level, if **no**, skip to **O0500**, Restorative Nursing Programs. If Yes, **code item O0450A as 1**. Determine when therapy will resume and code item **O0450B with the date** that therapy will resume. For example:

- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of

## O0450: Resumption of Therapy (cont.)

a doctor's appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450 A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. Item **O0450B was coded as 11132011** because therapy resumed on November 13, 2011.

NOTE: If the EOT OMRA has not been accepted in the QIES ASAP when therapy resumes, code the EOT-R items (O0450A and O0450B) on the assessment and submit the record. If the EOT OMRA without the EOT-R items have been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy items (O0450A and O0450B) and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

NOTE: When an EOT-R is completed, the Therapy start date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the date of the Resumption of therapy on the EOT-R (O0450B). If therapy is ongoing, the Therapy end date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

## O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the <b>number of days</b> 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
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

## O0600: Physician Examinations (cont.)

### Steps for Assessment

1. Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.

### Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).

### Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
  - Chapter 15 of the *Medicare Benefit Policy Manual* (Pub. 100-2) and Chapter 12 of the *Medicare Claims Processing Manual* (Pub. 100-4) may be accessed at: <http://www.cms.hhs.gov/Manuals>.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.
- Does not include visits made by Medicine Men.

## O0700: Physician Orders

O0700. Physician Orders	
<div>Enter Days</div> <div><input type="text"/></div>	Over the last 14 days, <b>on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?</b>

### Item Rationale

#### Health-related Quality of Life

- Health status that requires frequent physician order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities.

#### Planning for Care

- Frequency of physician order changes can be an indication of medical complexity and stability of the resident's health status.

### Steps for Assessment

1. Review the physician order sheets in the medical record.
2. Determine the number of days during the 14-day look-back period that a physician changed the resident's orders.

### Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders.

### Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
- Do not count orders prior to the date of admission or re-entry.
- 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.

## SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

**Intent:** 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 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach to insure 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 least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

### Q0100: Participation in Assessment



Q0100. Participation in Assessment	
Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other available
Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative available

### Item Rationale

#### Health-related Quality of Life

- Residents who actively participate in the assessment process and in developing 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 §483.15 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 perspective during assessment.

## Q0100: Participation in Assessment (cont.)

- During the care planning meetings, the resident should be made comfortable and verbal communication should be directly with him or her.
- 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, his or her 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, family members, significant others, and/or guardian/legally authorized representatives can provide information about the resident's needs, goals, and priorities.

### 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, however, 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 medical 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 he or she 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 Q0100A, Resident Participated in Assessment

*Record the participation of the resident in the assessment process.*

- Code 0, no: if the resident did not actively participate in the assessment process.
- Code 1, yes: if the resident actively and meaningfully participated in the assessment process.

### Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

*Record the participation of the family or significant other in the assessment process.*

- Code 0, no: if the family or significant other did not participate in the assessment process.

## Q0100: Participation in Assessment (cont.)

- Code 1, yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, no family or significant other available: None of the above—resident has no family or significant other.

### Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

*Record the participation of the guardian or legally authorized representative in the assessment process.*

- Code 0, no: if guardian or legally authorized representative did not participate in the assessment process.
- Code 1, yes: if guardian or legally authorized representative did participate in the assessment process.
- Code 9, no guardian or legally authorized representative available: None of the above—resident has no guardian or legally authorized representative.

### 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 he or she is able to express it.
- Significant other does not include nursing home staff.
- No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.

## Q0300: Resident's Overall Expectation



*Complete only when A0310E=1. (First assessment on admission/entry or reentry.)*

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="checkbox"/>	<b>A. Select one for resident's overall goal established during assessment process</b> 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	<b>B. Indicate information source for Q0300A</b> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain

## Q0300: Resident's Overall Expectation (cont.)

### Item Rationale

This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her 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 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.

#### Health-related Quality of Life

- Unless the resident's goals for care are understood, his or her needs, goals, and priorities are not likely to be met.

#### Planning for Care

- The resident's goals should be the basis for care planning.

#### DEFINITIONS

##### DISCHARGE

To release from nursing home care. Can be to home, another community setting, or healthcare setting.

### Steps for Assessment

1. Ask the resident about his or her overall expectations to be sure that he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices.
2. Ask the resident to consider his or her 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 his or her 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 his or her 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.

## Q0300: Resident's Overall Expectation (cont.)

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 his or her goals, the response selected must reflect the resident's perspective if he or she is 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 resident is not able to comprehend and communicate their wishes.

### Coding Instructions for Q0300A, Resident's Overall Goals Established during Assessment Process

*Record the resident's expectations as expressed by her or him. It is important to document their expectations.*

- Code 1, expects to be discharged to the community: if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- Code 2, expects to remain in this facility: if the resident indicates that he or she expects to remain in the nursing home.
- Code 3, expects to be discharged 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

- This item is 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 or not.
- Q0300A, Code 1 "expects to be discharged to the community" may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid 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).
- 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 him or her to make the decision and to be supported in directing his or her care planning.

## Q0300: Resident's Overall Expectation (cont.)

- If the resident is unable to communicate his or her 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 Q0300B, Indicate Information Source for Q0300A

- Code 1, resident: if the resident is the source for completing this item.
- Code 2, if not resident, then family or significant other: if the resident is unable to respond and a family member or significant other is the source for completing this item.
- Code 3, if not resident, family or significant other, then guardian or legally authorized representative: if the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond.
- Code 9, unknown or uncertain (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 (Q0300A = 9).

### Examples

1. Mrs. F. is a 55-year-old married woman who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. She was admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait training, and wheelchair mobility training. Mrs. F. is extremely motivated to return home. Her husband is supportive and has been busy adapting their home to promote her independence. Her goal is to return home once she has completed rehabilitation.

Coding: Q0300A would be coded 1, expects to be discharged to the community.

Q0300B would be coded 1, resident.

Rationale: Mrs. F. has clear expectations and a goal to return home.

2. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer and was readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. He relies on nursing staff for all activities of daily living (ADLs). He indicates that he is "strongly optimistic" about his future and only wants to think "positive thoughts" about what is going to happen and needs to believe that he will return home.

Coding: Q0300A would be coded 1, expects to be discharged to the community.

Q0300B would be coded 1, resident.

## Q0300: Resident's Overall Expectation (cont.)

Rationale: Mr. 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. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states 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 daughter wants care oriented toward making her mother comfortable in her final days and that the family does not have the capacity to provide all the care the resident needs.

Coding: Q0300A would be coded 2, expects to remain in this facility.

Q0300B would be coded 2, family or significant other.

Rationale: Ms. T is not able to respond, but her daughter has clear expectations that her mother will remain in the nursing home where she will be made comfortable for her remaining days.

4. Mrs. G., an 84-year-old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she "just needs to have a break." Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.

Coding: Q0300A would be coded 1, expects to be discharged to the community.

Q0300B would be coded 2, family or significant other.

Rationale: Mrs. G. is not able to respond but her daughter has clear expectations that her mother will return home at the end of the 7-day respite visit.

5. Mrs. C. is a 72-year-old woman who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care. She has no living relatives and no significant other who is willing to participate in her care decisions. The court appointed a legal guardian to oversee her care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Mrs. C.'s best interest that she be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

Coding: Q0300A would be coded 3, expects to be discharged to another facility/institution.

Q0300B would be coded 3, guardian or legally authorized representative.

## Q0300: Resident's Overall Expectation (cont.)

Rationale: Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions. A court-appointed legal guardian determined that it is in Mrs. C.'s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.

Coding: Q0300A would be coded 1, expects to be discharged to the community (small group homes are considered to be community setting).

Q0300B would be coded 1, Resident.

Rationale: Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed that it is in Ms. K.'s best interest to be transferred to a group home. This information should also be recorded in the individual's clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)

## Q0400: Discharge Plan

Q0400. Discharge Plan	
Enter Code	A. Is active discharge planning already occurring for the resident to return to the community?
<input type="checkbox"/>	0. No
	1. Yes → Skip to Q0600, 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 local contact agency (LCA) experts about returning to the community. There are improved community resources and supports 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 rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

## 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.
- Important progress has been made so that individuals have more choices, care options, and available supports 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 right to receive services in the least restrictive and most integrated setting.
- 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 the durable medical equipment (if needed), formal and informal supports that will be available, the persons 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, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (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 individual's preferences and needs for care and supports:
    - o personal identification and contact information, including Advance Directives;
    - o provider contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - o brief medical history;
    - o current medications, treatments, therapies, and allergies;
    - o arrangements for durable medical equipment;
    - o arrangements for housing;
    - o arrangements for transportation to follow-up appointments; and
    - o 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.

## Q0400: Discharge Plan (cont.)

- 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 facility procedures and discharge planning for subacute and rehabilitation community discharges are most often well defined and efficient.
- 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.
  - o 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 his or her wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
  - o The NF 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 transition services planning. They 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 by a state's on-line/website or by other state-approved processes. 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.
  - o 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 resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
  - o Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now more readily available. Resource availability and eligibility coverage varies across States and local communities.
  - o 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.
- Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help him or her to readjust to community living.

## Q0400: Discharge Plan (cont.)

- Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge.
- For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at <http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf>

### Steps for Assessment

1. A review should be conducted of the care plan, the medical 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 his or her 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. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and the capability to address a resident's needs and arrange for that resident to discharge back to the community, a referral to the LCA may not be necessary. Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them.
4. Record the resident's expectations as expressed/communicated, whether you assess that they are realistic or not realistic.
5. If the resident's discharge needs cannot be met by the nursing facility, an evaluation of the community living situation to evaluate whether it can meet the resident's needs should be conducted by the LCA, along with other community providers who will be providing the transition and other community based services to determine the need for assistive/adaptive devices, medical supplies, and equipment and other services.
6. The resident, his or her interdisciplinary team, and LCA (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).
7. 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, etc.).
8. A determination of family involvement, capability, and support after discharge should also be made.

## 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; skip to **Referral** item (Q0600).

## Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

*For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)*

<b>Q0490. Resident's Preference to Avoid Being Asked Question Q0500B</b>	
Complete only if A0310A = 02, 06, or 99	
Enter Code <input type="checkbox"/>	Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?
	0. No
	1. Yes → Skip to Q0600, Referral
	8. Information not available

### 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 annual 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 Q0550 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 Q0600, Referral.

Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.

### Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

- Code 0, no: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again.

## Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (cont)

- Code 1, yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, Referral. If this is a comprehensive assessment, proceed to the next item Q0500B.

- Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment.

### 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 Q0550.

If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

### Examples

1. Ms. G is a 45-year-old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.

Coding: Q0490 would be coded 1, Yes, skip to Q0600; because this is a quarterly assessment.

If this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

Coding: Q0490 would be coded 1, Yes, skip to Q0600; Unless this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.

## Q0500: Return to Community



*For Admission, Quarterly, and Annual Assessments.*

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	<b>B. Ask the resident (or family or significant other if resident is unable to 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?"</b> 0. No 1. Yes 9. Unknown or uncertain

### Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure 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. 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.

### Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident's 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 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 his or her 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 obtained 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.

### Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.

## Q0500: Return to Community (cont.)

### 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 him or her that this is a routine question that is asked of all residents.
2. Ask the resident if he or she would like to speak with someone about the possibility of returning to live 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 leave the nursing home 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 he or she can change his or her decision (i.e., whether or not he or she wants 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. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input. 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 his/her mind at any time.
4. If the resident is unable to communicate his or her 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 he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her 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.

**Coding Instructions for Q0500B, Ask the resident (or family or significant other or guardian or legally authorized representative 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?”**

## Q0500: Return to Community (cont.)

- Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to the community.
- Code 1, yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to 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 Tips

- A “yes” response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency about the resident's request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires.
- Follow-up is expected in a “reasonable” amount of time and 10 business days is a recommendation and not a requirement. 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 services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a critical step. It is important to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually provides and can arrange, and obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24-hour care issues, etc.
- The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support.
- Current 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 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 could be asked the question.

## Q0500: Return to Community (cont.)

### Examples

1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he 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 nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.

2. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in the Hope Nursing Home for the past 20 years. She once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Ms. C. was sent to the nursing home because she now required regular chest physical therapy and was told that she could no longer live in her previous group home because her needs were more intensive. No one had asked her about returning to the community until now. When administered the MDS assessment, she responded yes to item Q0500B.

Coding: Q0500B would be coded 1, yes.

Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.

3. Mr. D. is a 65-year-old man with a severe heart condition and interstitial pulmonary fibrosis. At the last quarterly assessment, Mr. D. had been asked about returning to the community and his response was no. He also responds no to item Q0500B. The assessor should ask why he responded no. Depending on the 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?" Mr. D. responds no to the follow-up questions and does not want to offer any more information or talk about it.

Coding: Q0500B would be coded 0, no.

Rationale: During this assessment, he was asked about returning to the community and he responded no.

## Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code <input type="checkbox"/>	<b>A. Does the resident (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on <u>all</u> assessments? (Rather than only on comprehensive assessments.)</b> 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 <input type="checkbox"/>	<b>B. Indicate information source for Q0550A</b> 1. Resident 2. If not resident, then family or significant other 3. If not resident, family or significant other, then guardian or legally authorized representative 8. No information source available

### Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life 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, if resident is unable to respond) want to be asked about returning to the community on all assessments (rather than being asked yearly only on comprehensive assessments)?

- Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then 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 he or she does want to be asked the return to community question Q0500B on all assessments.
- Code 9, 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.

## Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again (cont.)

### Coding Instructions for Q0550B, Indicate information source for Q0550A

- Code 1, Resident: if resident responded to Q0550A.
- Code 2, If not resident, then family or significant other.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative.
- Code 8, No information source 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.

### Example

1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her and she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.

Coding: Q0550A would be coded 1, Yes.

Q0550B would be coded 1.

Rationale: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

## Q0600: Referral

Q0600. Referral	
Enter Code	Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)
<input type="checkbox"/>	0. No - referral not needed
	1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment (Resources #20))
	2. Yes - referral made

### Item Rationale

#### Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.

## Q0600: Referral (cont.)

### Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

### Steps for Assessment: Interview Instructions

- If Item Q0400A is coded 1, yes, then complete this item.
- If Item Q0490B is coded 1, yes, then complete this item.
- If Item Q0500B is coded 1, yes, then complete this item.

### Coding Instructions

- Code 0, no: Referral not needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family, etc., responded no to Q0500B.
- Code 1, no: Referral is or may be needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.
- Code 2, yes: Referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

#### DEFINITIONS

##### **DESIGNATED LOCAL CONTACT AGENCY**

Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging/Disabled Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities. See Appendix C for listings.

#### Local Contact Agency (LCA) Point of Contact List

See [www.cms.gov/CommunityServices/downloads/State by %20State POC list.pdf](http://www.cms.gov/CommunityServices/downloads/State%20State%20POC%20list.pdf) for listings.

## Q0600: Referral (cont.)

### Coding Tips

- State Medicaid Agencies have designated Local Contact Agencies and a State point of contact (POC) to coordinate efforts to implement Section Q designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.
- Several resources are available at the Return to Community web site at:  
[http://www.cms.gov/CommunityServices/10\\_CommunityLivingInitiative.asp#TopOfPage](http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage).
  - The State-by-State list of Local Contact Agencies and POC Section Q Coordinator Information.
  - MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
  - The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q.
- Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident's return to their community. The nursing home and local agency staff members should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
- Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.
- The local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transitions back to the community is possible.
- Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc., preventing discharge to the community.
- When Q0600 is answered 1, No, 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.

## Q0600: Referral (cont.)

### Examples

1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was “Yes” to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son’s school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops and appliances.

Coding: Q0500B would be coded 1, yes.

Q0600 would be coded 2, yes.

Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes.

2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V.

Coding: Q0600 would be coded 1, no.

Rationale: Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600 would be coded as no- “referral is or may be needed.” 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 local contact agency.

## 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.

## V0100: Items From the Most Recent Prior OBRA or 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- 06	
Enter Code <input type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)</b> 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 <input type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)</b> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) 99. None of the above
	<b>C. Prior Assessment Reference Date (A2300 value from prior assessment)</b> <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
Enter Score <input type="text"/>	<b>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)</b>
Enter Score <input type="text"/>	<b>E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)</b>
Enter Score <input type="text"/>	<b>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)</b>

### 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 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 through 07 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 through 07, 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-9<sup>®</sup>) Total Severity Score (D0300 Value from Prior Assessment)**

- Record in V0100E the value of D0300 (Resident Mood Interview [PHQ-9<sup>®</sup>] 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<sup>®</sup>) Total Severity Score (D0600 Value from Prior Assessment)**

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood Interview [PHQ-9-OV<sup>®</sup>] 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 <u>Care Planning Decision</u> 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 <u>Location and Date of CAA Documentation</u> 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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	
09. Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
10. Activities	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dehydration/Fluid Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	
15. Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	
16. Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychotropic Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
18. Physical Restraints	<input type="checkbox"/>	<input type="checkbox"/>	
19. Pain	<input type="checkbox"/>	<input type="checkbox"/>	
20. Return to Community Referral	<input type="checkbox"/>	<input type="checkbox"/>	
B. Signature of RN Coordinator for CAA Process and Date Signed			
1. Signature		2. Date	
		<div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>	
C. Signature of Person Completing Care Plan Decision and Date Signed			
1. Signature		2. Date	
		<div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div>-</div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> <div><input type="text"/></div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>	

## 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 14<sup>th</sup> 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.

## 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 the QIES Assessment Submission and Processing (ASAP) system 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 National MDS Database.

A modification request is used to correct a QIES ASAP 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 the QIES ASAP database.

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 the QIES ASAP database 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 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 the QIES ASAP database. 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 the QIES ASAP database. This requires a request from the facility to the facility's state agency to manually delete all traces of a record from the QIES ASAP database. 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 the QIES ASAP system 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 QIES ASAP database. 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 the QIES ASAP database 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 QIES ASAP record was submitted for an incorrect facility, the record must be removed manually and then a new record for the correct facility must be submitted to the **QIES ASAP database. 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

X0150. Type of Provider	
Enter Code <input type="text"/>	<b>Type of provider</b> 1. Nursing home (SNF/NF) 2. Swing Bed

### Coding Instructions for X0150, Type of Provider

This item contains the type of provider identified from 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

These items contain the resident's name from the prior erroneous record to be modified/  
inactivated.

[illegible]

## 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. If the first name was left blank on the prior record, leave X0200A blank.
- 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 (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

X0300. Gender on existing record to be modified/inactivated	
Enter Code <input type="checkbox"/>	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.
- 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.

## X0400: Birth Date

X0400. Birth Date on existing record to be modified/inactivated											
		<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
		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

<b>X0500. Social Security Number</b> 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.

## X0600: Type of Assessment/Tracking

These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated.

<b>X0600. Type of Assessment</b> on existing record to be modified/inactivated	
Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 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 <input type="text"/>	<b>B. PPS Assessment</b> <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above
Enter Code <input type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 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

## X0600: Type of Assessment/Tracking (cont.)

### 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 does not have to match the current value of A0310A on a modification request. The entries may be different if the modification is correcting the Federal OBRA reason for assessment/tracking code.

### 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 does not have to match the current value of A0310B on a modification request. The entries may be different if the modification is correcting the PPS assessment code.

### Coding Instructions for X0600C, PPS Other Medicare Required Assessment—OMRA

- Fill in the boxes with the PPS OMRA code exactly as submitted for item A0310C “PPS—OMRA” on the prior erroneous record to be modified/inactivated.
- Note that the PPS OMRA code in X0600C does not have to match the current value of A0310C on a modification request. The entries may be different if the modification is correcting the PPS OMRA code.

### Coding Instructions for X0600D, Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)

- Enter the code exactly as submitted for item A0310D “Is this a Swing Bed clinical change assessment?” on the prior erroneous record to be modified/inactivated.
- Code 0, no: if the assessment submitted was not coded as a swing bed clinical change assessment.
- Code 1, yes: if the assessment submitted was coded as a swing bed clinical change assessment.
- Note that the code in X0600D does not have to match the current value of A0310D on a modification request. The entries may be different if the modification is correcting the Swing Bed clinical change assessment code.

## X0600: Type of Assessment/Tracking (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 does not have to match the current value of A0310F on a modification request. The entries may be different if the modification is correcting the Entry/discharge reason for completing the assessment or tracking record.

## 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 the QIES ASAP system, this date is often referred to as the “target date.” Enter only one (1) date in X0700

<b>X0700. Date on existing record to be modified/inactivated - Complete one only</b>	
<b>A. Assessment Reference Date</b> - Complete only if X0600F = 99	<div> <div> <div></div> <div></div> </div> <div>Month</div> </div> <div> <div>–</div> </div> <div> <div> <div></div> <div></div> </div> <div>Day</div> </div> <div> <div>–</div> </div> <div> <div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div> </div>

### Coding Instructions for X0700A, Assessment Reference Date—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 does not have to match the current value of A2300 on a modification request. The entries may be different if the modification is correcting the assessment reference date. The entries may also be different if the type of assessment/tracking record is being changed.

## X0700: Date on Existing Record to Be Modified/Inactivated (cont.)

For example, if the incorrect QIES ASAP database record indicates an admission assessment but the record should have been an entry record, then the assessment reference date for the prior record is entered in Item X0700A (Assessment Reference Date). However, the new assessment reference date in A2300 would be blank. The assessment reference date is not active on an entry record. Instead, the entry date would be entered in item A1600.

### Coding Instructions for X0700B, Discharge Date—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 does not have to match the current value of A2000 on a modification request. The entries may be different if the modification is correcting the discharge date. The entries may also be different if the type of assessment/tracking record is being changed.

### Coding Instructions for X0700C, Entry Date—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 does not have to match the current value of A1600 on a modification request. The entries may be different if the modification is correcting the entry date. The entries may also be different if the type of assessment/tracking record is being changed.

## X0800: Correction Attestation Section

The items in this section indicate the number of times the QIES ASAP database record 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 date entry software, however, if it is not, the nursing home should enter this information.

<b>Correction Attestation Section</b> - Complete this section to explain and attest to the modification/inactivation request	
<b>X0800. Correction Number</b>	
Enter Number <input type="text"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one

## X0800: Correction Attestation Section (cont.)

### Coding Instructions for X0800, Correction Number

- Enter the total number of correction requests to modify/inactivate the QIES ASAP record 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 the QIES ASAP database.

## X0900: Reasons for Modification

The items in this section indicate the possible reasons for the modification request of the record in the QIES ASAP database. 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	
<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	E. End of Therapy - Resumption (EOT-R) date
<input type="checkbox"/>	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 QIES ASAP record 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 QIES ASAP record 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.

## X0900: Reasons for Modification (cont.)

### Coding Instructions for X0900C, Software Product Error

- Check the box if any errors in the prior QIES ASAP record 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 QIES ASAP record were caused by item coding errors.
- An item coding error includes any error made coding an MDS item, such as choosing an incorrect code for the Activities of Daily Living (ADL) bed mobility self-performance item G0110A1 (e.g., choosing a code of “4” for a resident who requires limited assistance and should be coded as “2”). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

### Coding Instructions for X0900E, End of Therapy-Resumption (EOT-R) date

- Check the box if the error in the prior QIES ASAP record was caused by an erroneous End of Therapy-Resumption (EOT-R) date.

### Coding Instructions for X0900Z, Other Error Requiring Modification

- Check the box if any errors in the prior QIES ASAP record were caused by other types of errors not included in Items X0900A through X0900E.
- Such an error includes any other type of error that causes a QIES ASAP record 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.

<b>X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)</b>	
↓ Check all that apply	
<input type="checkbox"/>	A. Event did not occur
<input type="checkbox"/>	Z. Other error requiring inactivation If “Other” checked, please specify: _____

## X1050: Reasons for Inactivation (cont.)

### Coding Instructions for X1050A, Event Did Not Occur

- Check the box if the prior QIES ASAP record does not represent an event that actually occurred.
- An example would be a discharge record 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 prior QIES ASAP record 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.

## 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	
	<b>A. Attesting individual's first name:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>B. Attesting individual's last name:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<b>C. Attesting individual's title:</b> <input type="text"/>
	<b>D. Signature</b> <input type="text"/>
	<b>E. Attestation date</b> <div style="display: flex; align-items: center;"> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <div style="margin-left: 10px;"> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> </div> </div>

### 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.

## X1100: RN Assessment Coordinator Attestation of Completion (cont.)

### 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 QIES ASAP record. 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
---	---	---	---	---	---	---	---

### Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion

- If an inactivation is being completed, Z0400 must also be completed.

## Z0300: Insurance Billing

Z0300. Insurance Billing	
A. RUG billing code:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
B. RUG billing version:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

### 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, RUG billing code

- If the other payer has selected a standard RUG 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.

### Coding Instructions for Z0300B, RUG billing version

- If the other payor has selected a standard RUG 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.

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 State-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 his or her 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
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(b)). 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

## 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 483.75(i) 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.<sup>1</sup>

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;

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<sup>1</sup> 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 [F 309]).

Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.75(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., F314 42 CFR 483.25(c) Pressure Sores and F329 42 CFR 483.25(l) 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

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/resident representative input and goals for health care;
- 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 his/her family or representative regarding the resident, care plans, and their wishes.

**The overall care plan should be oriented towards:**

1. 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).
2. Managing risk factors to the extent possible or indicating the limits of such interventions.
3. Addressing ways to try to preserve and build upon resident strengths.
4. Applying current standards of practice in the care planning process.
5. Evaluating treatment of measurable objectives, timetables and outcomes of care.
6. Respecting the resident's right to decline treatment.
7. Offering alternative treatments, as applicable.
8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.

9. Involving resident, resident's family and other resident representatives as appropriate.
10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs.
11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.
12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.

## 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 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:

<i>Subject</i>	<i>Verb</i>	<i>Modifiers</i>	<i>Time frame</i>	<i>Goal</i>
Mr. Jones <b>OR I</b>	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. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed.

- 6) 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.
- 7) 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.
- 8) 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.
- 9) 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.
- 10) 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.

**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

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, 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:

- 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

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.

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thinking, altered level of consciousness or psychomotor retardation as indicated by:

**(C1300A = 1 OR C1300A = 2) OR**

**(C1300B = 1 OR C1300B = 2) OR**

**(C1300C = 1 OR C1300C = 2) OR**

**(C1300D = 1 OR C1300D = 2)**

1. 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)**

2. Rejection of care occurred at least 1 day in the past 7 days as indicated by:

**E0800 >= 1 AND E0800 <= 3**

3. Wandering occurred at least 1 day in the past 7 days as indicated by:

**E0900 >= 1 AND E0900 <= 3**

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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.

**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, toileting, changing position in bed, 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):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary

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( (C1000 >= 0 AND C1000 <= 2) OR  
(C0500 >= 5 AND C0500 <= 15) )

13. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while resident believes he/she is capable of increased independence as indicated by:

**G0900A = 1 AND**  
( (C1000 >= 0 AND C1000 <= 2) OR  
(C0500 >= 5 AND C0500 <= 15) )

14. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while direct care staff believe resident is capable of increased independence as indicated by:

**G0900B = 1 AND**  
((C1000 >= 0 AND C1000 <= 2) OR  
(C0500 >= 5 AND C0500 <= 15) )

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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

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#### Triggering Conditions (any of the following):

1. ADL assistance for toileting was needed as indicated by:

**(G0110I1 >= 2 AND G0110I1 <= 4)**

2. Resident requires a indwelling catheter as indicated by:

**H0100A = 1**

3. Resident requires an external catheter as indicated by:

**H0100B = 1**

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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**

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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.

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### Psychosocial Well-Being CAT Logic Table

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#### Triggering Conditions (any of the following):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:

**D0200A1 = 1**

2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:

**D0500A1 = 1**

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- 
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 = not checked**

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)**

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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.

### Mood State CAT Logic Table

#### Triggering Conditions (any of the following):

1. Resident has had thoughts he/she would be better off dead, or thoughts of hurting him/herself as indicated by:

**D0200I1 = 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 (D0300) is greater than the prior assessment (V0100E) as indicated by:

**((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND**

**((D0300 >= 00) AND (D0300 <= 27)) AND**

**((V0100E >= 00) AND (V0100E <= 27)) AND**

**(D0300 > V0100E)**

4. The resident mood interview is not successfully completed (missing value on D0300), 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**

**((D0300 < 00) OR (D0300 > 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

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score has a value of 10 through 27 as indicated by:

**D0300 >= 10 AND D0300 <= 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**

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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.

### Behavioral Symptoms CAT Logic Table

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#### Triggering Conditions (any of the following):

1. Rejection of care has a value of 1 through 3 indicating resident has rejected evaluation
-

**If A0310A = 01 AND J1700A = 1**

4. 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**

5. Resident has fallen at least one time since admission or the prior assessment as indicated by:

**J1800 = 1**

6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

**N0410B >= 1 AND N0410B <= 7**

7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

**N0410C >= 1 AND N0410C < 7**

8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

**P0100B = 1 OR P0100B = 2**

9. 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 him or her 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:

**K0510A1 = 1 OR K0510A2 = 1**

6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

**K0510C1 = 1 OR K0510C2 = 1**

7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

**K0510D1 = 1 OR K0510D2 = 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 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.

### 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:

**K0510B = 1 OR K0510B2 = 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.

### 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:

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**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:

**K0510A1 = 1 OR K0510A2 = 1**

8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

**K0510B1 = 1 OR K0510B2 = 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.

## 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

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.

### Pressure Ulcer CAT Logic Table

**Triggering Conditions (any of the following):**

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

**(G0110A1 >= 1 AND G0110A1 <= 4) OR**

**(G0110A1 = 7 OR G0110A1 = 8)**

2. Frequent urinary incontinence as indicated by:

**H0300 = 2 OR H0300 = 3**

3. Frequent bowel continence 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. Resident has one or more pressure ulcer(s) that has gotten worse since prior assessment as indicated by:

**(M0800A > 0 AND M0800A <= 9) OR**

**(M0800B > 0 AND M0800B <= 9) OR**

**(M0800C > 0 AND M0800C <= 9)**

9. Trunk restraint used in bed has value of 1 or 2 as indicated by:

**P0100B = 1 OR P0100B = 2**

10. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

**P0100E = 1 OR P0100E = 2**

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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.

## 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.

### Psychotropic Medication Use CAT Logic Table

#### Triggering Conditions (any of the following):

1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:  
**N0410A>= 1 AND N0410A<=7**
2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:  
**N0410B>= 1 AND N0410B<7**
3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:  
**N0410C>= 1 AND N0410C<7**
4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:  
**N0410D>= 1 AND N0410D<7**

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.

## 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 his or her 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**

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:

**J0500A = 1**

2. Resident has limited day-to-day activity because of pain over past 5 days as indicated by:

**J0500B = 1**

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 1 or 2 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:

**(J0400 = 1 OR J0400 = 2) AND**

**((J0600A >= 04 AND J0600A <= 10) OR**

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**(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)**

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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.

## 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 can choose to leave the facility and/or request to talk to someone about returning to the community 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 least 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,

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.

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### Return to Community Referral CAT Logic Table

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#### Triggering Conditions (any of the following):

1. Referral is or may be needed but has not been made to local contact agency as indicated by:

**Q0600 = 1**

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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 his or her highest level of functioning and the involvement of the designated 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 his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

## 4.11 Reserved

## CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act required (OBRA) MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals 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' Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. 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 and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans. After completion of the required assessment and/or tracking record information, 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 web site at:

[http://www.cms.gov/NursingHomeQualityInits/30\\_NHQIMDS30TechnicalInformation.asp](http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp)

In addition, providers must be certain they are submitting MDS assessments under the appropriate authority. There must be a federal and/or state authority to submit MDS assessment data to the QIES ASAP system. The software used by providers should have a prompt for confirming the authority to submit each record.

The provider indicates the submission authority for a record in the MDS Submission Requirement item (A0410).

- **Value = 1**      **Neither federal nor state required submission.**
- **Value = 2**      **State but not federal required submission**  
                         (FOR NURSING HOMES ONLY).
- **Value = 3**      **Federal required submission.**

See Chapter 3 for details concerning the coding of the Submission Requirement item (A0410). Note: CMS certified Swing Bed units are always Value 3, Federal required submission.

Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office web site at:

<https://www.qtso.com>

## 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 the QIES ASAP system. 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 the QIES ASAP system.

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 the QIES ASAP system. 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 insure 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 the QIES ASAP system 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 through 07) 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.

- Type of Provider (Item A0200),
- Type of Assessment (A0310),
- Entry Date (Item A1600) on an Entry tracking record (A0310F = 1),
- Discharge Date (Item A2000) on a Discharge/Death in Facility record (A0310F = 10, 11, 12),
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
  - Submission Requirement (Item A0410),
  - State-assigned facility submission ID (FAC\_ID),
  - Production/test code (PRODN\_TEST\_CD).

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 the QIES ASAP system, 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 the QIES ASAP system, 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 the QIES ASAP system have been corrected in a more current OBRA comprehensive or quarterly assessment (Item A0130A = 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 the QIES ASAP system is corrected.

## Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system 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), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.

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 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that an event date (ARD, entry date, and discharge date) or type of assessment item (A0310) is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment, ensuring that the clinical information is accurate.

## 5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system 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 submission requirement in item A0410.
3. The record has the wrong facility ID in the control item FAC\_ID.

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 MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility **must** submit the completed form to the State Agency via certified mail through the United States Postal Service (USPS). The State Agency **must** approve the provider's request and submit a signed form to the QIES Help Desk via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be manually evaluated in the QIES ASAP system and the QIES ASAP system 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 correction is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect submission requirement in item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system 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 the QIES ASAP system. 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 QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (federal submission requirement) but there was actually no state or federal requirement for the record (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual correction is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 (federal submission requirement) but the record is only 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 QIES ASAP system history file.

If a QIES ASAP system record has the wrong main facility ID (control item FAC\_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct FAC\_ID value when indicated.

Examples:

1. When rehabilitation therapy begins during the middle of a Medicare Part A stay, a Start of Therapy OMRA may optionally be performed with an ARD set for within 5 to 7 days after the earliest start of therapy date (items O0400A5, O0400B5, or O0400C5). The Start of Therapy OMRA changes the RUG payment rate previously established by a previous PPS assessment from the earliest start of therapy date through the end of the standard payment period. **Consider Example 1.**
    - **EXAMPLE 1.** The 14-Day assessment is performed with an ARD on Day 14. This assessment establishes the RUG payment for Days 15 through 30. Rehabilitation therapy starts on Day 18 and a Start of Therapy OMRA is performed with an ARD 6 days later on Day 24. The Start of Therapy OMRA will change the RUG payment starting on Day 18 until Day 30 (the end of the standard payment period).
  2. The unscheduled Start of Therapy assessment changes the RUG payment rate for days prior to the ARD of that Start of Therapy assessment. Because of this policy, there are cases where a Start of Therapy OMRA can change the RUG payment rate for an entire standard payment period. **Consider Example 2.**
    - **EXAMPLE 2.** The scheduled 14-day assessment is performed with ARD on Day 14 of the stay. This 14-day assessment establishes the RUG payment rate for the standard Day 15 to Day 30 payment period. Rehabilitation therapy had started on Day 13. The facility opts to perform a Start of Therapy OMRA with ARD on Day 19 (6 days after the start of therapy). This Start of Therapy OMRA will change the RUG payment beginning with Day 13 through Day 30 (the end of the standard payment period). In this case, the HIPPS code from the Start of Therapy OMRA will be used for the entire Day 15 through Day 30 payment period and the 14-day assessment will not be used for billing. If the entire set of claims for the stay is reviewed, then there will be no HIPPS code with an Assessment Indicator code for the 14-day assessment. This does not present a SNF billing compliance problem. Examination of all the assessments and claims will indicate that a 14-day assessment was performed but that the Start of Therapy OMRA controlled the payment rate for the entire Day 15 to Day 30 payment period.
- Example 2 also illustrates that there are cases where a single Start of Therapy OMRA can change the RUG payment rate in 2 separate payment periods. In Example 2, the Start of Therapy OMRA changes the RUG payment rate for the last 2 days (Days 13 and 14) of the 5-Day assessment payment period and all of the days (Days 15 through 30) of the 14-Day assessment payment period.
3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed with an ARD set for within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. **Example 3** presents the most common situation.

- EXAMPLE 3. Rehabilitation therapy ends on Day 20 of a Medicare stay. An End of Therapy OMRA is performed with ARD on Day 22 and the Medicare Non-Therapy RUG (Z0150A) is billed from Day 21 (day after the last day therapy provided) to the end of the current payment period of Day 30.
4. Consider Example 4 where a scheduled PPS assessment has set the payment rate for the next payment period and then an End of Therapy OMRA is conducted before the beginning of that payment period.
- EXAMPLE 4. The PPS 30-day assessment is performed with ARD on Day 27 to establish a Medicare RUG (Z0100A) for the Day 31 to Day 60 payment period. Rehabilitation therapy ends on Day 26 and an End of Therapy OMRA is performed with ARD on Day 29. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 27 through Day 30. The Medicare **Non-Therapy** RUG from the 30-day assessment is then billed for the next payment period. The Non-Therapy RUG from the 30-day assessment is used since all therapy had previously ended.
5. Consider Example 5 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment.
- EXAMPLE 5. The End of Therapy OMRA assessment is performed with an ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25 through Day 30. The Medicare **Non-Therapy** RUG (Z150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.
6. Consider Example 6, a complicated example where an End of Therapy OMRA is performed, followed shortly by a scheduled PPS assessment, and then therapy is resumed at the prior level and this is reported with the Resumption of Therapy items (O0450A and O0450B) being added to the End of Therapy OMRA converting it to an End of Therapy OMRA reporting Resumption of Therapy (EOT-R).
- EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30-Day assessment is then performed with an ARD on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and the EOT-R items (O0450A, and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's

most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.

When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.

The first Change of Therapy OMRA evaluation occurs on Day 7 after the most recent assessment ARD (except in cases where the last assessment is an EOT-R, as outlined in Chapter 2) and the provision of therapy services are evaluated for the first COT observation period (Day 1 through Day 7 after the assessment ARD). If the provision of therapy services during this 7 day period no longer reflects the RUG-IV classification category on the most recent PPS assessment (as described in Chapter 2), then a Change of Therapy OMRA must be performed with the ARD on Day 7 of the COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed and changes in the provision of therapy services would next be evaluated on Day 14 after the most recent assessment ARD using the second COT observation period (Day 8 through Day 14 after the assessment ARD). If a different RUG-IV classification category results for Day 14, then a Change of Therapy OMRA must be performed with an ARD on Day 14, which is Day 7 of that COT observation period, and payment is set retroactively back to the beginning of that COT observation period.

If the provision of therapy services are reflective of the most recent PPS assessment RUG category classification, a Change of Therapy OMRA is not performed with an ARD on Day 14 and the evaluation of the change in therapy services provided would next be evaluated on Day 21 after the most recent assessment ARD using the third COT observation period (Day 15 through Day 21 after the assessment ARD). This process continues until the next scheduled or unscheduled PPS assessment used for payment. When a new PPS assessment is performed (Change of Therapy OMRA, any other unscheduled PPS assessment, or scheduled PPS assessment), then the COT OMRA evaluation process restarts the day following the ARD of that intervening assessment. If at any point, rehabilitation therapy ends before the last day of a COT observation period and an End of Therapy OMRA is performed with an ARD set for on or prior to Day 7 of the COT observation period, then the change of therapy evaluation process ends until the next PPS assessment used for payment reflecting the utilization of skilled therapy services.

7. Example 7 presents a case where a Change of Therapy OMRA is performed.

- **EXAMPLE 7.** The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were reflective of the RUG-IV classification

category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed with an ARD set for Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different Rehabilitation category results and a Change of Therapy OMRA is performed with an ARD set for Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the COT observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA.

8. If a new PPS assessment used for payment occurs with an ARD set for on or prior to the last day of a COT observation period, then a Change of Therapy OMRA is not required for that observation period. Example 8 illustrates this case.
  - **EXAMPLE 8.** An SCSPA is performed with an ARD of Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed with an ARD on Day 17. Rather, the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22.
9. Example 9 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a COT observation period.
  - **EXAMPLE 9.** The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No Change of Therapy OMRA is performed with an ARD on Day 21 and the change of therapy evaluation process is discontinued.

Table 3 presents the types of unscheduled assessments, the second AI digit associated with each assessment type, and the payment impact for standard payment periods.

**Table 3. Assessment Indicator Second Digit Table**

Second Digit Values	Assessment Type	Impact on Standard Payment Period
0	Either a scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment OR an OBRA assessment not coded as a PPS assessment	<ul style="list-style-type: none"> <li>No impact on the standard payment period (the assessment is not unscheduled).</li> <li>If the second digit value is 0, then the first digit must be 1 through 6, indicating a scheduled PPS assessment or an OBRA assessment not coded as a PPS assessment.</li> <li>If the first digit value is a 6, then the second digit value must be 0.</li> </ul>

(continued)

**STEP # 2**

Calculate the total minutes for occupational therapy as follows:

Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). If classification is for Medicare for FY2011 add all of the group minutes (O0400B3) and record as Total Minutes. Otherwise beginning with FY 2012, add one-quarter of the group minutes and record as Total Minutes. Total Minutes\* = \_\_\_\_\_

When the 25% group therapy limitation applies (i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes as follows:

If total group minutes (O0400B3) for FY2011 Medicare classification or allocated group minutes (one-quarter) for FY2012 Medicare classification divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400B1) and one-half of concurrent minutes (O0400B2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes\* = \_\_\_\_\_

Record Total Minutes or Adjusted Minutes as appropriate:

Occupational Therapy Minutes\* = \_\_\_\_\_

**STEP # 3**

Calculate the total minutes for physical therapy as follows:

Add the individual minutes (O0400C1) and one-half of the concurrent minutes (O0400C2). If classification is for Medicare for FY2011 add all of the group minutes (O0400C3) and record as Total Minutes. Otherwise beginning with FY 2012, add one-quarter of the group minutes and record as Total Minutes.

Total Minutes\* = \_\_\_\_\_

When the 25% group therapy limitation applies (i.e., for Medicare Part A residents for FY2011 or FY2012), calculate the adjusted total minutes as follows:

If total group minutes (O0400C3) for FY2011 Medicare classification or allocated group minutes (one-quarter) for FY2012 Medicare classification divided by Total Minutes (using group minutes allocation only for Medicare FY2012 classification) is greater than 0.25, then add individual minutes (O0400C1) and one-half of concurrent minutes (O0400C2), multiply this sum by 4.0 and then divide by 3.0, and record as Adjusted Minutes.

Adjusted Minutes\* = \_\_\_\_\_

Record Total Minutes or Adjusted Minutes as appropriate:

Physical Therapy Minutes\* = \_\_\_\_\_

## CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

### RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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Start the classification process beginning with the Rehabilitation Plus Extensive Services category. In order for a resident to qualify for this category, he/she must meet three requirements: (1) have an ADL score of 2 or more, (2) meet one of the criteria for the Extensive Services category, and (3) meet the criteria for one of the Rehabilitation categories.

#### STEP # 1

Check the resident's ADL score. If the resident's ADL score is 2 or higher, **go to Step #2.**

**If the ADL score is less than 2, skip to Category II now.**

#### STEP # 2

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Infection isolation while a resident

**If the resident does not receive one of these treatments or services, skip to Category II now.**

#### STEP # 3

Determine if the resident's rehabilitation therapy services (speech-language pathology services, or occupational or physical therapy) satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for a Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

- **Ultra High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the past 7 days:
  - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 720 minutes or more
  - and**
  - One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
  - and**
  - A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
  - Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUX
2-10	RUL

- **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
  1. In the last 7 days:
 

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more  
**and**  
At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
  2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVX
2-10	RVL

- **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
  1. In the last 7 days:
 

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more  
**and**  
At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days
  2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHX
2-10	RHL

- **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)
  1. In the last 7 days:
 

Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more  
**and**  
At least 5 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)
  2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMX
2-10	RML

- **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):
    1. In the last 7 days:
      - Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more  
**and**
      - At least 3 days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4)  
**and**
      - Two or more restorative nursing services\* received for 6 or more days for at least 15 minutes a day
    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**
      - Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes
- \*Restorative Nursing Services
- H0200C, H0500\*\* Urinary toileting program and/or bowel toileting program
  - O0500A,B\*\* Passive and/or active ROM
  - 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

**RUG-IV ADL Score**

2-16

**RUG-IV Class**

RLX

**RUG-IV Classification** \_\_\_\_\_

**If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.**

## CATEGORY II: REHABILITATION

### RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech-language pathology services, and is located in Section O (Items at O0400A,B,C). Nursing rehabilitation is also considered for the low intensity classification level. It consists of urinary or bowel toileting program, providing active or passive range of motion, providing splint/brace assistance, training in bed mobility or walking, training in transfer, training in dressing/grooming, training in eating/swallowing, training in amputation/prosthesis care, and training in communication. This information is found in Sections H0200C, H0500, and O0500.

#### STEP # 1

Determine whether the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-IV Rehabilitation categories. **If the resident does not meet all of the criteria for one Rehabilitation category (e.g., Ultra High Intensity), then move to the next category (e.g., Very High Intensity).**

#### A. Ultra High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:  
 Total Therapy Minutes (calculated on page 6-25 - 6-28) of 720 minutes or more  
**and**  
 One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days  
**and**  
 A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**  
 Medicare Short Stay Average Therapy Minutes (see page 6-19) of 144 minutes or more

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RUC
6-10	RUB
0-5	RUA

#### B. Very High Intensity Criteria (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:  
 Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more  
**and**  
 At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**  
 Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RVC
6-10	RVB
0-5	RVA

**C. High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:  
Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more  
**and**  
At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**  
Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RHC
6-10	RHB
0-5	RHA

**D. Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:  
Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more  
**and**  
At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4)
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**  
Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

<u>RUG-IV ADL Score</u>	<u>RUG-IV Class</u>
11-16	RMC
6-10	RMB
0-5	RMA

**E. Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:  
Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more  
**and**  
At least 3 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)  
**and**  
Two or more restorative nursing services\* received for 6 or more days for at least 15 minutes a day

2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:**

Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes

**\*Nursing Restorative Services**

H0200C, H0500\*\* Urinary toileting program and/or bowel toileting program

O0500A,B\*\* Passive and/or active ROM

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

**RUG-IV ADL Score**

11-16

0-10

**RUG-IV Class**

RLB

RLA

**RUG-IV Classification \_\_\_\_\_**

**If the resident does not classify in the Rehabilitation Category, proceed to Category III.**

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 early or late assessment scheduling practices may result in a review. The default rate (AAA) takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

### Early Assessment

An assessment must be completed according to the designated Medicare PPS assessment schedule. If a scheduled Medicare-required assessment or an OMRA is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-day assessment with an ARD of Day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

### Late Assessment

The SNF must complete a late assessment if the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare-required assessment (including the grace days) or an OMRA when the resident is still on Part A coverage. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period for which the Medicare-required assessment would have been effective, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of Day 41 would be paid the default rate for Days 31 through 40 and at the HIPPS classification from the assessment beginning on Day 41.

If the ARD of the late assessment is set after the end of the payment period for which the Medicare-required assessment would have been effective and the resident is still on Part A, the

provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period at the default rate regardless of the HIPPS code calculated from the late assessment. For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment that covers Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services.

## Missed Assessment

If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the resident is no longer a SNF Part A resident, and as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.

However, there are instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP system. 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.

In situations 2-6, the provider may use the OBRA Admission assessment to bill for all days of covered care associated with Medicare-required 5-day and 14-day assessments, even if the beneficiary is no longer receiving therapy services that were identified under the most recent clinical assessment. The ARD of the OBRA Admission assessment may be before or during the Medicare stay and does not have to fall within the ARD window of the 5-day or 14-day assessment.

When an OBRA Admission assessment does not exist, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the 5-day or the 14-day (including grace days) in order to receive full payment at the RUG category in which the resident grouped for days 1-14 **or** days 15-30. This assessment may only cover **one** payment period. If the ARD of the valid OBRA assessment falls

Term	Abbreviation	Definition
<b>Designated Local Contact Agency</b>		Each state has designated a local contact agency responsible for contacting the individual with information about community living options. This local contact agency 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 contractor. A list of LCA point of contacts can be found on CMS' website: <a href="https://www.cms.gov/CommunityServices/downloads/LCA_Point_of_Contact_List.pdf">https://www.cms.gov/CommunityServices/downloads/LCA_Point_of_Contact_List.pdf</a>
<b>Disorganized Thinking</b>		Having thoughts that are fragmented or not logically connected.
<b>Dose</b>		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."
<b>Down Syndrome</b>		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.
<b>Dually Certified Facilities</b>		Nursing facilities that participate in both the Medicare and Medicaid programs.
<b>Duplicate Assessment Error</b>		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.
<b>Entry Date</b>		The initial date of admission/entry to the nursing home, or the date on which the resident most recently re-entered the nursing home after being discharged (whether or not the return was anticipated).
<b>Epilepsy</b>		A chronic neurological disorder that is characterized by recurrent unprovoked seizures, as a result of abnormal neuronal activity in the brain.
<b>External Condom Catheter</b>		Device attached to the shaft of the penis like a condom and connected to a drainage bag.

(continued)

<b>Term</b>	<b>Abbreviation</b>	<b>Definition</b>
<b>Modification</b>		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.
<b>Monitoring</b>		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.
<b>Most Recent Medicare Stay</b>		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.
<b>Music Therapy</b>		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.
<b>National Drug Code</b>	<b>NDC</b>	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.
<b>National Provider Identifier</b>	<b>NPI</b>	A unique federal number that identifies providers of health care services. The NPI applies to the nursing facility for all of its residents.
<b>Nephrostomy Tube</b>		A catheter inserted through the skin into the kidney or its collecting system.

(continued)

<b>Term</b>	<b>Abbreviation</b>	<b>Definition</b>
<b>Non-medication Pain Intervention</b>		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.
<b>Non-pharmacological Intervention</b>		Approaches that do not involve the use of medication to address a medical condition.
<b>Nursing Facility</b>	<b>NF</b>	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.
<b>Nursing Monitoring</b>		Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).
<b>Nutrition or Hydration Intervention to Manage Skin Problems</b>		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.)
<b>Occupational Therapy</b>	<b>OT</b>	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 he or she is 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.

(continued)

## 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.

✓	<b>Indicators of Dehydration</b>	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Dehydration CAA triggered, indicating signs or symptoms of dehydration are present (J1550C)	
<input type="checkbox"/>	• Recent decrease in urine volume or more concentrated urine than usual (I and O) (clinical record)	
<input type="checkbox"/>	• Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss (K0300)	
<input type="checkbox"/>	• Nausea, vomiting (J1550B), diarrhea, or blood loss	
<input type="checkbox"/>	• Receiving intravenous drugs (O0100H)	
<input type="checkbox"/>	• Receiving diuretics or drugs that may cause electrolyte imbalance (medication administration record)(N0410G)	
✓	<b>Functional Status</b>	
<input type="checkbox"/>	• Recent decline in ADL status (Section G0110) (may be related to delirium) (C1300)	
<input type="checkbox"/>	• Increased risk for falls (J1700) (may be related to delirium) (See Falls CAA)	
✓	<b>Medications</b> (that may contribute to delirium)	
<input type="checkbox"/>	• New medication(s) or dosage increase(s)	
<input type="checkbox"/>	• Drugs with anticholinergic properties (for example, some antipsychotics (N0410A), antidepressants (N0410C), antiparkinsonian drugs, antihistamines)	
<input type="checkbox"/>	• Opioids (narcotic pain drug)	
<input type="checkbox"/>	• Benzodiazepines, especially long-acting agents (N0410B)	
<input type="checkbox"/>	• Analgesics, cardiac and GI medications, anti-inflammatory drugs	
<input type="checkbox"/>	• Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0410B)	
<input type="checkbox"/>	• Drug interactions (pharmacist review may be required)	
<input type="checkbox"/>	• Resident taking more than one drug from a particular class of drugs	
<input type="checkbox"/>	• Possible drug toxicity, especially if the person is dehydrated (J1550C) or has renal insufficiency (I1500). Check serum drug levels	

✓	<b>Functional limitations related to vision problems</b> (from clinical record, resident and staff interviews, direct observation)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Peripheral vision or other visual problem that impedes ability to eat, walk, or interact with others (B1000 = 3, 4)	
<input type="checkbox"/>	• Ability to recognize staff limited by vision problem (B1000 = 3, 4)	
<input type="checkbox"/>	• Difficulty negotiating the environment due to vision problem (B1000 = 3, 4)	
<input type="checkbox"/>	• Balance problems (G0300) exacerbated by vision problem (B1000, B1200)	
<input type="checkbox"/>	• Participation in self-care limited by vision problem (B1000)	
<input type="checkbox"/>	• Difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problem (B1000 = 2, 3, 4)	
<input type="checkbox"/>	• Increased risk for falls due to vision problems or due to bifocals or trifocals (B1200 = 1)	

✓	<b>Environment</b>	
<input type="checkbox"/>	• Is resident's environment adapted to his or her unique needs, such as availability of large print books, high wattage reading lamp, night light, etc.?	
<input type="checkbox"/>	• 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.?	

✓	<b>Medications</b> that can impair vision (consultant pharmacist review of medication regimen can be very helpful)	
<input type="checkbox"/>	• Narcotics	
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Antidepressants (N0410C)	
<input type="checkbox"/>	• Anticholinergics	
<input type="checkbox"/>	• Hypnotics (N0410D)	
<input type="checkbox"/>	• Other	

✓	<b>Use of visual appliances</b> (B1200)	
<input type="checkbox"/>	• Reading glasses	
<input type="checkbox"/>	• Distance glasses	
<input type="checkbox"/>	• Contact lenses	
<input type="checkbox"/>	• Magnifying glass	


**4. COMMUNICATION****Review of Indicators of Communication**

	<b>Diseases and conditions</b> that may be related to communication problems	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Alzheimer's Disease or other dementias (I4200, I4800, I8000)	
<input type="checkbox"/>	• Aphasia (I4300) following a cerebrovascular accident (I4500)	
<input type="checkbox"/>	• Parkinson's disease (I5300)	
<input type="checkbox"/>	• Mental health problems (I5700 – I6100)	
<input type="checkbox"/>	• Conditions that can cause voice production deficits, such as	
<input type="checkbox"/>	— Asthma (I6200)	
<input type="checkbox"/>	— Emphysema/COPD (I6200)	
<input type="checkbox"/>	— Cancer (I0100)	
<input type="checkbox"/>	— Poor-fitting dentures (L0200)	
<input type="checkbox"/>	• Transitory conditions, such as	
<input type="checkbox"/>	— Delirium (C1300, I8000, clinical record)	
<input type="checkbox"/>	— Infection (I1700 – I2500)	
<input type="checkbox"/>	— Acute illness (I8000, clinical record)	
<input type="checkbox"/>	• Other (I8000, clinical record)	
<input checked="" type="checkbox"/>	<b>Medications</b> (consultant pharmacist review of medication regimen can be very helpful)	
<input type="checkbox"/>	• Narcotic analgesics (medication administration record)	
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Antianxiety (N0410B)	
<input type="checkbox"/>	• Antidepressants (N0410C)	
<input type="checkbox"/>	• Parkinson's medications (medication administration record)	
<input type="checkbox"/>	• Hypnotics (N0410D)	
<input type="checkbox"/>	• Gentamycin (N0410F) (medication administration record)	
<input type="checkbox"/>	• Tobramycin (N0410F) (medication administration record)	
<input type="checkbox"/>	• Aspirin (medication administration record)	
<input type="checkbox"/>	• Other (clinical record)	

## 5. ACTIVITIES OF DAILY LIVING (ADLs) – FUNCTIONAL STATUS/REHABILITATION POTENTIAL

### Review of Indicators of ADLs - Functional Status/Rehabilitation Potential

	<b>Possible underlying problems</b> that may affect function. Some may be reversible.	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Delirium (C1300) (clinical record and Delirium CAA)	
<input type="checkbox"/>	• Acute episode or flare-up of chronic condition (I8000, clinical record)	
<input type="checkbox"/>	• Changing cognitive status (C0100) (see Cognitive Loss CAA)	
<input type="checkbox"/>	• Mood decline (D0100)(clinical record and Mood State CAA)	
<input type="checkbox"/>	• Daily behavioral symptoms/decline in behavior(E0200) (see Behavioral Symptoms CAA)	
<input type="checkbox"/>	• Use of physical restraints(P0100) (See Physical Restraints CAA)	
<input type="checkbox"/>	• Pneumonia (I2000)	
<input type="checkbox"/>	• Fall(J1700) (from record and Falls CAA)	
<input type="checkbox"/>	• Hip fracture (I3900)	
<input type="checkbox"/>	• Recent hospitalization (clinical record) (A1700, A1800= 3, 4)	
<input type="checkbox"/>	• Fluctuating ADLs (G0110A-J, G0120, G0300A-E, G0900) (observation, clinical record)	
<input type="checkbox"/>	• Nutritional problems (K0510A1, K0510A2) (clinical record and Nutrition CAA)	
<input type="checkbox"/>	• Pain(J0700) (See Pain CAA)	
<input type="checkbox"/>	• Dizziness	
<input type="checkbox"/>	• Communication problems (B0200, B0700, B0800) (clinical record and Communication CAA)	
<input type="checkbox"/>	• Vision problems(B1000) (observation, interview, clinical record, and Vision CAA)	

	<b>Abnormal laboratory values</b> (from clinical record)	
<input type="checkbox"/>	• Electrolytes	
<input type="checkbox"/>	• Complete blood count	
<input type="checkbox"/>	• Blood sugar	
<input type="checkbox"/>	• Thyroid function	
<input type="checkbox"/>	• Arterial blood gases	
<input type="checkbox"/>	• Other	

<input checked="" type="checkbox"/>	<b>Medications</b> that can contribute to functional decline	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Psychoactive medications (N0410A-D)	
<input type="checkbox"/>	• Other medications – ask consultant pharmacist to review medication regimen to identify these medications	

<input checked="" type="checkbox"/>	<b>Limiting factors</b> resulting in need for assistance with any of the ADLs (observation, interview, clinical record)	
<input type="checkbox"/>	• Mental errors such as sequencing problems, incomplete performance, or anxiety limitations	
<input type="checkbox"/>	• Physical limitations such as weakness (G0110A–J.1 = 2,3, 4) (G0110 A-J.2 = 2, 3), limited range of motion (G0400A = 1, 2, G0400B = 1, 2), poor coordination, poor balance (G0300A-E =2), visual impairment (B1000 = 1-4), or pain (J0300 = 1, J0700 =1)	
<input type="checkbox"/>	• Facility conditions such as policies, rules, or physical layout	

<input checked="" type="checkbox"/>	<b>Problems resident is at risk for</b> because of functional decline (from observation, assessment, clinical record)	
<input type="checkbox"/>	• Falls (J1700)	
<input type="checkbox"/>	• Weight loss (K0300)	
<input type="checkbox"/>	• Unidentified pain (J0700)	
<input type="checkbox"/>	• Social isolation	
<input type="checkbox"/>	• Restraint use (P0100)	
<input type="checkbox"/>	• Depression(D0100)	
<input type="checkbox"/>	• Complications of immobility, such as — Pressure ulcers (M0210) — Muscular atrophy — Contractures (G0400 A, B = 1, 2) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory infections	

		<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
✓	<b>Diseases and conditions</b>	
<input type="checkbox"/>	• Benign prostatic hypertrophy (I1400)	
<input type="checkbox"/>	• Congestive Heart Failure (CHF), pulmonary edema (I0600)	
<input type="checkbox"/>	• Cerebrovascular Accident (CVA) (I4500)	
<input type="checkbox"/>	• Transient Ischemic Attack (TIA) (I4500)	
<input type="checkbox"/>	• Diabetes (I2900)	
<input type="checkbox"/>	• Depression (I5800)	
<input type="checkbox"/>	• Parkinson's disease (I5300)	
<input type="checkbox"/>	• Prostate cancer (I0100)	

✓	<b>Type of incontinence</b>	
<input type="checkbox"/>	• Stress (occurs with coughing, sneezing, laughing, lifting heavy objects, etc.)	
<input type="checkbox"/>	• Urge (overactive or spastic bladder)	
<input type="checkbox"/>	• Mixed (stress incontinence with urgency)	
<input type="checkbox"/>	• Overflow (due to blocked urethra or weak bladder muscles)	
<input type="checkbox"/>	• Transient (temporary/occasional related to a potentially improvable/reversible cause)	
<input type="checkbox"/>	• Functional (can't get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating)	

✓	<b>Medications</b> (from medication administration record and preadmission records if new admission; review by consultant pharmacist)	
<input type="checkbox"/>	• Diuretics(N0410G)– can cause urge incontinence	
<input type="checkbox"/>	• Sedative hypnotics (N0410B, N0410D)	
<input type="checkbox"/>	• Anticholinergics – can lead to overflow incontinence <ul style="list-style-type: none"> <li>— Parkinson's medications (except Sinemet and Deprenyl)</li> <li>— Disopyramide</li> <li>— Antispasmodics</li> <li>— Antihistamines</li> <li>— Antipsychotics (N0410A)</li> <li>— Antidepressants (N0410C)</li> <li>— Narcotics</li> </ul>	
<input type="checkbox"/>	• Drugs that stimulate or block sympathetic nervous system	
<input type="checkbox"/>	• Calcium channel blockers	

✓	<b>Medications</b> (from medication administration record and preadmission records if new admission)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Antibiotics (N0410F)	
<input type="checkbox"/>	• Anticholinergics	
<input type="checkbox"/>	• Antihypertensives	
<input type="checkbox"/>	• Anticonvulsants	
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Cardiac medications	
<input type="checkbox"/>	• Cimetidine	
<input type="checkbox"/>	• Clonidine	
<input type="checkbox"/>	• Chemotherapeutic agents	
<input type="checkbox"/>	• Digitalis	
<input type="checkbox"/>	• Other	
<input type="checkbox"/>	• Glaucoma medications	
<input type="checkbox"/>	• Guanethidine	
<input type="checkbox"/>	• Immuno-suppressive medications	
<input type="checkbox"/>	• Methyldopa	
<input type="checkbox"/>	• Narcotics	
<input type="checkbox"/>	• Nitrates	
<input type="checkbox"/>	• Propranolol	
<input type="checkbox"/>	• Reserpine	
<input type="checkbox"/>	• Steroids	
<input type="checkbox"/>	• Stimulants	

✓	<b>Laboratory tests</b>	
<input type="checkbox"/>	• Serum calcium	
<input type="checkbox"/>	• Thyroid function	
<input type="checkbox"/>	• Blood glucose	
<input type="checkbox"/>	• Potassium	
<input type="checkbox"/>	• Porphyrria	

✓	<b>Health issues</b> that result in reduced activity participation	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Indicators of depression or anxiety (D0200, D0300, D0500, D0600)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Use of psychoactive medications (N0410A-N0410D)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Functional/mobility (G0110) or balance (G0300) problems; physical disability (G0300, G0400)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Cognitive deficits (C0500, C0700-C1000), including stamina, ability to express self (B0700), understand others (B0800), make decisions (C1000)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Unstable acute/chronic health problem (clinical record, O0100, J0100, J1100, J0700, J1400, J1550, I8000, M1040, M1200)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Chronic health conditions, such as incontinence (H0300, H0400) or pain (J0300)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Embarrassment or unease due to presence of equipment (O0100D, E, F), such as tubes, oxygen tank (O0100C), or colostomy bag (H0100) (observation, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Receives numerous treatments (O0100, O0400) that limit available time/energy (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Performs tasks slowly due to reduced energy reserves (observation, clinical record)</li> </ul>	

✓	<b>Environmental or staffing issues</b> that hinder participation	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Physical barriers that prevent the resident from gaining access to the space where the activity is held (observation)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Need for additional staff responsible for social activities (observation)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Lack of staff time to involve residents in current activity programs (observation)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Resident's fragile nature results in feelings of intimidation by staff responsible for the activity (from observation, interviews, clinical record)</li> </ul>	

		<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
✓	<b>Medications</b>	
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Antianxiety agents (N0410B)	
<input type="checkbox"/>	• Antidepressants (N0410C)	
<input type="checkbox"/>	• Hypnotics (N0410D)	
<input type="checkbox"/>	• Cardiovascular medications (from medication administration record)	
<input type="checkbox"/>	• Diuretics (N0410G) (from medication administration record)	
<input type="checkbox"/>	• Narcotic analgesics (from medication administration record)	
<input type="checkbox"/>	• Neuroleptics (from medication administration record)	
<input type="checkbox"/>	• Other medications that cause lethargy or confusion (from medication administration record)	

✓	<b>Internal risk factors</b> (from diagnosis list and clinical indicators)	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Circulatory/Heart               <ul style="list-style-type: none"> <li>— Anemia (I0200)</li> <li>— Cardiac Dysrhythmias (I0300)</li> <li>— Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400)</li> <li>— Congestive Heart Failure (CHF) pulmonary edema (I0600)</li> <li>— Cerebrovascular Accident (CVA) (I4500)</li> <li>— Transient Ischemic Attack (TIA) (I4500)</li> <li>— Postural/Orthostatic hypotension (I0800)</li> </ul> </li> </ul>	

(continued)

	<b>Other diseases and conditions</b> that can affect appetite or nutritional needs (continued)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Radiation therapy (O0100B)	
<input type="checkbox"/>	• Recent acute illness (I8000)	
<input type="checkbox"/>	• Recent surgical procedure (I8000) (M1200F)	
<input type="checkbox"/>	• Renal disease (I1500)	
<input type="checkbox"/>	• Respiratory disease (I6200)	
<input type="checkbox"/>	• Thyroid problem (I3400)	
<input type="checkbox"/>	• Weight loss (K0300)	
<input type="checkbox"/>	• Weight gain (K0310)	

	<b>Abnormal laboratory values</b> (from clinical record)	
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Electrolytes	
<input type="checkbox"/>	• Pre-albumin level	
<input type="checkbox"/>	• Plasma transferrin level	
<input type="checkbox"/>	• Others	

	<b>Medications</b> (from medication administration record and preadmission records if new admission)	
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Chemotherapy (O0100A)	
<input type="checkbox"/>	• Cardiac drugs	
<input type="checkbox"/>	• Diuretics (N0410G)	
<input type="checkbox"/>	• Anti-inflammatory drug	
<input type="checkbox"/>	• Anti-Parkinson's drugs	
<input type="checkbox"/>	• Laxatives	
<input type="checkbox"/>	• Antacids	
<input type="checkbox"/>	• Start of a new drug	

	<b>Environmental factors</b> (from direct observation and clinical record)	
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Sufficient eating assistance	
<input type="checkbox"/>	• Availability of adaptive equipment	
<input type="checkbox"/>	• Dining environment fosters pleasant social experience	
<input type="checkbox"/>	• Appropriate lighting	
<input type="checkbox"/>	• Sufficient personal space during meals	
<input type="checkbox"/>	• Proper positioning in wheelchair/chair for dining	

		<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
✓	<b>Psychosocial issues</b> related to tube feeding	
<input type="checkbox"/>	• Signs of depression ((D0300, D0600, I5800); see Mood State CAA)	
<input type="checkbox"/>	• Ways to socially engage the resident with a feeding tube	
<input type="checkbox"/>	• Emotional and social support from social workers, other members of the healthcare team	

✓	<b>Periodic evaluations and consultations</b>	
<input type="checkbox"/>	• Weight check at least monthly (K0300, K0310)	
<input type="checkbox"/>	• Lab tests to monitor electrolytes, serum albumin, hematocrit	
<input type="checkbox"/>	• Periodic evaluations by nutritionist or dietitian	
<input type="checkbox"/>	• Periodic evaluation of possibility of resuming oral feeding	
<input type="checkbox"/>	• Regular changing and replacement of PEG tubes and J-tubes, per physician order and facility protocol (K0510B1, K0510B2)	

✓	<b>Factors that may impede removal of feeding tube</b>	
<input type="checkbox"/>	• Comatose (B0100)	
<input type="checkbox"/>	• Failure to eat and resists assistance in eating (E0800)	
<input type="checkbox"/>	• Cerebrovascular accident (I4500)	
<input type="checkbox"/>	• Gastric ulcers, gastric bleeding, or other stomach disorder (I1200, I1300)	
<input type="checkbox"/>	• Chewing problems unresolvable (L0200F)	
<input type="checkbox"/>	• Swallowing problems (K0100) unresolvable	
<input type="checkbox"/>	• Mouth pain (L0200F)	
<input type="checkbox"/>	• Anorexia (I8000)	
<input type="checkbox"/>	• Lab values indicating compromised nutritional status	
<input type="checkbox"/>	• Significant weight loss (K0300)	
<input type="checkbox"/>	• Significant weight gain (K0310)	
<input type="checkbox"/>	• Prolonged illness	
<input type="checkbox"/>	• Neurological disorder (I4200 – I5500)	
<input type="checkbox"/>	• Cancer or side effects of cancer treatment (I0100, clinical record)	
<input type="checkbox"/>	• Advanced dementia (I4800)	

✓	<b>Cognitive, communication, and mental status</b> issues that can interfere with intake	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Depression (I5800, D0300, D0600) or anxiety (I5700)	
<input type="checkbox"/>	• Behavioral disturbance that interferes with intake (E0200, clinical record)	
<input type="checkbox"/>	• Recent change in mental status (C1600)	
<input type="checkbox"/>	• Alzheimer's or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating/drinking, etc. (I4200, I4800)	
<input type="checkbox"/>	• Difficulty making self understood (B0700)	
<input type="checkbox"/>	• Difficulty understanding others (B0800)	

✓	<b>Diseases and conditions</b> that predispose to limitations in maintaining normal fluid balance	
<input type="checkbox"/>	• Infection (I1700 – I2500)	
<input type="checkbox"/>	• Fever (J1550A)	
<input type="checkbox"/>	• Diabetes (I2900)	
<input type="checkbox"/>	• Congestive heart failure (I0600)	
<input type="checkbox"/>	• Swallow problem (K0100)	
<input type="checkbox"/>	• Renal disease (I1500)	
<input type="checkbox"/>	• Weight loss (K0300)	
<input type="checkbox"/>	• Weight gain (K0310)	
<input type="checkbox"/>	• New cerebrovascular accident (clinical record, I4500)	
<input type="checkbox"/>	• Unstable acute or chronic condition (clinical record, I8000)	
<input type="checkbox"/>	• Nausea or vomiting (J1550B)	
<input type="checkbox"/>	• Diarrhea (clinical record)	
<input type="checkbox"/>	• Excessive sweating (clinical record)	
<input type="checkbox"/>	• Recent surgery (clinical record, I8000)	
<input type="checkbox"/>	• Recent decline in activities of daily living (G0110), including body control or hand control problems, inability to sit up (G0300), etc. (observation, interview, clinical record)	
<input type="checkbox"/>	• Parkinson's or other neurological disease that requires unusually long time to eat (I4200 – I5500)	
<input type="checkbox"/>	• Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, J1550B)	

(continued)

✓	<b>Diseases and conditions</b> that predispose to limitations in maintaining normal fluid balance (continued)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Newly taking a diuretic or recent increase in diuretic dose (N0410G) (medication records)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Takes excessive doses of a laxative (interview, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Hot weather (increases risk for elderly in absence of increased fluid intake)</li> </ul>	

✓	<b>Oral intake</b> (from observation and clinical record)	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Recent change in oral intake</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Skips meals or consumes less than 25 percent of meals</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Fluid restriction</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Newly prescribed diet</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Decreased perception of thirst</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Limited fluid-drinking opportunities</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Fluid intake limited to try to control incontinence</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Dependence on staff for fluid intake</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Excessive output compared to fluid intake</li> </ul>	

**15. DENTAL CARE****Review of Indicators of Oral/Dental Condition/Problem**

		<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
<input checked="" type="checkbox"/>	<b>Cognitive problems</b> that contribute to oral/dental problems	
<input type="checkbox"/>	• Needs reminders to clean teeth	
<input type="checkbox"/>	• Cannot remember steps to complete oral hygiene	
<input type="checkbox"/>	• Decreased ability to understand others (B0800) or to perform tasks following demonstration	
<input type="checkbox"/>	• Cognitive deficit (C0500, C0700 – C1000)	

<input checked="" type="checkbox"/>	<b>Functional impairment</b> limiting ability to perform personal hygiene	
<input type="checkbox"/>	• Loss of voluntary arm movement (G0400A)	
<input type="checkbox"/>	• Impaired hand dexterity (G0400A)	
<input type="checkbox"/>	• Functional limitation in upper extremity range of motion (G0400A)	
<input type="checkbox"/>	• Decreased mobility (G0110)	
<input type="checkbox"/>	• Resists assistance with activities of daily living (E0800)	
<input type="checkbox"/>	• Lacks motivation or knowledge regarding adequate oral hygiene, dental care	
<input type="checkbox"/>	• Requires adaptive equipment for oral hygiene	

<input checked="" type="checkbox"/>	<b>Dry mouth</b> causing buildup of oral bacteria	
<input type="checkbox"/>	• Dehydration (see Dehydration/Fluid Maintenance CAA)	
<input type="checkbox"/>	• Medications (from MDS and medication administration record) — Antipsychotics (N0410A) — Antidepressants (N0410C) — Antianxiety agents (N0410B) — Sedatives/hypnotics (N0410D) — Diuretics (N0410G) — Antihypertensives — Antiparkinsons medications — Narcotics — Anticonvulsants — Antihistamines — Decongestants — Antiemetics	
<input type="checkbox"/>	• Antineoplastics	

## 16. PRESSURE ULCER(S)

### Review of Indicators of Pressure Ulcer(s)

✓	<b>Existing pressure ulcer(s) (M0100)</b>	<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
☐	<ul style="list-style-type: none"> <li>Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin (M0610)               <ul style="list-style-type: none"> <li>Note if eschar or slough is present (M0300F, M0700 = 4)</li> <li>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</li> <li>Note whether granulation tissue (required for healing) is present and the wound is healing as expected (M0700 = 2)</li> </ul> </li> </ul>	
☐	<ul style="list-style-type: none"> <li>If the ulcer does not show signs of healing despite treatment, consider complicating factors               <ul style="list-style-type: none"> <li>Elevated bacterial level in the absence of clinical infection</li> <li>Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed</li> <li>Underlying osteomyelitis (bone infection)</li> </ul> </li> </ul>	
✓	<b>Extrinsic risk factors</b>	
☐	<ul style="list-style-type: none"> <li>Pressure               <ul style="list-style-type: none"> <li>Requires staff assistance to move sufficiently to relieve pressure over any one site</li> <li>Confined to a bed or chair all or most of the time</li> <li>Needs special mattress or seat cushion to reduce or relieve pressure (M1200A, M1200B)</li> <li>Requires regular schedule of turning (M1200C)</li> </ul> </li> </ul>	
☐	<ul style="list-style-type: none"> <li>Friction and shear               <ul style="list-style-type: none"> <li>Slides down in the bed</li> <li>Moved by sliding rather than lifting</li> </ul> </li> </ul>	
☐	<ul style="list-style-type: none"> <li>Maceration               <ul style="list-style-type: none"> <li>Persistently wet, especially from fecal incontinence, wound drainage, or perspiration</li> <li>Moisture associated skin damage (M1040H)</li> </ul> </li> </ul>	

		<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
✓	<b>Intrinsic risk factors</b>	
<input type="checkbox"/>	• Immobility (G0110)	
<input type="checkbox"/>	• Altered mental status — Delirium limits mobility (see Delirium CAA) — Cognitive loss (C0500, C0700-C1000) limits mobility (see Cognitive Loss CAA)	
<input type="checkbox"/>	• Incontinence (H0300, H0400, M1040H) (see Incontinence CAA)	
<input type="checkbox"/>	• Poor nutrition (see Nutrition CAA)	

✓	<b>Medications</b> that increase risk for pressure ulcer development	
<input type="checkbox"/>	• Antipsychotics (N0410A)	
<input type="checkbox"/>	• Antianxiety agents (N0410B)	
<input type="checkbox"/>	• Antidepressants (N0410C)	
<input type="checkbox"/>	• Hypnotics (N0410D)	
<input type="checkbox"/>	• Steroids	
<input type="checkbox"/>	• Narcotics	

✓	<b>Diagnoses and conditions</b> that present complications or increase risk for pressure ulcers	
<input type="checkbox"/>	• Delirium (C1600)	
<input type="checkbox"/>	• Comatose (B0100)	
<input type="checkbox"/>	• Cancer (I0100)	
<input type="checkbox"/>	• Peripheral Vascular Disease (I0900)	
<input type="checkbox"/>	• Diabetes (I2900)	
<input type="checkbox"/>	• Alzheimer's disease (I4200)	
<input type="checkbox"/>	• Cerebrovascular Accident (I4500)	
<input type="checkbox"/>	• Other dementia (I4800)	
<input type="checkbox"/>	• Hemiplegia/hemiparesis (I4900)	
<input type="checkbox"/>	• Paraplegia (I5000), Quadriplegia (I5100)	
<input type="checkbox"/>	• Multiple sclerosis (I5200)	
<input type="checkbox"/>	• Depression (D0300, D0600, I5800)	
<input type="checkbox"/>	• Edema	
<input type="checkbox"/>	• Severe pulmonary disease (I6200)	
<input type="checkbox"/>	• Sepsis (I2100)	
<input type="checkbox"/>	• Terminal illness (O0100K)	

(continued)

✓	<b>Diagnoses and conditions</b> that present complications or increase risk for pressure ulcers (continued)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Chronic or end-stage renal (I1500) , liver, or heart disease (I0400, I0600)	
<input type="checkbox"/>	• Pain (J0300)	
<input type="checkbox"/>	• Dehydration (J1500C, I8000)	
<input type="checkbox"/>	• Shortness of breath (J1100)	
<input type="checkbox"/>	• Recent weight loss (K0300)	
<input type="checkbox"/>	• Recent weight gain (K0310)	
<input type="checkbox"/>	• Malnutrition (I5600)	
<input type="checkbox"/>	• Decreased sensory perception	
<input type="checkbox"/>	• Recent decline in Activities of Daily Living (ADLs) (G0110-G0600)	

✓	<b>Treatments and other factors</b> that cause complications or increase risk	
<input type="checkbox"/>	• Newly admitted or readmitted (A1700)	
<input type="checkbox"/>	• History of healed pressure ulcer(s) (M0900)	
<input type="checkbox"/>	• Chemotherapy (O0100A)	
<input type="checkbox"/>	• Radiation therapy (O0100B)	
<input type="checkbox"/>	• Ventilator or respirator (O0100F)	
<input type="checkbox"/>	• Renal dialysis (O0100J)	
<input type="checkbox"/>	• Functional limitation in range of motion (G0400)	
<input type="checkbox"/>	• Head of bed elevated most or all of the time	
<input type="checkbox"/>	• Physical restraints (P0100)	
<input type="checkbox"/>	• Devices that can cause pressure, such as oxygen (O0100C) or indwelling catheter (H0100A) tubing, TED hose, casts, or splints	

**17. PSYCHOTROPIC MEDICATION USE****Review of Indicators of Psychotropic Drug Use**

	<b>Class(es) of medication</b> this resident is taking	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input checked="" type="checkbox"/>		
<input type="checkbox"/>	• Antipsychotic (N0410A)	
<input type="checkbox"/>	• Antianxiety (N0410B)	
<input type="checkbox"/>	• Antidepressant (N0410C)	
<input type="checkbox"/>	• Sedative/Hypnotic (N0410D)	

<input checked="" type="checkbox"/>	<b>Unnecessary drug evaluation</b> (from clinical record)	
<input type="checkbox"/>	• Excessive dose, including duplicate medications	
<input type="checkbox"/>	• Excessive duration and/or without gradual dose reductions	
<input type="checkbox"/>	• Inadequate monitoring for effectiveness and/or adverse consequences	
<input type="checkbox"/>	• Inadequate or inappropriate indications for use	
<input type="checkbox"/>	• In presence of adverse consequences of the drug	

<input checked="" type="checkbox"/>	<b>Treatable/reversible reasons for use of</b> psychotropic drug	
<input type="checkbox"/>	• Environmental stressors such as excessive heat, noise, overcrowding, etc. (observation, clinical record)	
<input type="checkbox"/>	• Psychosocial stressors such as abuse, taunting, not following resident's customary routine, etc. (observation, clinical record) (F0300 – F0800)	
<input type="checkbox"/>	• Treatable medical conditions, such as heart disease (I0200 – I0900) , diabetes (I2900), or respiratory disease (from medical evaluation) (I6200, I6300)	

✓	<b>Adverse consequences of ANTIDEPRESSANTS</b> exhibited by this resident	<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
<input type="checkbox"/>	• Worsening of depression and/or suicidal behavior or thinking (D0350, D0650, V0100E, V0100F, clinical record)	
<input type="checkbox"/>	• Delirium unrelated to medical illness or severe depression (C1600, clinical record)	
<input type="checkbox"/>	• Hallucinations (E0100A)	
<input type="checkbox"/>	• Dizziness (clinical record)	
<input type="checkbox"/>	• Nausea (clinical record)	
<input type="checkbox"/>	• Diarrhea (clinical record)	
<input type="checkbox"/>	• Anxiety (I5700, clinical record)	
<input type="checkbox"/>	• Nervousness, fidgety or restless (clinical record)	
<input type="checkbox"/>	• Insomnia (clinical record)	
<input type="checkbox"/>	• Somnolence (clinical record)	
<input type="checkbox"/>	• Weight gain (K0310, clinical record)	
<input type="checkbox"/>	• Anorexia or increased appetite (clinical record)	
<input type="checkbox"/>	• Increased risk for falls (clinical record), falls (J1700-J1900)	
<input type="checkbox"/>	• Seizures (I5400)	
<input type="checkbox"/>	• Hypertensive crisis if combined with certain foods, cheese, wine (MAO inhibitors)	
<input type="checkbox"/>	• Anticholinergic (tricyclics), such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)	
<input type="checkbox"/>	• Postural hypotension (tricyclics) (I0800, clinical record)	

✓	<b>Adverse consequences of ANTIPSYCHOTICS</b> exhibited by this resident	
<input type="checkbox"/>	• Anticholinergic effects, such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)	
<input type="checkbox"/>	• Increase in total cholesterol and triglycerides (clinical record)	
<input type="checkbox"/>	• Akathisia (inability to sit still) (clinical record)	
<input type="checkbox"/>	• Parkinsonism (any combination of tremors, postural unsteadiness, muscle rigidity, pill-rolling of hands, shuffling gait, etc.) (clinical record)	

(continued)

✓	<b>Adverse consequences of SEDATIVES/HYPNOTICS</b> exhibited by this resident	<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>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 (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Hypotension (I0800, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Dizziness, lightheadedness (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>“Hangover” effect (interview, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Drowsiness (observation, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Confusion, delirium unrelated to acute illness or severe depression (C1600, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Mental depression (I5800, I5900)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Unusual excitement (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Nervousness (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Headache (interview, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Insomnia (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Nightmares (interview, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Hallucinations (E0100A)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Falls (J1700-J1900)</li> </ul>	

✓	<b>Drug-related discomfort</b> requiring treatment and/or prevention	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Dehydration (J1550C, I8000)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Reduced dietary bulk (from observation of food intake)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Lack of exercise (observation, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Constipation/fecal impaction (H0600, clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Urinary retention (clinical record)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Dry mouth (interview, clinical record)</li> </ul>	

✓	<b>Overall status change</b> for relationship to psychotropic drug use (from clinical record)	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Major differences in a.m./p.m. performance</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Decline in cognition/communication (V0100D)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Decline in mood (V0100E, V0100F)</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Decline in behavior</li> </ul>	
<input type="checkbox"/>	<ul style="list-style-type: none"> <li>Decline in Activities of Daily Living (ADLs) (G0110)</li> </ul>	

**18. PHYSICAL RESTRAINTS****Review of Indicators of Physical Restraints**

✓	<b>Evaluation of current restraint use</b> (based on chart documentation, including care plan)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA)	
<input type="checkbox"/>	• Evidence of informed consent not evident on chart	
<input type="checkbox"/>	• Medical symptom not identified for treatment via restraints	
<input type="checkbox"/>	• Used for staff convenience	
<input type="checkbox"/>	• Used for discipline purposes	
<input type="checkbox"/>	• Multiple restraints in use	
<input type="checkbox"/>	• Non-restraint interventions not attempted prior to restraining	
<input type="checkbox"/>	• Less restrictive devices not attempted	
<input type="checkbox"/>	• No regular schedule for removing restraints	
<input type="checkbox"/>	• No schedule for frequency by hour of the day for checking on resident's well-being	
<input type="checkbox"/>	• No plan for reducing/eliminating restraints	

✓	<b>Medical conditions/treatments that may lead to restraint use</b>	
<input type="checkbox"/>	• Indwelling catheter (H0100A), external catheter (H0100B), or ostomy (H0100C)	
<input type="checkbox"/>	• Parenteral/IV feeding (K0510A1, K0510A2)	
<input type="checkbox"/>	• Feeding tube (K0510B1, K0510B2)	
<input type="checkbox"/>	• Pressure ulcer (M0210) or pressure ulcer care (M1200E)	
<input type="checkbox"/>	• Other skin ulcers, wounds, skin problems (M1040) or wound care (M1200F-M1200I)	
<input type="checkbox"/>	• Oxygen therapy (O0100C)	
<input type="checkbox"/>	• Tracheostomy (O0100E, clinical record)	
<input type="checkbox"/>	• Ventilator or respirator (O0100F)	
<input type="checkbox"/>	• IV medications (O0100H)	
<input type="checkbox"/>	• Transfusions (O0100I)	
<input type="checkbox"/>	• Functional decline, decreased mobility (clinical record)	
<input type="checkbox"/>	• Other medical problem or equipment associated with restraint use (clinical record)	

		<b>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</b>
✓	<b>Adverse reaction to restraint use</b>	
<input type="checkbox"/>	• Skin breakdown (Section M)	
<input type="checkbox"/>	• Incontinence or increased incontinence (H0300, H0400, clinical record)	
<input type="checkbox"/>	• Moisture associated skin damage (M1040H)	
<input type="checkbox"/>	• Constipation (H0600)	
<input type="checkbox"/>	• Increased agitation behavior (E0200, clinical record) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.	
<input type="checkbox"/>	• Depression, withdrawal, diminished dignity, social isolation (I5800, I5900, clinical record)	
<input type="checkbox"/>	• Loss of muscle mass, contractures, lessened mobility (G0110, G0300, G0400) and stamina (clinical record)	
<input type="checkbox"/>	• Infections, such as UTI or pneumonia (I1700 – I2500)	
<input type="checkbox"/>	• Frequent attempts to get out of the restraints (P0100), falls (J1700 – J1900, clinical record)	

## 19. PAIN

### Review of Indicators of Pain

✓	<b>Diseases and conditions that may cause pain</b> (diagnosis OR signs/symptoms present)	<b>Supporting Documentation</b> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Cancer (I0100)	
<input type="checkbox"/>	• Circulatory/heart — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Deep Vein Thrombosis (I0500) — Peripheral Vascular Disease (I0900)	
<input type="checkbox"/>	• Skin/Wound — Pressure ulcer (section M) — Other ulcers, wounds, incision, skin problems (M1040) — Moisture associated skin damage (M1040H)	
<input type="checkbox"/>	• Infections — Urinary tract infection (I2300) — Pneumonia (I2000)	
<input type="checkbox"/>	• Neurological (I4200 – I5500) — Head trauma (clinical record) — Headache — Neuropathy — Post-stroke syndrome	
<input type="checkbox"/>	• Gastrointestinal — Gastroesophageal Reflux Disease/Ulcer (I1200) — Ulcerative Colitis/Crohn's Disease/Inflammatory Bowel Disease (I1300) — Constipation (H0600, clinical record, resident interview)	
<input type="checkbox"/>	• Hospice care (O0100K)	
<input type="checkbox"/>	• Musculoskeletal — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Other fracture (I4000) — Back problems (I8000) — Amputation (O0500) — Other (I8000)	
<input type="checkbox"/>	• Dental problems (section L) (L0200)	

## 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.*

- Advancing Excellence in America's Nursing Homes Resources:  
[http://www.nhqualitycampaign.org/star\\_index.aspx?controls=resImplementationGuides](http://www.nhqualitycampaign.org/star_index.aspx?controls=resImplementationGuides);
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: <http://www.ahrq.gov/clinic/>;
- Alzheimer's Association Resources:  
[http://www.alz.org/professionals\\_and\\_researchers\\_14899.asp#professional](http://www.alz.org/professionals_and_researchers_14899.asp#professional);
- American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version):  
<http://www.eatright.org/About/Content.aspx?id=8373>;
- American Geriatrics Society Clinical Practice Guidelines and Tools:  
[http://www.americangeriatrics.org/health\\_care\\_professionals/clinical\\_practice/featured\\_programs\\_products/](http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_programs_products/);
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: <http://www.amda.com/tools>;
- American Pain Society: [http://www.ampainsoc.org/pub/cp\\_guidelines.htm](http://www.ampainsoc.org/pub/cp_guidelines.htm);
- American Society of Consultant Pharmacists Practice Resources:  
<http://www.ascp.com/articles/professional-development/clinical-practice-resources>;
- Association for Professionals in Infection Control and Epidemiology Practice Resources:  
<http://www.apic.org/AM/Template.cfm?Section=Practice>;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: [http://www.cdc.gov/HAI/settings/ltc\\_settings.html](http://www.cdc.gov/HAI/settings/ltc_settings.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): [http://cms.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltc.pdf](http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltc.pdf);
- Emerging Solutions in Pain Tools: <http://www.emergingsolutionsinpain.com/>;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools:  
<http://www.hartfordign.org/resources>;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content:  
<http://www.hartfordign.org/practice/consultgerirn/>;
- Improving Nursing Home Culture (CMS Special Study):  
<http://www.healthcentricadvisors.org/images/stories/documents/inhc.pdf>
- Institute for Safe Medication Practices: <http://www.ismp.org/>;
- Quality Improvement Organizations:  
<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793>

- **Sit where the resident can see you clearly and you can see his or her expressions.**
  - Have your face well lighted.
  - Minimize glare.
  - Ask the resident where you should sit so that he or she 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 his or her 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.

**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 his or her response by first echoing what he or she 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 he or she prefers.
- **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 he or she should have said.
- **If the resident becomes deeply sorrowful or agitated**, sympathetically respond to his or her feelings.
  - Allowing emotional expression—even when it is uncomfortable for you as the interviewer—recognizes its validity and provides cathartic support to residents.

- If the resident remains agitated or overly emotional and does not want to continue, respond to his or her 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 his or her 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.

## 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. In the example,  $9 \times 1.286 = 11.250$ .
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
<b>D0600</b>	<b>11</b>

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. In the example,  $8 \times 1.286 = 11.250$ .
3. Round the result to the nearest integer. In the example, 11.250 rounds to 11.
4. Place the rounded result in D0600.

## APPENDIX G: REFERENCES

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC. American Psychiatric Association, 1994.

Baker, D.W., Cameron, K.A., Feinglass, J., Georgas, P., Foster, S., Pierce, D., Thompson, J.A., and Hasnain-Wynia, R.: Patients' attitudes toward health care providers collecting information about their race and ethnicity. J. Gen. Intern. Med. 20:895-900, 2005.

Bergstrom, N., Smout, R., Horn, S., Spector, W., Hartz, A., and Limcangco, M.R.: Stage 2 pressure ulcer healing in nursing homes. Journal of the American Geriatrics Society 56(7):1252-1258, 14 May 2008.

Centers for Disease Control and Prevention: 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Available from <http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf>.

Centers for Disease Control and Prevention: The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases, 12th ed. Available from <http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters>

Centers for Disease Control and Prevention: Prevention of pneumococcal disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Recommended Adult Immunization Schedule – United States. MMWR Recomm. Rep. 57(53); Q1-Q-4, Jan. 9, 2009.

Centers for Medicare & Medicaid Services: HIPPS Codes. Jun. 22, 2009; retrieved Nov. 18, 2009, from [http://www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/02\\_HIPPSCodes.asp#TopOfPage](http://www.cms.hhs.gov/PropMedicareFeeSvcPmtGen/02_HIPPSCodes.asp#TopOfPage)

Centers for Medicare & Medicaid Services: MDS 3.0 Data Submission Specifications. Available from [http://www.cms.gov/NursingHomeQualityInits/30\\_NHQIMDS30TechnicalInformation.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage)

Centers for Medicare & Medicaid Services: MDS 3.0 for Nursing Home. Available from [http://www.cms.gov/NursingHomeQualityInits/30\\_NHQIMDS30TechnicalInformation.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage)

Centers for Medicare & Medicaid Services: Medicare Benefit Policy Manual (Pub. 100-2). Available from <http://www.cms.hhs.gov/manuals/iom/List.asp>

Centers for Medicare & Medicaid Services: Medicare Claims Processing Manual (Pub. 100-4). <http://www.cms.hhs.gov/manuals/iom/List.asp>

Centers for Medicare & Medicaid Services: Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1). Available from <http://www.cms.hhs.gov/manuals/iom/List.asp>

Centers for Medicare & Medicaid Services: Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Jun. 22, 2007; retrieved Oct. 16, 2009, from <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf>

Centers for Medicare & Medicaid Services: Minimum Data Set (MDS) 3.0 Provider User's Guide. Available from <https://www.qtso.com/mds30.html>

Centers for Medicare & Medicaid Services: State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Section 483.20(b) Utilization Guidelines for Completion of the RAI. Available from [http://cms.hhs.gov/manuals/Downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf)

Folstein, M.F., Folstein, S.E., and McHugh, P.R.: "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. J. Psychiatr. Res. 12(3):189-198, Nov. 1975.

Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh). CMS NH QIOSC Contract. Providence, RI. 2006. Available from <http://healthcentricadvisors.org/images/stories/documents/inhc.pdf>.

Inouye, S.K., Van Dyck, C.H., Alessi, C.A., et al.: Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann. Intern. Med. 113(12):941-948, 1990.

Institute of Medicine: Improving the Quality of Care in Nursing Homes. Washington, DC. National Academy Press, 1986.

National Institute of Mental Health: Suicide and the Elderly. n.d. Available from <http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm>

National Pressure Ulcer Advisory Panel: Suspected Deep Tissue Injury [image of cross-sectioned suspected deep tissue injury]. Retrieved November 18, 2009, from <http://www.npuap.org/images/NPUAP-SuspectDTI.jpg>

National Pressure Ulcer Advisory Panel: Unstageable [image of cross-sectioned unstageable pressure ulcer]. Retrieved November 18, 2009, from <http://www.npuap.org/images/NPUAP-Unstage2.jpg>

Newman, D.K., and Wein, A.J.: Managing and Treating Urinary Incontinence. 2nd ed. Baltimore, MD. Health Professions Press, 2009.

Physicians' Desk Reference: Physicians' Desk Reference 2008. Montvale, NJ. Thomson PDR, 2007.

Quality Improvement and Evaluation System (QIES) Technical Support Office: QIES Technical Support Office Web site. Retrieved Nov. 18, 2009, from <https://www.qtso.com/>

Saliba, D., and Buchanan, J.: Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0 Final Report to CMS. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA. Rand Corporation, April 2008. Available from <http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf>.

U.S. Department of Health and Human Services, Health Care Financing Administration: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Final Rule. Fed. Regist. 63(91):26251-26316, May 12, 1998.

U.S. Department of Health and Human Services, Health Care Financing Administration: Medicare program; Prospective payment system and consolidated billing for skilled nursing facilities—Update; final rule and notice. Fed. Regist. 64(146):41644-41683, Jul. 30, 1999.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: Healthy People 2020. Available from <http://www.healthypeople.gov/2020/default.aspx>

**Track Changes  
from Chapter 1 V1.07  
to Chapter 1 V1.08**

Chapter	Section	Page	Change
1	-	1-2	<b>Contractors</b> <b>RTI International</b> Roberta Constantine, RN, PhD <b>Karen Reilly, Sc.D.</b>
1	-	1-3	<del>www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp</del> <a href="http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp">http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp</a>
1	1.3	1-6	<ul style="list-style-type: none"> <li> <b>Monitoring the Quality of Care.</b> MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based <del>quality indicators (QIs)</del> and quality measures (QMs) 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 usefulness of the <del>QI/QMs</del>, which may be modified in the future to enhance their effectiveness.         </li> </ul>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
2	2.1	2-1	The OBRA regulations require nursing homes that are Medicare certified, <del>or</del> Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The <b>Resident Assessment Instrument (RAI)</b> process is the basis for the accurate assessment of each nursing home 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.
2	2.2	2-1	While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S <del>Items</del> . As such, each <del>state</del> <b>State</b> must have CMS approval of the State's Comprehensive and Quarterly assessments.
2	2.2	2-2	<ul style="list-style-type: none"> <li>• CMS's approval of a <del>state's</del> <b>State's</b> RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.</li> <li>• CMS's approval of a <del>state's</del> <b>State's</b> RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).</li> <li>• All comprehensive RAIs authorized by <del>states</del> <b>States</b> 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 CATs and the CAA Summary (Section V)).</li> <li>• 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 <del>state</del> <b>State</b> can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-approved State's RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts.</li> <li>• 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 the State's RAI (i.e., using the exact wording and sequencing of</li> </ul>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
			<p>items as is found on the State RAI).</p> <p>Additional information about State specification of the RAI, variations in format and CMS approval of a <del>state's</del> <b>State's</b> RAI can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual (<b>SOM</b>). For more information about your <del>state's</del> <b>State's</b> assessment requirements, contact your <del>state</del> <b>State</b> RAI coordinator (see Appendix B).</p>
2	2.3	2-2	<p>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 <del>state</del> <b>State</b> from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.</p>
2	2.3	2-2 & 2-3	<ul style="list-style-type: none"> <li>• <b>Hospice Residents:</b> When a SNF or NF is the hospice patient'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 <del>between, and participation</del> 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.</li> <li>• <b>Short-term or respite residents:</b> 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, a Discharge assessment is required:</li> </ul>
2	2.3	2-4	<p>— The OBRA assessments are a requirement for long-term</p>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
			<p>care facilities; therefore resident assessments are conducted prior to certification as if the beds were already certified.</p> <p>— For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. If a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. <del>—t</del> The facility simply continues the OBRA schedule using the actual admission date as Day 1.</p>
2	2.3	2-4 & 2-5	<ul style="list-style-type: none"> <li>o There are no links to the prior provider, including sanctions, deficiencies, resident assessments, <del>Quality Indicators</del>, Quality Measures, debts, provider number, etc.</li> <li>o The previous owner would complete <del>discharge a</del> <b>Discharge assessment</b> - return not anticipated, thus code A0310F=10, A2000=date of ownership change, and A2100=02 for those residents who will remain in the facility.</li> <li>o The new owner would complete <del>an admission entry tracking records</del> <b>Admission assessment and Entry tracking record</b> for all residents, thus code A0310F=01, A1600=date of ownership change, A1700=1 (admission), and A1800=02.</li> </ul>
2	2.3	2-5	<p>— 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 <b>return not anticipated</b> 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 <del>State agency and their</del> Regional Office, State agency, and Medicare contractor for guidance.</p>
2	2.4	2-6	<ul style="list-style-type: none"> <li>• After the 15-month period, RAI information may be thinned from the 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 <b>exception</b> is that demographic information (Items</li> </ul>

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to Chapter 2 V1.08**

Chapter	Section	Page	Change
			<p>A0500-A1600) from the most recent <del>admission</del> <b>Admission</b> assessment must be maintained in the active clinical record until the resident is discharged return not anticipated.</p> <ul style="list-style-type: none"> <li>Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by <del>state</del> <b>State</b> and local law and when authorized by the long-term care 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 to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.</li> </ul>
2	2.4	2-7	<ul style="list-style-type: none"> <li>Nursing homes that are not capable of <del>maintaining MDSs</del> <b>maintenance of the MDS</b> electronically must adhere to the current requirement that either <del>(not both)-a</del> hand written <b>or</b> a computer-generated copy be maintained in the clinical record. <del>E</del>—either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.</li> <li>All <del>state</del> <b>State</b> licensure and <del>state</del> <b>State</b> practice regulations continue to apply to Medicare and/or Medicaid certified long-term care facilities. Where <del>state</del> <b>State</b> law is more restrictive than <del>federal</del> <b>Federal</b> requirements, the provider needs to apply the <del>state</del> <b>State</b> law standard.</li> </ul>
2	2.5	2-8	<p><b>Assessment Reference Date (ARD)</b> refers to the last day of the observation (or “look back”) period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS <del>form</del> <b>Item Set</b> <del>itself</del> or in the facility software within the appropriate timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.</p>
2	2.5	2-9	<ul style="list-style-type: none"> <li>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</li> </ul>

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			<p>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, <del>states</del> <b>States</b> may have more stringent restrictions.</p> <p><b>Death in In facility Facility</b> 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. A Discharge assessment is not required.</p>
2	2.5	2-10	<p><b>Entry and Discharge reporting Reporting</b> 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 or leave a nursing home. Entry/Discharge reporting includes Entry tracking record, Discharge assessments, and Death in Facility tracking record.</p>
2	2.5	2-10	<p><b>Interdisciplinary Team (IDT)<sup>1</sup></b> is a group of clinicians from several medical fields that combines knowledge, skills, and resources to provide care to the resident.</p> <p><sup>1</sup> 42 CFR 483.20(k)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative;"</p>
2	2.5	2-10	<ul style="list-style-type: none"> <li>• <b>Nursing Home</b> <ul style="list-style-type: none"> <li>— <b>Comprehensive (NC<sup>+2</sup>) Item Set.</b> This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment).</li> </ul> </li> </ul> <p><sup>+2</sup> The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.</p>
2	2.5	2-12	<p><b>Leave of Absence (LOA)</b>, which does not require completion of either a <b>D</b>ischarge assessment or an <b>E</b>nter tracking record, occurs when a resident has a:</p>
2	2.5	2-12	<p>Upon return, providers should make appropriate</p>

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			documentation in the medical record regarding any changes in the resident. <b>If there are changes noted, they should be documented in the medical record.</b>
2	2.5	2-12	<p><b>MDS assessment</b><del>Assessment</del> <b>codes</b><del>Codes</del> are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, and A0310F of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.</p> <p><b>Medicare- required</b><del>Required</del> <b>PPS assessments</b><del>Assessments</del> 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. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment) and A0310C (PPS Other Medicare Required Assessment – OMRA) <del>–they</del>. <b>They include:</b></p>
2	2.5	2-13	<p><b>Non-comprehensive</b><del>Comprehensive</del> 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 and Significant Correction to Prior Quarterly (SCQA) assessments.</p>
2	2.5	2-13	<p><b>OBRA-required</b><del>Required</del> <b>tracking</b><del>Tracking</del> <b>records</b><del>Records and assessments</del> <b>Assessments</b> 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) <del>–they</del>. <b>They include:</b></p>
2	2.5	2-14	<p><b>Respite</b> 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 <del>Tracking</del><b>tracking</b> record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA admission.</p>

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2	2.6	2-17	<p><b>Comprehensive Assessments</b></p> <p>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:</p>
2	2.6	2-17	<ul style="list-style-type: none"> <li>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 a 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 <del>time frame</del> <b>timeframe</b> 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.</li> </ul>
2	2.6	2-18	<p>must be maintained in the resident's medical record.<sup>23</sup> In closing the record, the nursing home should note why the RAI was not completed.</p> <ul style="list-style-type: none"> <li>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.<sup>34</sup> In closing the record, the nursing home should note why the RAI was not completed.</li> </ul> <p><sup>23</sup> 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.</p> <p><sup>34</sup> 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.</p>
2	2.6	2-18	<ul style="list-style-type: none"> <li>In the process of completing any assessment except an</li> </ul>

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			<p>Admission and a SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the MDS system, 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 a SCPA, and chapter 5 for detailed information on processing corrections.</p> <ul style="list-style-type: none"> <li>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 <del>chapter</del> <b>Chapter 5</b>.</li> </ul>
2	2.6	2-19	<ul style="list-style-type: none"> <li>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 <b>requires</b> an Entry <del>Tracking</del> <b>tracking</b> record <b>each time</b> the resident returns to the facility and a Discharge assessment <b>each time</b> the resident is discharged. The nursing home may combine the Admission assessment with the Discharge assessment when applicable.</li> </ul>
2	2.6	2-20	<p><i>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, <del>mental retardation</del> <b>intellectual disability (ID)</b>, or <b>related</b> condition <del>related to mental retardation</del> is present or is suspected to be present.</i></p>
2	2.6	2-21	<p>— 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 <del>Tracking</del> <b>tracking</b> record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from a Significant</p>

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			Change in Status Assessment during the intervening period, the staff must complete a 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).
2	2.6	2-21	<ul style="list-style-type: none"> <li>A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) 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). A 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, <del>t</del>. 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 his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.</li> </ul>
2	2.6	2-22	<ul style="list-style-type: none"> <li>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 a SCSA. This <del>time-frame</del> <b>timeframe</b> 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 a 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</li> </ul>

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			comprehensive assessment would not be required.
2	2.6	2-23	— Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9 <sup>®</sup> ), e.g., <del>I</del> 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 ( <del>B</del> behavior);
2	2.6	2-24	— Resident's <del>decision-making</del> <b>decision making</b> changes for the better;
2	2.6	2-25	<i>Examples (SCSA):</i>  1. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia <del>—</del> , diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.
2	2.6	2-26	<ul style="list-style-type: none"> <li>• If a SCSA occurs for an individual <i>known or suspected</i> to have a mental illness, <b>intellectual disability</b> ("mental retardation" <b>in the regulation</b>), or <del>condition</del> related to <del>mental retardation</del> <b>condition</b> (as defined by 42 CFR 483.102), a referral to the state mental health or <del>mental retardation</del> <b>ID/DD</b> authority (SMH/MR/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<sup>45</sup>.</li> </ul> <p><sup>45</sup> 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.</p>

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2	2.6	2-26	<i>Referral for Level II Resident Review Evaluations are Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual DisabilityMental Retardation, or a Condition Related Condition to Mental Retardation in the Following Circumstances:</i>
2	2.6	2-27	<p>2. Ms. K has <del>intellectual disability</del> <del>mental retardation</del>. She is normally cooperative, but after she had a fall and sustained a leg injury, she becomes agitated and combative with the physical therapist and with staff who try to assess her status. She does not understand why her normal routine has changed and why staff are touching a painful area of her body.</p> <p><i>Referral for Level II Resident Review Evaluations are Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual DisabilityMental Retardation, or a Related Condition Related to Mental Retardation in the Following Circumstances: Note: this is not an exhaustive list</i></p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• A resident whose <del>intellectual disability</del> <del>mental retardation</del> as defined under 42 CFR 483.100, or <del>related</del> condition <del>related to mental retardation</del> as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.</li> <li>• A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.</li> </ul>
2	2.6	2-29	<p>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 a SCSA. For example:</p> <p>— Resident A has a <del>quarterly</del> <b>Quarterly</b> assessment with</p>

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			<p>an ARD of March 20<sup>th</sup>. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23<sup>rd</sup> and returns on March 25<sup>th</sup>. 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 continue with the assessment that was not fully completed before discharge and complete the assessment by April 3<sup>rd</sup> (which is day 14 after the ARD).</p> <p>— Resident B also has a <del>quarterly</del> <b>Quarterly</b> assessment with an ARD of March 20<sup>th</sup>. She goes to the hospital on March 20<sup>th</sup> and returns March 30<sup>th</sup>. While there is no significant change the facility decides to start <b>a</b> new assessment and sets the ARD for April 2<sup>nd</sup> and completes the assessment.</p>
2	2.6	2-29	<ul style="list-style-type: none"> <li>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.<sup>56</sup> In closing the record, the nursing home should note why the RAI was not completed.</li> </ul> <p><sup>56</sup> 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.</p>
2	2.6	2-31	<ul style="list-style-type: none"> <li>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, <del>states</del> <b>States</b> may have more stringent restrictions.</li> </ul>
2	2.6	2-32	<p><b>Tracking Records and Discharge Assessments (A0310F)</b></p> <p>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—<del>they</del>. <b>I</b>they do not include completion of the CAA process and care planning. The Discharge assessments include items for</p>

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			quality monitoring. Entry and discharge reporting is required for Swing Bed residents and respite residents.
2	2.6	2-32	<p><b>Admission (Item A1700=1)</b></p> <ul style="list-style-type: none"> <li>Entry <del>Tracking</del>tracking record is coded an Admission every time a resident: <ul style="list-style-type: none"> <li>— is admitted for the first time to this facility; ; or</li> </ul> </li> </ul>
2	2.6	2-33	<ul style="list-style-type: none"> <li>— is readmitted after a discharge return anticipated when return was not within 30 days of discharge.</li> <li>For swing bed facilities, the Entry <del>Tracking</del>tracking record will always be coded 1, Admission, since these providers do not complete an OBRA Admission assessment.</li> </ul>
2	2.6	2-33	<p><i>Example (Admission):</i></p> <ol style="list-style-type: none"> <li>Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the <del>entry</del>Entry tracking record for the August 27, 2011 return as follows:</li> </ol> <p><b>Reentry (Item A1700=2)</b></p> <ul style="list-style-type: none"> <li>Entry <del>Tracking</del>tracking record is coded Reentry every time a person is readmitted to a nursing home when the resident was previously admitted to this nursing home (i.e., an OBRA Admission was completed), <b>and</b> was discharged return anticipated from this nursing home, <b>and</b> returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.</li> </ul> <p><i>Example (Reentry):</i></p> <ol style="list-style-type: none"> <li>Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital. On May 18, 2011, Mr. W.</li> </ol>

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			<p>returned to the facility. Code the Entry <del>tracking</del> <b>Record</b> for the May 18, 2011 return, as follows:</p> <p><i>Assessment Management Requirements and Tips for Entry <del>Tracking</del> <b>Records</b>:</i></p> <ul style="list-style-type: none"> <li>• The Entry <del>Tracking</del> <b>tracking</b> record is the first item set completed for all residents.</li> <li>• Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility).</li> <li>• Must be completed for a respite resident every time the resident enters the facility.</li> <li>• Must be completed within 7 days after the admission/reentry.</li> <li>• Must be submitted no later than the 14<sup>th</sup> calendar day after the entry (entry date (A1600) + 14 calendar days).</li> </ul>
2	2.6	2-34	<ul style="list-style-type: none"> <li>• Is a <del>stand-alone</del> <b>stand-alone</b> tracking record.</li> </ul>
2	2.6	2-34	<b>08. Death in Facility <del>t</del>Tracking <b>Record</b> (A0310F=12)</b>
2	2.6	2-34	<p><i>Example (Death in Facility):</i></p> <p>1. Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility <del>Tracking</del> <b>Record</b> <del>record</del> as follows:</p>
2	2.6	2-34	<b>09. Discharge assessment <del>Assessment-return</del> <b>Return</b> <del>not</del> <b>Not anticipated</b> <del>Anticipated</del> (A0310F=10)</b>
2	2.6	2-35	<p><i>Example (Discharge-return not anticipated):</i></p> <p>1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 Discharge <del>Assessment</del> <b>assessment</b> as follows:</p> <p><b>10. Discharge assessment <del>Assessment-return</del> <b>Return</b> <del>anticipated</del> <b>Anticipated</b> (A0310F=11)</b></p>
2	2.6	2-35	<ul style="list-style-type: none"> <li>• 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</li> </ul>

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			<p>expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. This status requires an Entry <del>Tracking</del><b>tracking</b> record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged.</p> <ul style="list-style-type: none"> <li>When a resident had a prior Discharge <del>Assessment</del><b>assessment</b> completed indicating that the resident was expected to return (A0310E=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 Discharge assessment. Please contact your State RAI Coordinator for specific <del>state</del><b>State</b> requirements.</li> </ul>
2	2.7	2-38	<p>The RAI process, which includes the <del>federally</del><b>Federally</b> 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.</p>
2	2.7	2-38	<p><b>CAA(s) Completion</b></p> <ul style="list-style-type: none"> <li>Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or <del>t</del><b>T</b>tracking records.</li> </ul>
2	2.7	2-39	<p><b>Care Plan Completion</b></p> <ul style="list-style-type: none"> <li>Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or <del>t</del><b>T</b>tracking records.</li> <li>After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment</li> </ul>

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			<p>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 strengths, problems, and needs (described in detail in <del>chapter</del> <b>Chapter</b> 4 of this manual).</p> <ul style="list-style-type: none"> <li>Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and <del>on an on-going basis</del>, modify the care <b>plan on an ongoing basis</b>, <del>plan</del> if appropriate.</li> </ul>
2	2.10	2-52	<p><b><i>PPS Scheduled Assessment and Start of Therapy OMRA</i></b></p> <ul style="list-style-type: none"> <li>If the ARD for the SOT OMRA falls within the ARD <b>window</b> (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments <b>MUST</b> be combined.</li> </ul>
2	2.10	2-53	<p><b><i>PPS Scheduled Assessment and End of Therapy OMRA</i></b></p> <ul style="list-style-type: none"> <li>If the ARD for the EOT OMRA falls within the ARD <b>window</b> (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments <b>MUST</b> be combined.</li> </ul> <p><b><i>PPS Scheduled Assessment and Start and End of Therapy OMRA</i></b></p> <ul style="list-style-type: none"> <li>If the ARD for the EOT and SOT OMRA falls within the ARD <b>window</b> (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments <b>MUST</b> be combined.</li> </ul>
2	2.11	2-55	<p><b>2.11 Combining Medicare Assessments and OBRA Assessments<sup>67</sup></b></p> <p><sup>67</sup> OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.</p>
2	2.11	2-56	<p>When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be</p>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
			<p>combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare 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 14-day Medicare assessment. For the OBRA admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. <del>For Medicare, the ARD must be set between days 11 and 14, but the regulation allows grace days up to day 19. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD between days 11 and 14 would have to be chosen in this situation.</del>For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation.</p> <p>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/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.</p>
2	2.12	2-58	<p><b><i>Medicare-required 14-Day and OBRA Admission Assessment</i></b></p> <ul style="list-style-type: none"> <li>• ARD (Item A2300) must be set on days <del>11 through 14</del> 13 or 14 of the Part A SNF stay.</li> <li>• ARD may not be extended from day 15 to day <del>19</del> 18</li> </ul>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
			(i.e., grace days may not be used).
2	2.12	2-59	<p><b><i>Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment</i></b></p> <ul style="list-style-type: none"> <li>• ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment <b>and</b> within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in the prior comprehensive assessment has occurred.</li> <li>• Must be completed (Item Z0500B) within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in the prior comprehensive assessment has occurred.</li> </ul>
2	2.12	2-61	<p><b><i>Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment</i></b></p> <ul style="list-style-type: none"> <li>• ARD (Item A2300) must be set within 14 days after determination that an uncorrected <del>major</del> <b>significant</b> error in a comprehensive assessment has occurred <b>and</b> 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).</li> <li>• Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in a comprehensive assessment has occurred.</li> </ul>
2	2.12	2-63	<p><b><i>End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment</i></b></p> <ul style="list-style-type: none"> <li>• ARD (Item A2300) must be set within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in the prior comprehensive assessment has occurred <b>and</b> 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).</li> <li>• Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in prior comprehensive assessment has occurred.</li> </ul>
2	2.12	2-65	<p><b><i>Start and End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment</i></b></p> <ul style="list-style-type: none"> <li>• ARD (Item A2300) must be set within 14 days after the</li> </ul>

**Track Changes  
from Chapter 2 V1.07  
to Chapter 2 V1.08**

Chapter	Section	Page	Change
			<p>determination that an uncorrected <del>major</del> <b>significant</b> error in the prior comprehensive assessment has occurred <b>and</b> 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) <b>and</b> 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).</p> <ul style="list-style-type: none"> <li>Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected <del>major</del> <b>significant</b> error in prior comprehensive assessment has occurred.</li> </ul>
2	2.12	2-66 & 2-67	<p><b><i>Change of Therapy OMRA and OBRA Admission Assessment</i></b></p> <ul style="list-style-type: none"> <li>Establishes a new RUG-IV classification and Medicare payment rate (Item <del>Z0150A</del> <b>Z0100A</b>), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.</li> </ul> <p><b><i>Change of Therapy OMRA and OBRA Quarterly Assessment</i></b></p> <ul style="list-style-type: none"> <li>Establishes a new RUG-IV classification and Medicare payment rate (Item <del>Z0150A</del> <b>Z0100A</b>), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.</li> </ul>
2	2.13	2-69	<p><b>2.13 Factors Impacting the SNF Medicare Assessment Schedule<sup>78</sup></b></p> <p><sup>78</sup> These requirements/policies also apply to swing bed providers.</p>
2	2.15	2-75	<p>There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. An inactivation request is indicated by <b>A0050</b> <del>X0100</del> = 3. The item set for this type of record is “Inactivation” with an ISC code of XX.</p>
2	2.15	2-75	<p>The “Inactivation” (XX) item set is also used for swing beds when Item <b>A0050</b> <del>X0100</del> = 3.</p>

**Track Changes  
from Chapter 3 Intro V1.05  
to Chapter 3 Intro V1.08**

Chapter	Section	Page	Change
3	3.2	3-2	<ul style="list-style-type: none"> <li>If you <u>require</u> further assistance, submit your question to your State RAI Coordinator listed in <b>Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts</b> available on CMS' website: <a href="http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp">http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp</a> <del>or to the MDS 3.0 Q&amp;A mailbox at MDSQuestions@cms.gov.</del></li> </ul> <p><b>2. Second, review the MDS item sets.</b></p> <ul style="list-style-type: none"> <li>Notice how sections are organized and where information should be recorded.</li> <li>Work through one section at a time.</li> <li>Examine item definitions and response categories as <u>provided</u> on the <b>item sets</b> <del>form</del>, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.</li> <li><b>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.</b></li> </ul>
3	3.2	3-3	<ul style="list-style-type: none"> <li>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 <b>Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts</b> available on CMS' website: <a href="http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp">http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp</a>)</li> </ul>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

Chapter	Section	Page	Change
3	A	A-1 & A-2	<div><div>A0050: Type of Record</div><div><div><div>A0050. Type of Record</div><div><div>Enter Code</div><div><input type="checkbox"/></div></div><div><div>1. Add new record → Continue to A0100, Facility Provider Numbers</div><div>2. Modify existing record → Continue to A0100, Facility Provider Numbers</div><div>3. Inactivate existing record → Skip to X0150, Type of Provider</div></div></div></div></div> <div>Coding Instructions for A0050, Type of Record</div> <div><div><div>• Code 1, Add new record: if this is a <b>new record</b> that has not been previously submitted and accepted in the QIES ASAP system. If this item is <b>coded as 1</b>, continue to A0100 Facility Provider Numbers.</div><div>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 the QIES ASAP system and a “fatal” error will be reported to the facility on the Final Validation Report.</div></div><div><div><div>• Code 2, Modify existing record: if this is a <b>request to modify</b> the MDS items for a record that already has been submitted and accepted in the QIES ASAP system.</div><div>If this item is coded as 2, continue to A0100, Facility Provider Numbers.</div><div>When a modification request is submitted, the QIES ASAP System will take the following steps:</div><div><div>1. The system will attempt to locate the existing record in the QIES ASAP database for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.</div><div>2. If the existing record is not found, the submitted modification record will be rejected and not accepted in the QIES ASAP system. A “fatal” error will be reported to the facility on the Final Validation Report.</div><div>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</div></div></div></div></div>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

Chapter	Section	Page	Change
			<p>modification record will be rejected and not accepted in the QIES ASAP system. The “fatal” error(s) will be reported to the facility on the Final Validation Report.</p> <p>4. If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP database. The prior record will be moved to a history file in the QIES ASAP database.</p> <ul style="list-style-type: none"> <li>• Code 3, Inactivate existing record: if this is a <b>request to inactivate</b> a record that already has been submitted and accepted in the QIES ASAP system. If this item is <b>coded as 3</b>, skip to X0150, Type of Provider. When an inactivation request is submitted, the QIES ASAP system will take the following steps: <ol style="list-style-type: none"> <li>1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.</li> <li>2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a “fatal” error will be reported to the facility on the Final Validation Report.</li> <li>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 the QIES ASAP system.</li> <li>4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file.</li> </ol> </li> </ul> <p><b>Identification of Record to be Modified/Inactivated</b></p> <p>The Section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information <b>EXACTLY</b> 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.</p>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

Chapter	Section	Page	Change
			<p><b>Example:</b> A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record. When the encoder “data entered” the prior assessment for Joan L Smith, he typed “John” by mistake. 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, the QIES ASAP system would not locate the prior assessment.</p> <p>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 the QIES ASAP system which causes the desired correction to be made.</p>
3	A	A-3	Page length change.
3	A	A-4	<p><b>A0310: Type of Assessment</b></p> <p><i>For Comprehensive, Quarterly, and PPS Assessments, Entry and Discharge <del>Tracking</del> Records.</i></p>

**Track Changes**  
**from Chapter 3 Section A V1.05**  
**to Chapter 3 Section A V1.08**

3

A

A-4

Replaced screen shot.

OLD

A0310. Type of Assessment	
Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 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. Not OBRA required assessment
Enter Code <input type="text"/>	<b>B. PPS Assessment</b> <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. Not PPS assessment
Enter Code <input type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment
Enter Code <input type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if A0200 = 2 0. No 1. Yes
Enter Code <input type="text"/>	<b>E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?</b> 0. No 1. Yes
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 01. Entry tracking record 10. Discharge assessment-return not anticipated 11. Discharge assessment-return anticipated 12. Death in facility tracking record 99. Not entry/discharge tracking record

NEW

A0310. Type of Assessment	
Enter Code <input type="text"/>	<b>A. Federal OBRA Reason for Assessment</b> 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 <input type="text"/>	<b>B. PPS Assessment</b> <u>PPS Scheduled Assessments for a Medicare Part A Stay</u> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment <u>PPS Unscheduled Assessments for a Medicare Part A Stay</u> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <u>Not PPS Assessment</u> 99. None of the above
Enter Code <input type="text"/>	<b>C. PPS Other Medicare Required Assessment - OMRA</b> 0. No 1. Start of therapy assessment 2. End of therapy assessment 3. Both Start and End of therapy assessment 4. Change of therapy assessment
Enter Code <input type="text"/>	<b>D. Is this a Swing Bed clinical change assessment?</b> Complete only if A0200 = 2 0. No 1. Yes
Enter Code <input type="text"/>	<b>E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry?</b> 0. No 1. Yes
Enter Code <input type="text"/>	<b>F. Entry/discharge reporting</b> 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 <input type="text"/>	<b>G. Type of discharge</b> - Complete only if A0310F = 10 or 11 1. Planned 2. Unplanned

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

3	A	A-5	Page length change.
3	A	A-6	<p><b>Coding Instructions for A0310C</b></p> <ul style="list-style-type: none"> <li>• Code 1, <b>S</b>start of therapy assessment (OPTIONAL): with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a short stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.</li> <li>• Code 2, <b>E</b>end of therapy assessment: with an ARD that is 1 to 3 days after the last day therapy services were provided.</li> <li>• Code 3, both the <b>S</b>start and <b>E</b>end of therapy assessment: with an ARD that is <u>both</u> 5 to 7 days after the first day therapy services were provided <u>and</u> that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a short stay assessment, see Chapter 6).</li> <li>• <b>Code 4, Change of therapy assessment: with an ARD that is Day 7 of the COT observation period.</b></li> </ul>
3	A	A-6	<p><b>Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?</b></p> <ul style="list-style-type: none"> <li>• Code 0, no: if this assessment is not the first assessment since the most recent <b>admission/entry or reentry</b> of any kind (admission or reentry).</li> <li>• Code 1, yes: if this assessment is the first assessment since the most recent <b>admission/entry or reentry</b> of any kind (admission or reentry).</li> </ul>
3	A	A-7	<p><b>Coding Instructions for A0310G, Type of Discharge</b></p> <ul style="list-style-type: none"> <li>• <b>Code 1: if type of discharge is a planned discharge.</b></li> <li>• <b>Code 2: if type of discharge is an unplanned</b></li> </ul>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

			<b>discharge.</b>
3	A	A-8 through A-15	Page length change.
3	A1500	A-16	Replaced screen shot.
<b>OLD</b> <div style="border: 1px solid black; padding: 5px;"> <p><b>A1500. Preadmission Screening and Resident Review (PASRR)</b>            Complete only if A0310A = 01</p> <p>Enter Code <input type="checkbox"/> <b>Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?</b></p> <p>0. <b>No</b>            1. <b>Yes</b>            9. <b>Not a Medicaid certified unit</b></p> </div>			
<b>NEW</b> <div style="border: 1px solid black; padding: 5px;"> <p><b>A1500. Preadmission Screening and Resident Review (PASRR)</b>            Complete only if A0310A = 01, 03, 04, or 05</p> <p>Enter Code <input type="checkbox"/> <b>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?</b></p> <p>0. <b>No</b> → Skip to A1550, Conditions Related to ID/DD Status            1. <b>Yes</b> → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions            9. <b>Not a Medicaid-certified unit</b> → Skip to A1550, Conditions Related to ID/DD Status</p> </div>			
3	A1500	A-16	<p><b>Health-related Quality of Life</b></p> <ul style="list-style-type: none"> <li>All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), <b>intellectual disability (ID)</b>, ("<b>mental retardation</b>" (<del>MI</del>/MR) <b>in federal regulation</b>), or related conditions regardless of the resident's method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).</li> <li>A resident with MI or <b>ID</b><del>MR</del> must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a significant change in status MDS assessment is completed for a resident with MI or <b>ID</b><del>MR</del>, the nursing home is required to notify the State mental health authority, <b>intellectual disability</b><del>mental retardation</del> or developmental <b>delay</b> 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.</li> </ul>
3	A1500	A-17	<p><b>Planning for Care</b></p> <ul style="list-style-type: none"> <li>The State is responsible for providing specialized services to individuals with MI/<b>ID</b><del>MR</del>. In some States specialized services are provided to residents in</li> </ul>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

			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.
3	A1500	A-17	<p><b>Steps for Assessment</b></p> <p>1. Complete if A0310A = 01, 03, 04 or 05 <del>(Admission Assessment)</del>. (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).</p>
3	A1500	A-17	<p><b>Coding Instructions</b></p> <ul style="list-style-type: none"> <li>Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: <ul style="list-style-type: none"> <li>PASRR Level I screening did not result in a referral for Level II screening, or</li> <li>Level II screening determined that the resident does not have a serious mental illness and/or intellectual disability <del>mental retardation</del> or related condition, or</li> </ul> </li> </ul>
3	A1500	A-18	<ul style="list-style-type: none"> <li>Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual disability or <del>mental retardation</del> related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.</li> <li>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. <ul style="list-style-type: none"> <li>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.</li> </ul> </li> </ul>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

3	A1510	A-18	<div>A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions</div> <div><div>A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions</div><div>Complete only if A0310A = 01, 03, 04, or 05</div><div>↓ Check all that apply</div><div><div><input type="checkbox"/></div><div>A. Serious mental illness</div></div><div><div><input type="checkbox"/></div><div>B. Intellectual Disability ("mental retardation" in federal regulation)</div></div><div><div><input type="checkbox"/></div><div>C. Other related conditions</div></div></div> <div><div>Steps for Assessment</div><div><div>1. Complete if A0310A = 01, 03, 04 or 05 (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).</div><div>2. Check all that apply.</div></div><div><div>Coding Instructions</div><div><div><div>• Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness.</div><div>• Code B, Intellectual Disability ("mental retardation" in federal regulation): if resident has been diagnosed with intellectual disability (or "mental retardation").</div><div>• Code C, Other related conditions: if resident has been diagnosed with other related conditions.</div></div></div></div></div>
3	A1550	A-19	<div>A1550: Conditions Related to Intellectual Disability/Mental Retardation/Developmental Delay (MRID/DD) Status</div>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

3	A1550	A-19	<div><b>DEFINITIONS</b>  <b>DOWN SYNDROME</b>  A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, mental retardation intellectual disability, low muscle tone, and other possible effects.  <b>AUTISM</b>  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.  <b>EPILEPSY</b>  A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.</div>
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**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

3

A1550

A-19

Replaced screen shot.

OLD

A1550. Conditions Related to MR/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 MR/DD status that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

☐

A. Down syndrome

☐

B. Autism

☐

C. Epilepsy

☐

D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐

E. MR/DD with no organic condition

No MR/DD

☐

Z. None of the above

NEW

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

3	A1550	A-19	<div>Item Rationale</div> <ul style="list-style-type: none"> <li>To document conditions associated with intellectual mental retardation or developmental delay disabilities.</li> </ul>
3	A1550	A-19 & A-20	<div>Coding Instructions</div> <ul style="list-style-type: none"> <li>Check all conditions related to MRID/DD status that were present before age 22.</li> <li>Code D: if other organic condition related to MRID/DD is present.</li> <li>Code E: if an MRID/DD condition is present but the resident does not have any of the specific conditions listed.</li> <li>Code Z: if MRID/DD condition is not present.</li> </ul>

3	A1550	A-20	<p><b>DEFINITION</b></p> <p><b>OTHER ORGANIC CONDITION RELATED TO MRID/DD</b></p> <p>Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningocele, congenital hydrocephalus, etc.</p>
3	A1600	A-20	A1600: Entry Date (date of this admission/entry or reentry into the facility)
3	A1600	A-20	Replaced screen shot.

OLD

A1600. Entry Date (date of this admission/reentry into the facility)			
	<div> <div></div> <div></div> </div> <div>Month</div>	<div> <div></div> <div></div> </div> <div>Day</div>	<div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>

NEW

A1600. Entry Date (date of this admission/entry or reentry into the facility)			
	<div> <div></div> <div></div> </div> <div>Month</div>	<div> <div></div> <div></div> </div> <div>Day</div>	<div> <div></div> <div></div> <div></div> <div></div> </div> <div>Year</div>

3	A1600	A-20	<p><b>Item Rationale</b></p> <ul style="list-style-type: none"> <li>To document the date of admission/entry or reentry into the nursing home.</li> </ul> <p><b>Coding Instructions</b></p> <p>Enter the most recent date of admission/entry or reentry to this nursing home. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.</p>
3	A1700	A-20	<p><b>Item Rationale</b></p> <ul style="list-style-type: none"> <li>Captures whether date in A1600 is an</li> </ul>

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

			admission/entry date or a reentry date. <b>Coding Instructions</b> <ul style="list-style-type: none"><li>Code 1, admission/entry: when one of the following occurs:</li></ul>
3	A1800	A-21	Replaced screen shot.

OLD

A1800. Entered From	
Enter Code <div><div></div><div></div></div>	<div>01. Community (private home/apt., board/care, assisted living, group home)</div> <div>02. Another nursing home or swing bed</div> <div>03. Acute hospital</div> <div>04. Psychiatric hospital</div> <div>05. Inpatient rehabilitation facility</div> <div>06. MR/DD facility</div> <div>07. Hospice</div> <div>99. Other</div>

NEW

A1800. Entered From	
Enter Code <div><div></div><div></div></div>	<div>01. Community (private home/apt., board/care, assisted living, group home)</div> <div>02. Another nursing home or swing bed</div> <div>03. Acute hospital</div> <div>04. Psychiatric hospital</div> <div>05. Inpatient rehabilitation facility</div> <div>06. ID/DD facility</div> <div>07. Hospice</div> <div>09. Long Term Care Hospital (LTCH)</div> <div>99. Other</div>

3	A1800	A-22 & A-23	<b>Coding Instructions</b> <ul style="list-style-type: none"><li>Code 06, IDMR/DD facility: 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 who have intellectual are mentally retarded or who have developmental delay disabilities.</li><li>Code 07, hospice: if the resident was admitted from a 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. Includes community-based or inpatient hospice programs.</li><li>Code 09, long term care hospital (LTCH): if the patient was discharged from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)((1)(B)(iv) of the Social</li></ul>
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**Track Changes**  
**from Chapter 3 Section A V1.05**  
**to Chapter 3 Section A V1.08**

			Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
3	A2100	A-23	Replaced screen shot.
OLD			
<div><div>A2100. Discharge Status</div><div>Complete only if A0310F = 10, 11, or 12</div><div><div>Enter Code</div><div><div></div><div></div></div></div><div><div>01. Community (private home/apt., board/care, assisted living, group home)</div><div>02. Another nursing home or swing bed</div><div>03. Acute hospital</div><div>04. Psychiatric hospital</div><div>05. Inpatient rehabilitation facility</div><div>06. MR/DD facility</div><div>07. Hospice</div><div>08. Deceased</div><div>99. Other</div></div></div>			
NEW			
<div><div>A2100. Discharge Status</div><div>Complete only if A0310F = 10, 11, or 12</div><div><div>Enter Code</div><div><div></div><div></div></div></div><div><div>01. Community (private home/apt., board/care, assisted living, group home)</div><div>02. Another nursing home or swing bed</div><div>03. Acute hospital</div><div>04. Psychiatric hospital</div><div>05. Inpatient rehabilitation facility</div><div>06. ID/DD facility</div><div>07. Hospice</div><div>08. Deceased</div><div>09. Long Term Care Hospital (LTCH)</div><div>99. Other</div></div></div>			
3	A2100	A-24 & A-25	<div>Coding Instructions</div> <div><div><div>• Code 06, IDMR/DD facility: if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectualare mentally retarded or who havedevelopmental delay disabilities.</div><div>• Code 09, long term care hospital (LTCH): if the patient was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)((1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.</div></div></div>
3	A	A-26	Page length change.

**Track Changes  
from Chapter 3 Section A V1.05  
to Chapter 3 Section A V1.08**

3	A2400	A-27	<p><b>Coding Instructions for A2400A</b></p> <ul style="list-style-type: none"> <li>Code 0, no: if the resident has not had a covered Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.</li> <li>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.</li> </ul>
3	A2400	A-27	<div> <p><b>DEFINITIONS</b></p> <p><b>MOST RECENT MEDICARE STAY</b> This is a Medicare Part A covered stay that has started on or after the most recent entry (admission or reentry) admission/entry or reentry to the nursing facility.</p> <p><b>MEDICARE-COVERED STAY</b> Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.</p> <p><b>CURRENT MEDICARE STAY</b> <b>NEW ADMISSION:</b> Day 1 of Medicare Part A stay. <b>READMISSION:</b> Day 1 of Medicare Part A coverage after readmission following a discharge.</p> </div>
3	A	A-28	Page number change.
3	A	A-29	Page number change.

**Track Changes  
from Chapter 3 Section C V1.07  
to Chapter 3 Section C V1.08**

Chapter	Section	Page	Change
3	C0100	C-1	Replaced screen shot.
OLD			
<div> <div>C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?</div> <div>Attempt to conduct interview with all residents</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <div>0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status</div> <div>1. Yes → Continue to C0200, Repetition of Three Words</div> </div> </div>			
NEW			
<div> <div>C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?</div> <div>Attempt to conduct interview with all residents</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <div>0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status</div> <div>1. Yes → Continue to C0200, Repetition of Three Words</div> </div> </div>			

**Track Changes**  
**from Chapter 3 Section E V1.04**  
**to Chapter 3 Section E V1.08**

Chapter	Section	Page	Change
3	E0100	E-1	Replaced screen shot.
OLD			
<div> <div>E0100. Psychosis</div> <div>↓ Check all that apply</div> <div> <input type="checkbox"/> A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)           <input type="checkbox"/> B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)           <input type="checkbox"/> Z. None of the above         </div> </div>			
NEW			
<div> <div>E0100. Potential Indicators of Psychosis</div> <div>↓ Check all that apply</div> <div> <input type="checkbox"/> A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)           <input type="checkbox"/> B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)           <input type="checkbox"/> Z. None of the above         </div> </div>			
3	E0800	E-13	Replaced screen shot.
OLD			
<div> <div>E0800. Rejection of Care - Presence &amp; Frequency</div> <div> <div>Enter Code</div> <input type="checkbox"/> <div>           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/or determined to be consistent with resident values, preferences, or goals.           <div>             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           </div> </div> </div> </div>			
NEW			
<div> <div>E0800. Rejection of Care - Presence &amp; Frequency</div> <div> <div>Enter Code</div> <input type="checkbox"/> <div>           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.           <div>             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           </div> </div> </div> </div>			
3	E1000	E-20	Page length change.
3	E1100	E-21	Replaced screen shot.
OLD			
<div> <div>E1100. Change in Behavior or Other Symptoms</div> <div>Consider all of the symptoms assessed in items E0100 through E1000</div> <div> <div>Enter Code</div> <input type="checkbox"/> <div>           How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or PPS)?           <div>             0. Same             1. Improved             2. Worse             3. N/A because no prior MDS assessment           </div> </div> </div> </div>			
NEW			
<div> <div>E1100. Change in Behavior or Other Symptoms</div> <div>Consider all of the symptoms assessed in items E0100 through E1000</div> <div> <div>Enter Code</div> <input type="checkbox"/> <div>           How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?           <div>             0. Same             1. Improved             2. Worse             3. N/A because no prior MDS assessment           </div> </div> </div> </div>			

**Track Changes**  
**from Chapter 3 Section G V1.05**  
**to Chapter 3 Section G V1.08**

Chapter	Section	Page	Change
3	G0110	G-1	Replaced screen shot.
OLD			
<b>G0110. Activities of Daily Living (ADL) Assistance</b> Refer to the ADL flow chart in the RAI manual to facilitate accurate coding			
<b>Instructions for Rule of 3</b> <ul style="list-style-type: none"> <li>■ When an activity occurs three times at any one given level, code that level.</li> <li>■ When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).</li> <li>■ When an activity occurs at various levels, but not three times at any given level, apply the following: <ul style="list-style-type: none"> <li>○ When there is a combination of full staff performance, and extensive assistance, code extensive assistance.</li> <li>○ When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).</li> </ul> </li> </ul> <b>If none of the above are met, code supervision.</b>			
<b>1. ADL Self-Performance</b> Code for <b>resident's performance</b> over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time  <b>Coding:</b> <u><b>Activity Occurred 3 or More Times</b></u> 0. <b>Independent</b> - no help or staff oversight at any time 1. <b>Supervision</b> - oversight, encouragement or cueing 2. <b>Limited assistance</b> - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance 3. <b>Extensive assistance</b> - resident involved in activity, staff provide weight-bearing support 4. <b>Total dependence</b> - full staff performance every time during entire 7-day period  <u><b>Activity Occurred 2 or Fewer Times</b></u> 7. <b>Activity occurred only once or twice</b> - activity did occur but only once or twice 8. <b>Activity did not occur</b> - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period		<b>2. ADL Support Provided</b> Code for <b>most support provided</b> over all shifts; code regardless of resident's self-performance classification  <b>Coding:</b> 0. <b>No</b> setup or physical help from staff 1. <b>Setup</b> help only 2. <b>One</b> person physical assist 3. <b>Two+</b> persons physical assist 8. ADL activity itself <b>did not occur</b> during entire period	
		<b>1.</b> <b>Self-Performance</b>	<b>2.</b> <b>Support</b>
		↓ Enter Codes in Boxes ↓	
<b>A. Bed mobility</b> - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Transfer</b> - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position ( <b>excludes</b> to/from bath/toilet)		<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Walk in room</b> - how resident walks between locations in his/her room		<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Walk in corridor</b> - how resident walks in corridor on unit		<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Locomotion on unit</b> - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Locomotion off unit</b> - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). <b>If facility has only one floor</b> , how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Dressing</b> - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses		<input type="checkbox"/>	<input type="checkbox"/>
<b>H. Eating</b> - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)		<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Toilet use</b> - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag		<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Personal hygiene</b> - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands ( <b>excludes</b> baths and showers)		<input type="checkbox"/>	<input type="checkbox"/>

**Track Changes**  
**from Chapter 3 Section G V1.05**  
**to Chapter 3 Section G V1.08**

NEW

G0110. Activities of Daily Living (ADL) Assistance			
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding			
Instructions for Rule of 3			
<ul style="list-style-type: none"><li>■ When an activity occurs three times at any one given level, code that level.</li><li>■ When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).</li><li>■ When an activity occurs at various levels, but not three times at any given level, apply the following:<ul style="list-style-type: none"><li>○ When there is a combination of full staff performance, and extensive assistance, code extensive assistance.</li><li>○ When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).</li></ul></li></ul> <b>If none of the above are met, code supervision.</b>			
1. ADL Self-Performance		2. ADL Support Provided	
Code for <b>resident's performance</b> over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time		Code for <b>most support provided</b> over all shifts; code regardless of resident's self-performance classification	
Coding:		Coding:	
<u>Activity Occurred 3 or More Times</u>		0. <b>No</b> setup or physical help from staff	
0. <b>Independent</b> - no help or staff oversight at any time		1. <b>Setup</b> help only	
1. <b>Supervision</b> - oversight, encouragement or cueing		2. <b>One person</b> physical assist	
2. <b>Limited assistance</b> - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance		3. <b>Two+</b> persons physical assist	
3. <b>Extensive assistance</b> - resident involved in activity, staff provide weight-bearing support		8. ADL activity itself <b>did not occur</b> or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period	
4. <b>Total dependence</b> - full staff performance every time during entire 7-day period			
<u>Activity Occurred 2 or Fewer Times</u>			
7. <b>Activity occurred only once or twice</b> - activity did occur but only once or twice			
8. <b>Activity did not occur</b> - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period			
A. <b>Bed mobility</b> - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture			
B. <b>Transfer</b> - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet)			
C. <b>Walk in room</b> - how resident walks between locations in his/her room			
D. <b>Walk in corridor</b> - how resident walks in corridor on unit			
E. <b>Locomotion on unit</b> - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			
F. <b>Locomotion off unit</b> - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			
G. <b>Dressing</b> - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses			
H. <b>Eating</b> - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)			
I. <b>Toilet use</b> - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag			
J. <b>Personal hygiene</b> - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)			

**Track Changes  
from Chapter 3 Section G V1.05  
to Chapter 3 Section G V1.08**

			<ul style="list-style-type: none"> <li>Code 8, activity did not occur: <del>if, over the 7-day look back period, the ADL activity (or any part of the ADL) was not performed by the resident or staff at all.</del> <b>if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.</b></li> </ul>
3	G0110	G-5	<p><b>Coding Instructions for G0110, Column 2</b></p> <ul style="list-style-type: none"> <li>Code 8, ADL activity itself did not occur during the entire period: <del>if, over the 7-day look back period, the ADL activity was not performed by the resident or staff at all.</del> <b>if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.</b></li> </ul>
3	G0110	G-6	<p>Changes to algorithm.</p> <div style="border: 1px solid black; padding: 10px;"> <p style="text-align: center;"><b>Instructions for Rule of 3</b></p> <ul style="list-style-type: none"> <li>When an activity occurs three times at any one given level, code that level.</li> <li>When an activity occurs three times at multiple levels, <b>code the most dependent</b>. Exceptions are: total dependence (4) – activity must require full assist every time; and activity did not occur (8) – activity must not have occurred at all <b>or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period</b>. Example, three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).</li> <li>When an activity occurs at more than one level but not three times at any one level, apply the following: <ul style="list-style-type: none"> <li>Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance - this is total dependence).</li> <li>When there are 3 or more episodes of a combination of full staff performance and weight-bearing assistance - code extensive assistance (3).</li> <li>When there are 3 or more episodes of a combination of full staff performance/weight bearing assistance, and non-weight bearing assistance, code limited assistance (2).</li> </ul> </li> </ul> <p><b>If none of the above are met, code supervision</b></p> </div>

**Track Changes  
from Chapter 3 Section G V1.05  
to Chapter 3 Section G V1.08**

3	G0110	G-8	<p>— <b>Toileting</b> would be <b>coded 8, activity did not occur</b>: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.</p> <p>— <b>Locomotion</b> would be <b>coded 8, activity did not occur</b>: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period.</p> <p>— <b>Eating</b> would be <b>coded 8, activity did not occur</b>: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, or if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.</p>
3	G0110	G-9	Page length change.
3	G0110	G-10	Page length change.
3	G0110	G-11	Page length change.
3	G0110	G-12	Page length change.
3	G0120	G-17	Replaced screen shot.

**OLD**

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for <b>most dependent</b> in self-performance and support	
Enter Code <input type="checkbox"/>	<b>A. Self-performance</b> 0. <b>Independent</b> - no help provided 1. <b>Supervision</b> - oversight help only 2. <b>Physical help limited to transfer only</b> 3. <b>Physical help in part of bathing activity</b> 4. <b>Total dependence</b> 8. <b>Activity itself did not occur</b> during the entire period
Enter Code <input type="checkbox"/>	<b>B. Support provided</b> (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)

**NEW**

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for <b>most dependent</b> in self-performance and support	
Enter Code <input type="checkbox"/>	<b>A. Self-performance</b> 0. <b>Independent</b> - no help provided 1. <b>Supervision</b> - oversight help only 2. <b>Physical help limited to transfer only</b> 3. <b>Physical help in part of bathing activity</b> 4. <b>Total dependence</b> 8. <b>Activity itself did not occur</b> or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code <input type="checkbox"/>	<b>B. Support provided</b> (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)

3	G0120	G-18	<b>Coding Instructions for G0120A, Self Performance</b>
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**Track Changes  
from Chapter 3 Section G V1.05  
to Chapter 3 Section G V1.08**

			<ul style="list-style-type: none"><li>Code 8, ADL activity itself did not occur during entire period: <del>if the resident was not bathed during the 7-day look-back period.</del> if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.</li></ul>
3	G0300	G-19	Replaced screen shot.
OLD			
<div><div>G0300. Balance During Transitions and Walking</div><div>After observing the resident, code the following walking and transition items for most dependent</div><div><div>Coding:<ul style="list-style-type: none"><li>0. Steady at all times</li><li>1. Not steady, but <u>able</u> to stabilize without human assistance</li><li>2. Not steady, <u>only able</u> to stabilize with human assistance</li><li>8. Activity did not occur</li></ul></div><div><div>↓ Enter Codes in Boxes</div><div><div><input type="checkbox"/></div>A. Moving from seated to standing position</div><div><div><input type="checkbox"/></div>B. Walking (with assistive device if used)</div><div><div><input type="checkbox"/></div>C. Turning around and facing the opposite direction while walking</div><div><div><input type="checkbox"/></div>D. Moving on and off toilet</div><div><div><input type="checkbox"/></div>E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)</div></div></div></div>			
NEW			
<div><div>G0300. Balance During Transitions and Walking</div><div>After observing the resident, code the following walking and transition items for most dependent</div><div><div>Coding:<ul style="list-style-type: none"><li>0. Steady at all times</li><li>1. Not steady, but <u>able</u> to stabilize without staff assistance</li><li>2. Not steady, <u>only able</u> to stabilize with staff assistance</li><li>8. Activity did not occur</li></ul></div><div><div>↓ Enter Codes in Boxes</div><div><div><input type="checkbox"/></div>A. Moving from seated to standing position</div><div><div><input type="checkbox"/></div>B. Walking (with assistive device if used)</div><div><div><input type="checkbox"/></div>C. Turning around and facing the opposite direction while walking</div><div><div><input type="checkbox"/></div>D. Moving on and off toilet</div><div><div><input type="checkbox"/></div>E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)</div></div></div></div>			
3	G0300	G-27	<b>Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer <u>between</u> <del>ring from Bed and Chair or to Wheelchair or Wheelchair to Bed</del>)</b>
3	G0300	G-28	<ul style="list-style-type: none"><li>Code 8, activity did not occur:<ul style="list-style-type: none"><li>— If the resident did not transfer from bed <del>to</del> <u>and chair</u> <del>or</del> <u>or</u> wheelchair/<del>chair or wheelchair/chair to bed</del> during the 7-day look-back period.</li></ul></li></ul> <p><b>Examples for G0300E, Surface-to-Surface Transfer (Transferring from <u>Between</u> <del>Bed and to Chair or Wheelchair or Wheelchair to Bed</del>)</b></p>
3	G0300	G-28	Example #1 Rationale: The resident was unsteady when transferring from

**Track Changes  
from Chapter 3 Section G V1.05  
to Chapter 3 Section G V1.08**

			bed to wheelchair and <del>did not require</del> required staff assistance to make a steady transfer.
3	G0300	G-28	2. A resident who needs assistance ambulating transfers to his wheelchair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his wheelchair.

**Track Changes  
from Chapter 3 Section H V1.04  
to Chapter 3 Section H V1.08**

Chapter	Section	Page	Change
3	H0600	H-13	<b>Coding Tips and Special Populations</b> <ul style="list-style-type: none"><li>Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation. Fecal impaction is constipation.</li></ul>

**Track Changes**  
**from Chapter 3 Section I V1.07**  
**to Chapter 3 Section I V1.08**

Chapter	Section	Page	Change
3	I	I-1	<b>Intent:</b> The items in this section are intended to code diseases that have a <b>direct</b> 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 <b>current</b> health status.
3	I	I-1	Replaced screen shot.

**OLD**

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	
<input type="checkbox"/>	<b>Cancer</b>
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
<input type="checkbox"/>	<b>Heart/Circulation</b>
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	<b>Gastrointestinal</b>
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
<input type="checkbox"/>	<b>Genitourinary</b>
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
<input type="checkbox"/>	<b>Infections</b>
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
<input type="checkbox"/>	<b>Metabolic</b>
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	<b>Musculoskeletal</b>
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	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)
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	<b>Neurological</b>
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	I4800. Dementia (e.g. Non-Alzheimer's dementia such as 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)

**Track Changes**  
**from Chapter 3 Section I V1.07**  
**to Chapter 3 Section I V1.08**

**NEW**

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	
<input type="checkbox"/>	<b>Cancer</b>
<input type="checkbox"/>	I0100. Cancer (with or without metastasis)
<input type="checkbox"/>	<b>Heart/Circulation</b>
<input type="checkbox"/>	I0200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
<input type="checkbox"/>	I0300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
<input type="checkbox"/>	I0400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
<input type="checkbox"/>	I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
<input type="checkbox"/>	I0600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
<input type="checkbox"/>	I0700. Hypertension
<input type="checkbox"/>	I0800. Orthostatic Hypotension
<input type="checkbox"/>	I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
<input type="checkbox"/>	<b>Gastrointestinal</b>
<input type="checkbox"/>	I1100. Cirrhosis
<input type="checkbox"/>	I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
<input type="checkbox"/>	I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease
<input type="checkbox"/>	<b>Genitourinary</b>
<input type="checkbox"/>	I1400. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/>	I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
<input type="checkbox"/>	I1550. Neurogenic Bladder
<input type="checkbox"/>	I1650. Obstructive Uropathy
<input type="checkbox"/>	<b>Infections</b>
<input type="checkbox"/>	I1700. Multidrug-Resistant Organism (MDRO)
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
<input type="checkbox"/>	I2200. Tuberculosis
<input type="checkbox"/>	I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
<input type="checkbox"/>	I2400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
<input type="checkbox"/>	I2500. Wound Infection (other than foot)
<input type="checkbox"/>	<b>Metabolic</b>
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/>	I3100. Hyponatremia
<input type="checkbox"/>	I3200. Hyperkalemia
<input type="checkbox"/>	I3300. Hyperlipidemia (e.g., hypercholesterolemia)
<input type="checkbox"/>	I3400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
<input type="checkbox"/>	<b>Musculoskeletal</b>
<input type="checkbox"/>	I3700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
<input type="checkbox"/>	I3800. Osteoporosis
<input type="checkbox"/>	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)
<input type="checkbox"/>	I4000. Other Fracture
<input type="checkbox"/>	<b>Neurological</b>
<input type="checkbox"/>	I4200. Alzheimer's Disease
<input type="checkbox"/>	I4300. Aphasia
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
<input type="checkbox"/>	I4800. Non-Alzheimer's Dementia (e.g. Lewybody 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

**Track Changes  
from Chapter 3 Section I V1.07  
to Chapter 3 Section I V1.08**

3	I	I-2	Replaced screen shot.
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**OLD**

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	
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	I5000. Paraplegia
<input type="checkbox"/>	I5100. Quadriplegia
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)
<input type="checkbox"/>	I5250. Huntington's Disease
<input type="checkbox"/>	I5300. Parkinson's Disease
<input type="checkbox"/>	I5350. Tourette's Syndrome
<input type="checkbox"/>	I5400. Seizure Disorder or Epilepsy
<input type="checkbox"/>	I5500. Traumatic Brain Injury (TBI)
Nutritional	
<input type="checkbox"/>	I5600. Malnutrition (protein or calorie) or at risk for malnutrition
Psychiatric/Mood Disorder	
<input type="checkbox"/>	I5700. Anxiety Disorder
<input type="checkbox"/>	I5800. Depression (other than bipolar)
<input type="checkbox"/>	I5900. Manic Depression (bipolar disease)
<input type="checkbox"/>	I5950. Psychotic Disorder (other than schizophrenia)
<input type="checkbox"/>	I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)
<input type="checkbox"/>	I6100. Post Traumatic Stress Disorder (PTSD)
Pulmonary	
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
<input type="checkbox"/>	I6300. Respiratory Failure
Vision	
<input type="checkbox"/>	I6500. Cataracts, Glaucoma, or Macular Degeneration
None of Above	
<input type="checkbox"/>	I7900. None of the above active diagnoses within the last 7 days
Other	
<input type="checkbox"/>	<b>I8000. Additional active diagnoses</b> Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.
A. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
B. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
C. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
D. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
E. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
F. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
G. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
H. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
I. _____	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; flex-wrap: wrap;"> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> <div style="width: 25px; height: 15px; border: 1px solid black;"></div> </div>
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**Track Changes  
from Chapter 3 Section I V1.07  
to Chapter 3 Section I V1.08**

**NEW**

**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

<b>Neurological - Continued</b>											
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>I4900. Hemiplegia or Hemiparesis</b> <b>I5000. Paraplegia</b> <b>I5100. Quadriplegia</b> <b>I5200. Multiple Sclerosis (MS)</b> <b>I5250. Huntington's Disease</b> <b>I5300. Parkinson's Disease</b> <b>I5350. Tourette's Syndrome</b> <b>I5400. Seizure Disorder or Epilepsy</b> <b>I5500. Traumatic Brain Injury (TBI)</b>										
<b>Nutritional</b>											
<input type="checkbox"/>	<b>I5600. Malnutrition</b> (protein or calorie) or at risk for malnutrition										
<b>Psychiatric/Mood Disorder</b>											
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>I5700. Anxiety Disorder</b> <b>I5800. Depression</b> (other than bipolar) <b>I5900. Manic Depression</b> (bipolar disease) <b>I5950. Psychotic Disorder</b> (other than schizophrenia) <b>I6000. Schizophrenia</b> (e.g., schizoaffective and schizophreniform disorders) <b>I6100. Post Traumatic Stress Disorder (PTSD)</b>										
<b>Pulmonary</b>											
<input type="checkbox"/> <input type="checkbox"/>	<b>I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease</b> (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis) <b>I6300. Respiratory Failure</b>										
<b>Vision</b>											
<input type="checkbox"/>	<b>I6500. Cataracts, Glaucoma, or Macular Degeneration</b>										
<b>None of Above</b>											
<input type="checkbox"/>	<b>I7900. None of the above active diagnoses within the last 7 days</b>										
<b>Other</b>											
<b>I8000. Additional active diagnoses</b> Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.											
A. _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>										
B. _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>										
C. _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>										
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E. _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>										
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I. _____	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>										
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**Track Changes  
from Chapter 3 Section I V1.07  
to Chapter 3 Section I V1.08**

3	I	I-3	<p>Replaced definition box.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p><b>OLD</b></p> <div style="border: 1px solid black; padding: 5px;"> <p><b>DEFINITIONS</b></p> <p><b>ACTIVE DIAGNOSES</b> Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.</p> <p><b>FUNCTIONAL LIMITATIONS</b> Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.</p> </div> </div> <div style="width: 48%;"> <p><b>NEW</b></p> <div style="border: 1px solid black; padding: 5px;"> <p><b>DEFINITIONS</b></p> <p><b>ACTIVE DIAGNOSES</b> 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..</p> <p><b>FUNCTIONAL LIMITATIONS</b> Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform, ADLs, paresis, or paralysis.</p> <p><b>NURSING MONITORING</b> Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).</p> </div> </div> </div>
3	I	I-3	<p>2. <b>Determine whether diagnoses are active:</b> Once a diagnosis is identified, <del>it must be determined if the diagnosis is active</del> <b>it must be determined if the diagnosis is active.</b> Do not include conditions that have been resolved or have no <b>longer</b> affected the resident's <b>current</b> functioning or plan of care, or that the resident has adjusted to as their "new normal," during the last 7 days. Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300 UTI.</p>
3	I	I-4	<ul style="list-style-type: none"> <li>• <b>Active</b> diagnoses have a <del>direct</del><b>direct</b> relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.</li> <li>• 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.</li> </ul>

**Track Changes  
from Chapter 3 Section I V1.07  
to Chapter 3 Section I V1.08**

			<p><b>Coding Instructions</b></p> <p><i>Code diseases that have a documented diagnosis in the last 60 days and have a <b>direct</b> relationship to the resident's <b>current</b> 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-8 for specific coding instructions).</i></p>
3	I	I-6	<ul style="list-style-type: none"> <li>14800, dementia (e.g., <del>non-Alzheimer's dementia,</del> including Lewy-Body <b>dementia</b>; 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)</li> </ul>

**Track Changes  
from Chapter 3 Section J V1.05  
to Chapter 3 Section J V1.08**

Chapter	Section	Page	Change
3	J1700	J-26	J1700: Fall History on Admission/Entry or Reentry
3	J1700	J-26	Replaced screen shot.
OLD			
<b>J1700. Fall History on Admission</b> Complete only if A0310A = 01 or A0310E = 1			
Enter Code <input type="checkbox"/>	A. Did the resident have a fall any time in the <b>last month</b> prior to admission? 0. No 1. Yes 9. Unable to determine		
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the <b>last 2-6 months</b> prior to admission? 0. No 1. Yes 9. Unable to determine		
Enter Code <input type="checkbox"/>	C. Did the resident have any <b>fracture related to a fall in the 6 months</b> prior to admission? 0. No 1. Yes 9. Unable to determine		
NEW			
<b>J1700. Fall History on Admission/Entry or Reentry</b> Complete only if A0310A = 01 or A0310E = 1			
Enter Code <input type="checkbox"/>	A. Did the resident have a fall any time in the <b>last month</b> prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine		
Enter Code <input type="checkbox"/>	B. Did the resident have a fall any time in the <b>last 2-6 months</b> prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine		
Enter Code <input type="checkbox"/>	C. Did the resident have any <b>fracture related to a fall in the 6 months</b> prior to admission/entry or reentry? 0. No 1. Yes 9. Unable to determine		
3	J1700	J-27	Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry?
3	J1700	J-28	Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to Admission/Entry or Reentry?  Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry?
3	J1800	J-29	J1800: Any Falls Since

**Track Changes**  
**from Chapter 3 Section J V1.05**  
**to Chapter 3 Section J V1.08**

Chapter	Section	Page	Change
			Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent
3	J1800	J-29	Replaced screen shot.
OLD			
<b>J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge),</b> whichever is more recent			
Enter Code <input type="checkbox"/>	Has the resident <b>had any falls since admission or the prior assessment</b> (OBRA, PPS, or Discharge), whichever is more recent? 0. <b>No</b> → Skip to K0100, Swallowing Disorder 1. <b>Yes</b> → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)		
NEW			
<b>J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS),</b> whichever is more recent			
Enter Code <input type="checkbox"/>	Has the resident <b>had any falls since admission/entry or reentry or the prior assessment</b> (OBRA or Scheduled PPS), whichever is more recent? 0. <b>No</b> → Skip to K0100, Swallowing Disorder 1. <b>Yes</b> → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)		
3	J1700	J-30	<ul style="list-style-type: none"><li>Code 1, yes: if the resident has fallen since the last assessment. Continue to <b>Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)</b> item (J1900), whichever is more recent.</li></ul>
3	J1900	J-31	J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

**Track Changes**  
**from Chapter 3 Section J V1.05**  
**to Chapter 3 Section J V1.08**

3 | J1800 | J-31 | Replaced screen shot.

OLD

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent	
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. <b>No injury</b> - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/> B. <b>Injury (except major)</b> - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/> C. <b>Major injury</b> - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

NEW

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
	<input type="checkbox"/> A. <b>No injury</b> - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	<input type="checkbox"/> B. <b>Injury (except major)</b> - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	<input type="checkbox"/> C. <b>Major injury</b> - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

3 | J1900 | J-32 | 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.

3 | J1900 | J-32 & J-33 | 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

**Track Changes  
from Chapter 3 Section J V1.05  
to Chapter 3 Section J V1.08**

			<p>(except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).</p> <ul style="list-style-type: none"> <li>• Code 1, one: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).</li> <li>• 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).</li> </ul> <p><b>Coding Instructions for J1900C, Major Injury</b></p> <ul style="list-style-type: none"> <li>• Code 0, none: if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).</li> <li>• Code 1, one: if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).</li> <li>• 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).</li> </ul>
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**Track Changes**  
**from Chapter 3 Section K V1.07**  
**to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
3	-	K-1	<b>Intent:</b> 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. <del>Nurse assessors</del> <b>The assessor</b> should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.
3	K0200	K-2	Replaced screen shot. <div> <div>OLD</div> <div> <div> <div>K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up</div> <div> <div> <div><input type="text"/></div><div><input type="text"/></div> <div>inches</div> </div> <div> <div>A. Height (in inches). Record most recent height measure since admission</div> </div> </div> <div> <div> <div><input type="text"/></div><div><input type="text"/></div><div><input type="text"/></div> <div>pounds</div> </div> <div> <div>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.)</div> </div> </div> </div> </div> <div> <div>NEW</div> <div> <div>K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up</div> <div> <div> <div><input type="text"/></div><div><input type="text"/></div> <div>inches</div> </div> <div> <div>A. Height (in inches). Record most recent height measure since the most recent admission/entry or reentry</div> </div> </div> <div> <div> <div><input type="text"/></div><div><input type="text"/></div><div><input type="text"/></div> <div>pounds</div> </div> <div> <div>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.)</div> </div> </div> </div> </div> </div>
3	K0200	K-3	<b>Steps for Assessment for K0200A, Height</b> 1. Base height on the most recent height since the most recent <del>On admission/entry or reentry,</del> <b>Measure and record height in inches.</b>
3	K0200	K-3	<b>Steps for Assessment for K0200B, Weight</b> 1. Base weight on the most recent measure in the last 30 <del>days</del> <b>On admission, weigh the resident and record results.</b>
3	K0200	K-5	<i>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 <del>gain or loss</del> assessed and addressed on the care plan as necessary.</i>
3	K0200	K-5	<ul style="list-style-type: none"> <li>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</li> </ul>

**Track Changes**  
**from Chapter 3 Section K V1.07**  
**to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change								
			physician orders for diuretics, K0300 can be coded as <b>1</b> .								
3	K0200	K-6	<b>Coding Tips</b> <ul style="list-style-type: none"><li>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.</li></ul> <p>If the resident is losing/<del>gaining</del> 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.</p>								
3	K0310	K-8 through K-10	<b>K0310: Weight Gain</b> <div><b>K0310. Weight Gain</b><table><tr><td>Enter Code</td><td>Gain of 5% or more in the last month or gain of 10% or more in last 6 months</td></tr><tr><td><input type="checkbox"/></td><td>0. No or unknown</td></tr><tr><td></td><td>1. Yes, on physician-prescribed weight-gain regimen</td></tr><tr><td></td><td>2. Yes, not on physician-prescribed weight-gain regimen</td></tr></table></div> <b>Item Rationale</b> <b>Health-related Quality of Life</b> <ul style="list-style-type: none"><li>Weight gain can result in debility and adversely affect health, safety, and quality of life.</li></ul> <b>Planning for Care</b> <ul style="list-style-type: none"><li>Weight gain may be an important indicator of a change in the resident’s health status or environment.</li><li>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., steroids), or changed fluid volume status.</li><li>Weight gain 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.</li></ul> <b>Steps for Assessment</b> <p><i>This item compares the resident’s weight in the current observation period with his or her weight at two snapshots in time:</i></p>	Enter Code	Gain of 5% or more in the last month or gain of 10% or more in last 6 months	<input type="checkbox"/>	0. No or unknown		1. Yes, on physician-prescribed weight-gain regimen		2. Yes, not on physician-prescribed weight-gain regimen
Enter Code	Gain of 5% or more in the last month or gain of 10% or more in last 6 months										
<input type="checkbox"/>	0. No or unknown										
	1. Yes, on physician-prescribed weight-gain regimen										
	2. Yes, not on physician-prescribed weight-gain regimen										

**Track Changes**  
**from Chapter 3 Section K V1.07**  
**to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
			<ul style="list-style-type: none"> <li>• At a point closest to 30-days preceding the current weight.</li> <li>• At a point closest to 180-days preceding the current weight.</li> </ul> <p><i>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.</i></p> <p><b>For a New Admission</b></p> <ol style="list-style-type: none"> <li>1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.</li> <li>2. Consult the resident's physician, review transfer documentation, and compare with admission weight.</li> <li>3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.</li> <li>4. Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.</li> </ol> <p><b>For Subsequent Assessments</b></p> <ol style="list-style-type: none"> <li>1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago.</li> <li>2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain.</li> <li>3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago.</li> <li>4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.</li> </ol> <p><b>Coding Instructions</b></p> <p><i>Mathematically round weights as described in Section K0200B before completing the weight gain calculation.</i></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>

**Track Changes  
from Chapter 3 Section K V1.07  
to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
			<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p><b>Coding Tips</b></p> <ul style="list-style-type: none"><li>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.</li><li>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.</li><li>To code K0310 as 1, yes, the expressed goal of the weight gain diet must be documented.</li></ul>
3	K0510	K-10	<b>K05010: Nutritional Approaches</b>
3	K0510	K-10	Replaced screen shot.

OLD

K0500. Nutritional Approaches	
↓ Check all that apply	
<input type="checkbox"/>	A. Parenteral/IV feeding
<input type="checkbox"/>	B. Feeding tube - nasogastric or abdominal (PEG)
<input type="checkbox"/>	C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
<input type="checkbox"/>	D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
<input type="checkbox"/>	Z. None of the above

NEW

**Track Changes  
from Chapter 3 Section K V1.07  
to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
<b>K0510. Nutritional Approaches</b> Check all of the following nutritional approaches that were performed during the last 7 days			
<b>1. While NOT a Resident</b> Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank <b>2. While a Resident</b> Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>		<b>1. While NOT a Resident</b>	<b>2. While a Resident</b>
		↓ Check all that apply ↓	
<b>A. Parenteral/IV feeding</b>		<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Feeding tube</b> - nasogastric or abdominal (PEG)		<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Mechanically altered diet</b> - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Therapeutic diet</b> (e.g., low salt, diabetic, low cholesterol)		<input type="checkbox"/>	<input type="checkbox"/>
<b>Z. None of the above</b>		<input type="checkbox"/>	<input type="checkbox"/>
3	K0510	K-11	<p><b>Steps for Assessment</b></p> <ul style="list-style-type: none"> <li>Review the medical record to determine if any of the listed nutritional approaches were <b>received performed</b> by the resident during the 7-day look-back period.</li> </ul> <p><b>Coding Instructions for Column 1</b></p> <p>Check all nutritional approaches performed <b>prior</b> to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.</p> <p><b>Coding Instructions for Column 2</b></p> <p>Check all nutritional approaches performed <b>after</b> admission/entry or reentry to the facility and within the 7-day look-back period.</p> <p><i>Check all that apply. If none apply, check K05100Z, None of the above.</i></p> <ul style="list-style-type: none"> <li>K05010A, parenteral/IV feeding</li> <li>K05010B, feeding tube – nasogastric or abdominal (PEG)</li> <li>K05010C, mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)</li> <li>K05010D, therapeutic diet (e.g., low salt, diabetic, low cholesterol)</li> <li>K05010Z, none of the above</li> </ul>

**Track Changes**  
**from Chapter 3 Section K V1.07**  
**to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
			<p><b>Coding Tips for K0510A</b></p> <p><i>K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, <b>provided they were administered for nutrition or hydration.</b></i></p>
3	K0510	K-12	<p>— IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.</p> <ul style="list-style-type: none"> <li>• <b>The following items are NOT to be coded in K0510A:</b></li> </ul>
3	K0510	K-12	<ul style="list-style-type: none"> <li>• Guidelines on basic fluid and electrolyte replacement can be found online at <a href="http://www.merck.com/mmpe/sec19/ch276/ch276b.htm">http://www.merck.com/mmpe/sec19/ch276/ch276b.htm</a> + <a href="http://guidelines.gov/content.aspx?id=15590&amp;search=fluid+and+electrolyte+replacement+amda">http://guidelines.gov/content.aspx?id=15590&amp;search=fluid+and+electrolyte+replacement+amda</a>.</li> <li>• Enteral feeding formulas: <ul style="list-style-type: none"> <li>— Should not be coded as a mechanically altered diet.</li> <li>— Should only be coded as <b>K0510D, Therapeutic Diet</b> when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.</li> </ul> </li> </ul>
3	K0510	K-12	<p><b>Coding Tips for K0510D</b></p> <ul style="list-style-type: none"> <li>• 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 <u>part</u> of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, 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).</li> </ul>
3	K0510	K-13	Example #1

**Track Changes**  
**from Chapter 3 Section K V1.07**  
**to Chapter 3 Section K V1.08**

Chapter	Section	Page	Change
			<p>Coding: K05010A would be checked. The IV medication would be coded at <b>IV Medications</b> item (O0100H).</p> <p>Example #2</p> <p>Coding: K05010A would NOT be checked. The IV medication would be coded at <b>IV Medications</b> item (O0100H).</p>
3	K0700	K-13	<i>Complete K0700 only if Column 1 K0500A and/or Column 2 K0500B is are checked for K0510A and/or K0510B. Skip to Section L, Oral/Dental Status, if neither is checked.</i>
3	K0700	K-13	Replaced screen shot.

OLD

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked	
Enter Code <input type="checkbox"/>	<b>A. Proportion of total calories the resident received through parenteral or tube feeding</b> 1. 25% or less 2. 26-50% 3. 51% or more
Enter Code <input type="checkbox"/>	<b>B. Average fluid intake per day by IV or tube feeding</b> 1. 500 cc/day or less 2. 501 cc/day or more

NEW

K0700. Percent Intake by Artificial Route - Complete K0700 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B	
Enter Code <input type="checkbox"/>	<b>A. Proportion of total calories the resident received through parenteral or tube feeding</b> 1. 25% or less 2. 26-50% 3. 51% or more
Enter Code <input type="checkbox"/>	<b>B. Average fluid intake per day by IV or tube feeding</b> 1. 500 cc/day or less 2. 501 cc/day or more

3	K0700	K-14	Page length change.
3	K0700	K-15	Page length change.
3	K0700	K-16	Page length change.

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

Chapter	Section	Page	Change
3	M0300B	M-8	Replaced screen shot.

OLD

Enter Number

Enter Number

**M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage**

**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

1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3

2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

Month

Day

Year

NEW

Enter Number

Enter Number

**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

1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3

2. Number of these 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

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

Month

Day

Year

3	M0300B	M-9	5. Identify the number of these these pressure ulcers that were present on admission/entry or re-entry reentry (see instructions on page M-6).
3	M0300C	M-10	Replaced screen shot.

OLD

Enter Number

Enter Number

**M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage**

**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 these Stage 3 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

NEW

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 these 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

3	M0300C	M-10	4. Identify the number of these these pressure ulcers that
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**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

Chapter	Section	Page	Change
			were present on admission/entry or <del>re-entry</del> <b>reentry</b> .
3	M0300C	M-11	<p>Example #1 Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or <del>re-entry</del> <b>reentry</b>.</p> <p>Example #2 Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or <del>re-entry</del> <b>reentry</b>.</p>
3	M0300C	M-12	<p>Example #3 Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or <del>re-entry</del> <b>reentry</b>. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or <del>re-entry</del> <b>reentry</b>.</p> <p>Example #4 Coding: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or <del>re-entry</del> <b>reentry</b>.</p>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M0300C	M-12	Replaced screen shot.
OLD			
<div><div><div>Enter Number</div><div><input type="text"/></div></div><div><div>Enter Number</div><div><input type="text"/></div></div></div> <div><div><b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b></div><div><div><b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</div><div><div>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</div><div>2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</div></div></div></div>			
NEW			
<div><div><div>Enter Number</div><div><input type="text"/></div></div><div><div>Enter Number</div><div><input type="text"/></div></div></div> <div><div><b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</div><div><div>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</div><div>2. Number of these 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</div></div></div> <div>M0300 continued on next page</div>			
3	M0300D	M-13	4. Identify the number of these these pressure ulcers that were present on admission/entry or re-entry.
3	M0300D	M-13	<b>Coding Instructions for M0300D</b> <ul style="list-style-type: none"><li>Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission/entry or re-entry reentry.</li></ul>
3	M0300E	M-14	Replaced screen shot.
OLD			
<div><div><div>Enter Number</div><div><input type="text"/></div></div><div><div>Enter Number</div><div><input type="text"/></div></div></div> <div><div><b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued</b></div><div><div><b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device</div><div><div>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar</div><div>2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</div></div></div></div>			
NEW			
<div><div><div>Enter Number</div><div><input type="text"/></div></div><div><div>Enter Number</div><div><input type="text"/></div></div></div> <div><div><b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device</div><div><div>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar</div><div>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</div></div></div>			
3	M0300E	M-14	3. Identify the number of these these pressure ulcers that were present on admission/entry or re-entry (see page M-6 for assessment process).
3	M0300E	M-15	<b>Coding Instructions for M0300E</b>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

			<ul style="list-style-type: none"> <li>Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device were first noted at the time of admission/entry or <del>re-entry</del> <b>reentry</b>.</li> </ul>
3	M0300F	M-15	Replaced screen shot.
<p>OLD</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued</b></p> <p><b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <div style="display: flex;"> <div style="width: 100px;"> <p>Enter Number</p> <input type="text"/> </div> <div> <p><b>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</b></p> </div> </div> <div style="display: flex;"> <div style="width: 100px;"> <p>Enter Number</p> <input type="text"/> </div> <div> <p><b>2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</b></p> </div> </div> </div> <p>NEW</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <div style="display: flex;"> <div style="width: 100px;"> <p>Enter Number</p> <input type="text"/> </div> <div> <p><b>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</b></p> </div> </div> <div style="display: flex;"> <div style="width: 100px;"> <p>Enter Number</p> <input type="text"/> </div> <div> <p><b>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</b></p> </div> </div> </div>			
3	M0300F	M-16	<p><b>Steps for Assessment</b></p> <p>2. Identify the number of <del>these</del> <b>these</b> pressure ulcers that were present on admission/entry or re-entry (see page M-6 for assessment process).</p>
3	M0300F	M-16	<p><b>Coding Instructions for M0300F</b></p> <p>Enter 0 if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or <del>re-entry</del> <b>reentry</b>.</p>
3	M0300F	M-17	<p><b>Example #1</b></p> <p>Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or <del>re-entry</del> <b>reentry</b>.</p> <p><b>Example #2</b></p> <p>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 <del>re-entry</del> <b>reentry</b>.</p>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M0300G	M-17	Replaced screen shot.
OLD			
<div> <div>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued</div> <div> <div>Enter Number</div> <input type="checkbox"/> </div> <div> <div>Enter Number</div> <input type="checkbox"/> </div> <div> <b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution               <ol style="list-style-type: none"> <li><b>Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</li> <li><b>Number of these unstageable pressure ulcers that were present upon admission/reentry</b> - enter how many were noted at the time of admission</li> </ol> </div> </div>			
NEW			
<div> <div>G. Unstageable - Deep tissue:</div> <div>Suspected deep tissue injury in evolution</div> <div> <div>Enter Number</div> <input type="checkbox"/> </div> <div> <div>Enter Number</div> <input type="checkbox"/> </div> <div> <b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar                <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry             </div> </div>			
3	M0300G	M-18	<b>Steps for Assessment</b>
			6. Identify the number of <del>these</del> <b>these</b> pressure ulcers that were present on admission/entry or re-entry (see page M-6 for instructions).
3	M0300G	M-19	<b>Coding Instructions for M0300G</b>
			<ul style="list-style-type: none"> <li>Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or <del>re-entry</del><b>reentry</b>.</li> </ul>
3	M0700	M-21	Replaced screen shot.
OLD			
<div> <div>M0700. Most Severe Tissue Type for Any Pressure Ulcer</div> <div> <div>Enter Code</div> <input type="checkbox"/> </div> <div>           Select the best description of the most severe type of tissue present in any pressure ulcer bed           <ol style="list-style-type: none"> <li><b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li><b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li><b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li><b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> </ol> </div> </div>			
NEW			
<div> <div>M0700. Most Severe Tissue Type for Any Pressure Ulcer</div> <div> <div>Enter Code</div> <input type="checkbox"/> </div> <div>           Select the best description of the most severe type of tissue present in any pressure ulcer bed           <ol style="list-style-type: none"> <li><b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li><b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li><b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li><b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> <li><b>None of the Above</b></li> </ol> </div> </div>			

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M0700	M-22	<ul style="list-style-type: none"> <li>Code 9, None of the above: if none of the above apply.</li> </ul>
3	M0700	M-23	<ul style="list-style-type: none"> <li>Code this item with <b>Code 9, None of the above</b>, <del>at</del> in the following situations <ul style="list-style-type: none"> <li>— Stage 1 pressure ulcer</li> <li>— Stage 2 pressure ulcer with intact blister</li> <li>— Unstageable pressure ulcer related to non-removable dressing /device</li> <li>— Unstageable pressure ulcer related to suspected deep tissue injury</li> </ul> </li> </ul> <p><b>Code 9</b> The dash is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.</p>
3	M0800	M-23	<b>M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled, PPS), or Last Admission/Entry or Reentry Discharge)</b>
3	M0800	M-23	Replaced screen shot.

**OLD**

<b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)</b>	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0	
Enter Number <input type="text"/>	<b>A. Stage 2</b>
Enter Number <input type="text"/>	<b>B. Stage 3</b>
Enter Number <input type="text"/>	<b>C. Stage 4</b>

**NEW**

<b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry</b>	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text"/>	<b>A. Stage 2</b>
Enter Number <input type="text"/>	<b>B. Stage 3</b>
Enter Number <input type="text"/>	<b>C. Stage 4</b>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M0800	M-24	<i>Look-back period for this item is back to the ARD of the prior assessment. <b>If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item.</b> Skip to M1030, Number of Venous and Arterial Ulcers.</i>
3	M0800	M-24 & M-25	<ul style="list-style-type: none"> <li>• If a pressure ulcer is acquired during a hospital admission, it is coded as present on admission/entry or <del>re-entry</del> <b>reentry</b> and not included in a count of worsening pressure ulcers.</li> <li>• If a pressure ulcer worsens to a more severe stage during a hospital admission, it should also be coded as present on admission/entry or <del>re-entry</del> <b>reentry</b> and not included in counts of worsening pressure ulcers. While not included in counts of worsening pressure ulcers, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates (worsens) to a higher (deeper) stage on subsequent MDS assessments, it would then be included in counts of worsening pressure ulcers.</li> </ul>
3	M0900	M-26	Replaced screen shot.

**OLD**

<b>M0900. Healed Pressure Ulcers</b>	
Complete only if A0310E = 0	
Enter Code <input type="checkbox"/>	<b>A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?</b> 0. <b>No</b> → Skip to M1030, Number of Venous and Arterial Ulcers 1. <b>Yes</b> → Continue to M0900B, Stage 2
Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0	
Enter Number <input type="checkbox"/>	<b>B. Stage 2</b>
Enter Number <input type="checkbox"/>	<b>C. Stage 3</b>
Enter Number <input type="checkbox"/>	<b>D. Stage 4</b>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

NEW

<b>M0900. Healed Pressure Ulcers</b> Complete only if A0310E = 0	
Enter Code <input style="width: 30px; height: 20px;" type="text"/>	<b>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</b> 0. <b>No</b> → Skip to M1030, Number of Venous and Arterial Ulcers 1. <b>Yes</b> → Continue to M0900B, Stage 2  Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<b>B. Stage 2</b>
Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<b>C. Stage 3</b>
Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<b>D. Stage 4</b>

3	M0900	M-27	<p><b>Steps for Assessment</b></p> <p><i>Complete on all residents, including those without a current pressure ulcer.</i></p> <p><i>Look-back period for this item is the ARD of the prior assessment. <b>If no prior assessment (i.e., if this is the first OBRA or <span style="background-color: yellow;">scheduled</span> PPS assessment), do not complete this item.</b> Skip to M1030.</i></p>
3	M1040	M-29	Replaced screen shot.

OLD

<b>M1040. Other Ulcers, Wounds and Skin Problems</b>	
↓ Check all that apply	
<b>Foot Problems</b>	
<input type="checkbox"/>	<b>A. Infection of the foot</b> (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	<b>B. Diabetic foot ulcer(s)</b>
<input type="checkbox"/>	<b>C. Other open lesion(s) on the foot</b>
<b>Other Problems</b>	
<input type="checkbox"/>	<b>D. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
<input type="checkbox"/>	<b>E. Surgical wound(s)</b>
<input type="checkbox"/>	<b>F. Burn(s)</b> (second or third degree)
<b>None of the Above</b>	
<input type="checkbox"/>	<b>Z. None of the above</b> were present

**Track Changes**  
**from Chapter 3 Section M V1.07**  
**to Chapter 3 Section M V1.08**

NEW

M1040. Other Ulcers, Wounds and Skin Problems	
↓	Check all that apply
<b>Foot Problems</b>	
<input type="checkbox"/>	<b>A. Infection of the foot</b> (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	<b>B. Diabetic foot ulcer(s)</b>
<input type="checkbox"/>	<b>C. Other open lesion(s) on the foot</b>
<b>Other Problems</b>	
<input type="checkbox"/>	<b>D. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
<input type="checkbox"/>	<b>E. Surgical wound(s)</b>
<input type="checkbox"/>	<b>F. Burn(s)</b> (second or third degree)
<input type="checkbox"/>	<b>G. Skin tear(s)</b>
<input type="checkbox"/>	<b>H. Moisture Associated Skin Damage (MASD)</b> (i.e. incontinence (IAD), perspiration, drainage)
<b>None of the Above</b>	
<input type="checkbox"/>	<b>Z. None of the above</b> were present

3	M1040	M-31	<ul style="list-style-type: none"> <li>M1040G, skin tear(s)</li> <li>M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage)</li> </ul>
3	M1040	M-32	<p><b>M1040G Skin Tear(s)</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>M1040H Moisture Associated Skin Damage (MASD)</b></p> <ul style="list-style-type: none"> <li>Moisture associated skin damage is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. MASD is also referred to as incontinence dermatitis.</li> </ul>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-32	Replaced screen shot.
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OLD

M1200. Skin and Ulcer Treatments	
↓	Check all that apply
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

NEW

M1200. Skin and Ulcer Treatments	
↓	Check all that apply
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<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

3	M1200	M-33	<b>Coding Instructions</b> <ul style="list-style-type: none"> <li>M1200E, <b>pressure</b> ulcer care</li> </ul>
3	M1200	M-34	Page length change.
3	M1200	M-35	<b>M1200E Pressure Ulcer Care</b> <ul style="list-style-type: none"> <li><b>Pressure u</b>lcer care includes <b>any</b> intervention for treating pressure ulcers coded in <b>Current Number of Unhealed Pressure Ulcers at Each Stage</b> item (M0300). Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.</li> </ul>
3	M1200	M-35	<b>M1200G...</b> <ul style="list-style-type: none"> <li>Do NOT code application of non-surgical dressings for</li> </ul>

**Track Changes  
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			pressure ulcer(s) other than to feet in this item; use <b>Pressure Ulcer Care</b> item (M1200E).
3	M1200	M-36	<b>M1200H</b> <ul style="list-style-type: none"> <li>Do NOT code application of ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers here; use <b>Pressure Ulcer Care</b>, item (M1200E).</li> </ul>
3	M1200	M-36	<b>M1200I</b> <ul style="list-style-type: none"> <li>Do NOT code application of dressings to pressure ulcers on the foot, use <b>Pressure Ulcer Care</b> item (M1200E).</li> </ul>
3	M1200	M-37	Page length change.
3	M1200	M-38	— M0300B2 (Number of <b>these</b> Stage 2 pressure ulcers present on admission/entry or <del>re-entry</del> <b>reentry</b> ), Code 1.
3	M1200	M-38	Replaced screen shot.

**OLD**

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">0</div>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">1</div>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">1</div>	<ol style="list-style-type: none"> <li><b>Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3</li> <li><b>Number of these Stage 2 pressure ulcers that were present upon admission/reentry</b> - enter how many were noted at the time of admission</li> <li><b>Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown:  <div style="display: flex; align-items: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> </ol>

**NEW**

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">0</div>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">1</div>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 0 auto;">1</div>	<ol style="list-style-type: none"> <li><b>Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3</li> <li><b>Number of <b>these</b> Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry</li> <li><b>Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown:  <div style="display: flex; align-items: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> </ol>

3	M1200	M-38	Quarterly Assessment #1: — M0300B2 (Number of <b>these</b> Stage 2 pressure ulcers present upon admission/entry or <del>re-entry</del> <b>reentry</b> ), Code 1.
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**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-38	Replaced screen shot.
OLD			
<div> <div> <div>Enter Number</div> <div>0</div> </div> <div>Enter Number</div> <div>1</div> <div>Enter Number</div> <div>1</div> </div> <div> <b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b>  <b>A. Number of Stage 1 pressure ulcers</b>  <b>Stage 1:</b> 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  <b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister  <b>1. Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3  <b>2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry</b> - enter how many were noted at the time of admission  <b>3. Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown:  <div> <div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div> <div>Month</div><div>Day</div><div>Year</div> </div> </div>			
NEW			
<div> <div> <div>Enter Number</div> <div>0</div> </div> <div>Enter Number</div> <div>1</div> <div>Enter Number</div> <div>1</div> </div> <div> <b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b>  <b>A. Number of Stage 1 pressure ulcers</b>  <b>Stage 1:</b> 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  <b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister  <b>1. Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3  <b>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry  <b>3. Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown:  <div> <div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div><div>-</div> <div>Month</div><div>Day</div><div>Year</div> </div> </div>			
3	M1200	M-39	— M0800 (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled; PPS; or Last Admission/Entry or Reentry Discharge) – M0800A (Stage 2) Code 0, M0800B (Stage 3) Code 1, M0800C (Stage 4) Code 0.

**Track Changes  
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to Chapter 3 Section M V1.08**

3	M1200	M-40	Replaced screen shot.
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OLD

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	<b>A. Number of Stage 1 pressure ulcers</b> <b>Stage 1:</b> 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 <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;"></div>	<b>1. Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3  <b>2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry</b> - enter how many were noted at the time of admission  <b>3. Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; 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**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-41	Replaced screen shot.
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**OLD**

**M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued**

Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device  1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar  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  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution  1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

**M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar**  
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0  
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

<input style="width: 30px; text-align: center;" type="text" value="0"/> <input style="width: 30px; text-align: center;" type="text" value="3"/> . <input style="width: 30px; text-align: center;" type="text" value="0"/> cm	<b>A. Pressure ulcer length:</b> Longest length from head to toe
<input style="width: 30px; text-align: center;" type="text" value="0"/> <input style="width: 30px; text-align: center;" type="text" value="2"/> . <input style="width: 30px; text-align: center;" type="text" value="4"/> cm	<b>B. Pressure ulcer width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input style="width: 30px; text-align: center;" type="text" value="0"/> <input style="width: 30px; text-align: center;" type="text" value="0"/> . <input style="width: 30px; text-align: center;" type="text" value="2"/> cm	<b>C. Pressure ulcer depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

Enter Code <input style="width: 30px; text-align: center;" type="text" value="2"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance 3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
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**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)**  
Complete only if A0310E = 0  
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge).  
If no current pressure ulcer at a given stage, enter 0

Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>A. Stage 2</b>
Enter Number <input style="width: 30px; text-align: center;" type="text" value="1"/>	<b>B. Stage 3</b>
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>C. Stage 4</b>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

**NEW**

**M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued**

Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;"></div>	<b>1. Number of unstageable pressure ulcers due to non-removable dressing/device</b> - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;"></div>	<b>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</b> - If 0 → Skip to M0300G, Unstageable: Deep tissue  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;"></div>	<b>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution</b> - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  <b>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry

**M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar**

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

<div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">3</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	cm	<b>A. Pressure ulcer length:</b> Longest length from head to toe
<div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">2</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">4</div>	cm	<b>B. Pressure ulcer width:</b> Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div> <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">2</div>	cm	<b>C. Pressure ulcer depth:</b> Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

**M0700. Most Severe Tissue Type for Any Pressure Ulcer**

Enter Code <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">2</div>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance 3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. <b>None of the Above</b>
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**M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry**

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	<b>A. Stage 2</b>
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">1</div>	<b>B. Stage 3</b>
Enter Number <div style="border: 1px solid black; width: 30px; text-align: center; margin: 2px;">0</div>	<b>C. Stage 4</b>

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-42	MO900 (Healed pressure ulcers). Skip to M1030 since this item is only completed if AO310E=0. The 5-Day PPS Assessment is the first assessment since the most recent entry of any kind (admission/entry or re-entry <b>reentry</b> ), therefore, AO310E=1.
3	M1200	M-43	Replaced screen shot.

OLD

<b>M1030. Number of Venous and Arterial Ulcers</b>	
Enter Number	Enter the total number of venous and arterial ulcers present
<input type="text" value="0"/>	
<b>M1040. Other Ulcers, Wounds and Skin Problems</b>	
↓ Check all that apply	
<b>Foot Problems</b>	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
<b>Other Problems</b>	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<b>None of the Above</b>	
<input checked="" type="checkbox"/>	Z. None of the above were present
<b>M1200. Skin and Ulcer Treatments</b>	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input checked="" type="checkbox"/>	Z. None of the above were provided

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

**NEW**

<b>M1030. Number of Venous and Arterial Ulcers</b>	
Enter Number	Enter the total number of venous and arterial ulcers present
<input style="width: 30px; border: 1px solid black;" type="text" value="0"/>	
<b>M1040. Other Ulcers, Wounds and Skin Problems</b>	
↓ Check all that apply	
<b>Foot Problems</b>	
<input type="checkbox"/>	<b>A. Infection of the foot</b> (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	<b>B. Diabetic foot ulcer(s)</b>
<input type="checkbox"/>	<b>C. Other open lesion(s) on the foot</b>
<b>Other Problems</b>	
<input type="checkbox"/>	<b>D. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
<input type="checkbox"/>	<b>E. Surgical wound(s)</b>
<input type="checkbox"/>	<b>F. Burn(s)</b> (second or third degree)
<input type="checkbox"/>	<b>G. Skin tear(s)</b>
<input type="checkbox"/>	<b>H. Moisture Associated Skin Damage (MASD)</b> (i.e. incontinence (IAD), perspiration, drainage)
<b>None of the Above</b>	
<input checked="" type="checkbox"/>	<b>Z. None of the above</b> were present
<b>M1200. Skin and Ulcer Treatments</b>	
↓ Check all that apply	
<input type="checkbox"/>	<b>A. Pressure reducing device for chair</b>
<input type="checkbox"/>	<b>B. Pressure reducing device for bed</b>
<input type="checkbox"/>	<b>C. Turning/repositioning program</b>
<input type="checkbox"/>	<b>D. Nutrition or hydration intervention</b> to manage skin problems
<input type="checkbox"/>	<b>E. Pressure ulcer care</b>
<input type="checkbox"/>	<b>F. Surgical wound care</b>
<input type="checkbox"/>	<b>G. Application of nonsurgical dressings</b> (with or without topical medications) other than to feet
<input type="checkbox"/>	<b>H. Applications of ointments/medications</b> other than to feet
<input type="checkbox"/>	<b>I. Application of dressings to feet</b> (with or without topical medications)
<input checked="" type="checkbox"/>	<b>Z. None of the above</b> were provided

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-44	<ul style="list-style-type: none"> <li>— M0300B2 (Number of <b>these</b> Stage 2 pressure ulcers present on admission/entry or re-entry), Code 0.</li> <li>— M0800 (Worsening in pressure ulcer status since prior assessment (OBRA <b>or scheduled</b>, PPS, or <b>Last Admission/Entry or Reentry</b> <del>Discharge</del>)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because the 14-Day PPS is NOT the first assessment since the most recent <del>entry of any kind</del> (admission/entry or <b>re-entry</b> <del>reentry</del>). Therefore, A0310E=0. M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.</li> <li>— M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is NOT the first assessment since the most recent <del>entry of any kind</del> (admission/entry or <b>re-entry</b> <del>reentry</del>). Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.</li> </ul>
3	M1200	M-45	<ul style="list-style-type: none"> <li>— M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (<b>Pressure u</b>lcer care) are all checked.</li> </ul> <p>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. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at A0310E. This is because the 14-Day PPS is NOT the first assessment since the most recent admission/entry or re-entry. Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of</p>

**Track Changes  
from Chapter 3 Section M V1.07  
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			breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings – with or without topical medications) would <b>NOT</b> be coded here because <b>any</b> intervention for treating pressure ulcers is coded in M1200E ( <b>Pressure u</b> lcer care)
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**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-46	Replaced screen shot.
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OLD

<b>M0100. Determination of Pressure Ulcer Risk</b>	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input checked="" type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above
<b>M0150. Risk of Pressure Ulcers</b>	
Enter Code	Is this resident at risk of developing pressure ulcers?
1	0. No 1. Yes
<b>M0210. Unhealed Pressure Ulcer(s)</b>	
Enter Code	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
1	0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
<b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b>	
Enter Number	A. Number of Stage 1 pressure ulcers
0	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	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
1	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3
Enter Number	2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">1</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">1</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">0</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">1</div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">2</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">0</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">1</div> <div style="border: 1px solid black; padding: 2px 5px; margin: 0 2px;">0</div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
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
0	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4
Enter Number	2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	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
Enter Number	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
Enter Number	2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	
<b>M0300 continued on next page</b>	

**Track Changes**  
**from Chapter 3 Section M V1.07**  
**to Chapter 3 Section M V1.08**

NEW

<b>M0100. Determination of Pressure Ulcer Risk</b>	
↓ Check all that apply	
<input checked="" type="checkbox"/>	<b>A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device</b>
<input checked="" type="checkbox"/>	<b>B. Formal assessment instrument/tool</b> (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	<b>C. Clinical assessment</b>
<input type="checkbox"/>	<b>Z. None of the above</b>
<b>M0150. Risk of Pressure Ulcers</b>	
Enter Code	<b>Is this resident at risk of developing pressure ulcers?</b>
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">1</div>	0. No 1. Yes
<b>M0210. Unhealed Pressure Ulcer(s)</b>	
Enter Code	<b>Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</b>
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">1</div>	0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
<b>M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</b>	
Enter Number	<b>A. Number of Stage 1 pressure ulcers</b>
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">0</div>	<b>Stage 1:</b> 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	<b>B. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">1</div>	1. <b>Number of Stage 2 pressure ulcers</b> - If 0 → Skip to M0300C, Stage 3
Enter Number	2. <b>Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">0</div>	3. <b>Date of oldest Stage 2 pressure ulcer</b> - Enter dashes if date is unknown: <div style="display: flex; align-items: center; justify-content: center; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">1</div> <div style="font-size: 1.2em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">1</div> <div style="font-size: 1.2em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">2</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">0</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">1</div> <div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; text-align: center;">0</div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em; margin-top: 2px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>
Enter Number	<b>C. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">0</div>	1. <b>Number of Stage 3 pressure ulcers</b> - If 0 → Skip to M0300D, Stage 4
Enter Number	2. <b>Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;"></div>	
Enter Number	<b>D. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;">0</div>	1. <b>Number of Stage 4 pressure ulcers</b> - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
Enter Number	2. <b>Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry</b> - enter how many were noted at the time of admission/entry or reentry
<div style="border: 1px solid black; width: 20px; height: 20px; line-height: 20px; margin: 0 auto;"></div>	
<b>M0300 continued on next page</b>	

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-47	Replaced screen shot.
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OLD

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	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  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission

NEW

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>E. Unstageable - Non-removable dressing:</b> Known but not stageable due to non-removable dressing/device
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	1. Number of unstageable pressure ulcers 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 that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>F. Unstageable - Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	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  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
Enter Number <input style="width: 30px; text-align: center;" type="text" value="0"/>	<b>G. Unstageable - Deep tissue:</b> Suspected deep tissue injury in evolution
Enter Number <input style="width: 30px; text-align: center;" type="text"/>	1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar  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

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-47	Replaced screen shot.
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OLD

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">1</div>	<p>Select the best description of the most severe type of tissue present in any pressure ulcer bed</p> <ol style="list-style-type: none"> <li>1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li>2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li>3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li>4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> </ol>

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present</b> or were at a <b>lesser stage</b> on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0	
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">1</div>	A. Stage 2
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	B. Stage 3
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	C. Stage 4

NEW

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">1</div>	<p>Select the best description of the most severe type of tissue present in any pressure ulcer bed</p> <ol style="list-style-type: none"> <li>1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin</li> <li>2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance</li> <li>3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous</li> <li>4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin</li> <li>9. <b>None of the Above</b></li> </ol>

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were <b>not present</b> or were at a <b>lesser stage</b> on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">1</div>	A. Stage 2
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	B. Stage 3
Enter Number <div style="border: 1px solid black; width: 20px; text-align: center; margin: 2px;">0</div>	C. Stage 4

**Track Changes**  
**from Chapter 3 Section M V1.07**  
**to Chapter 3 Section M V1.08**

3	M1200	M-48	Replaced screen shot.
OLD			
<b>M0900. Healed Pressure Ulcers</b> Complete only if A0310E = 0			
Enter Code <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; line-height: 30px; margin: 0 auto;">0</div>	<b>A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?</b> 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2  Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0		
Enter Number <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>B. Stage 2</b>		
Enter Number <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>C. Stage 3</b>		
Enter Number <div style="border: 1px solid black; width: 30px; height: 30px; margin: 0 auto;"></div>	<b>D. Stage 4</b>		
<b>M1030. Number of Venous and Arterial Ulcers</b>			
Enter Number <div style="border: 1px solid black; width: 30px; height: 30px; text-align: center; line-height: 30px; margin: 0 auto;">0</div>	Enter the total number of venous and arterial ulcers present		
<b>M1040. Other Ulcers, Wounds and Skin Problems</b>			
↓ Check all that apply			
<b>Foot Problems</b>			
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)		
<input type="checkbox"/>	B. Diabetic foot ulcer(s)		
<input type="checkbox"/>	C. Other open lesion(s) on the foot		
<b>Other Problems</b>			
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)		
<input type="checkbox"/>	E. Surgical wound(s)		
<input type="checkbox"/>	F. Burn(s) (second or third degree)		
<b>None of the Above</b>			
<input checked="" type="checkbox"/>	Z. None of the above were present		
<b>M1200. Skin and Ulcer Treatments</b>			
↓ Check all that apply			
<input checked="" type="checkbox"/>	A. Pressure reducing device for chair		
<input checked="" type="checkbox"/>	B. Pressure reducing device for bed		
<input checked="" type="checkbox"/>	C. Turning/repositioning program		
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems		
<input checked="" type="checkbox"/>	E. Ulcer care		
<input type="checkbox"/>	F. Surgical wound care		
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet		
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet		
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)		
<input type="checkbox"/>	Z. None of the above were provided		

**Track Changes**  
**from Chapter 3 Section M V1.07**  
**to Chapter 3 Section M V1.08**

NEW

**M0900. Healed Pressure Ulcers**

Complete only if A0310E = 0

Enter Code	0	<b>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</b> 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2  Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number	□	<b>B. Stage 2</b>
Enter Number	□	<b>C. Stage 3</b>
Enter Number	□	<b>D. Stage 4</b>

**M1030. Number of Venous and Arterial Ulcers**

Enter Number	0	Enter the total number of venous and arterial ulcers present
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**M1040. Other Ulcers, Wounds and Skin Problems**

↓	Check all that apply
	<b>Foot Problems</b>
<input type="checkbox"/>	<b>A. Infection of the foot</b> (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	<b>B. Diabetic foot ulcer(s)</b>
<input type="checkbox"/>	<b>C. Other open lesion(s) on the foot</b>
	<b>Other Problems</b>
<input type="checkbox"/>	<b>D. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
<input type="checkbox"/>	<b>E. Surgical wound(s)</b>
<input type="checkbox"/>	<b>F. Burn(s)</b> (second or third degree)
<input type="checkbox"/>	<b>G. Skin tear(s)</b>
<input type="checkbox"/>	<b>H. Moisture Associated Skin Damage (MASD)</b> (i.e. incontinence (IAD), perspiration, drainage)
	<b>None of the Above</b>
<input checked="" type="checkbox"/>	<b>Z. None of the above</b> were present

**M1200. Skin and Ulcer Treatments**

↓	Check all that apply
<input checked="" type="checkbox"/>	<b>A. Pressure reducing device for chair</b>
<input checked="" type="checkbox"/>	<b>B. Pressure reducing device for bed</b>
<input checked="" type="checkbox"/>	<b>C. Turning/repositioning program</b>
<input type="checkbox"/>	<b>D. Nutrition or hydration intervention</b> to manage skin problems
<input checked="" type="checkbox"/>	<b>E. Pressure ulcer care</b>
<input type="checkbox"/>	<b>F. Surgical wound care</b>
<input type="checkbox"/>	<b>G. Application of nonsurgical dressings</b> (with or without topical medications) other than to feet
<input type="checkbox"/>	<b>H. Applications of ointments/medications</b> other than to feet
<input type="checkbox"/>	<b>I. Application of dressings to feet</b> (with or without topical medications)
<input type="checkbox"/>	<b>Z. None of the above</b> were provided

**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

3	M1200	M-49 to M-53	<p><b>Scenarios for Pressure Ulcer Coding (cont.)</b></p> <p>Discharge Assessment:</p> <p><u>Coding:</u></p> <ul style="list-style-type: none"> <li>— <del>M0100A (Resident has a Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device), Check box.</del></li> <li>— <del>M0100B (Formal assessment instrument), Check box.</del></li> <li>— <del>M0100C (Clinical assessment), Check box.</del></li> <li>— <del>M0150 (Risk of Pressure Ulcers), Code 1.</del></li> <li>— <del>M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 1.</del></li> <li>— <del>M0300A (Number of Stage 1 pressure ulcers), Code 0.</del></li> <li>— <del>M0300B1 (Number of Stage 2 pressure ulcers), Code 1.</del></li> <li>— <del>M0300B2 (Number of Stage 2 pressure ulcers present on admission/entry or re-entry), Code 0.</del></li> <li>— <del>M0300B3 (Date of the oldest Stage 2 pressure ulcer), Enter 11-01-2010.</del></li> <li>— <del>M0300C1 (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).</del></li> <li>— <del>M0300D1 (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable: Non-removable dressing).</del></li> <li>— <del>M0300E1 (Unstageable: Non-removable dressing), Code 0 and skip to M0300F (Unstageable: Slough and/or eschar).</del></li> <li>— <del>M0300F1 (Unstageable: Slough and/or eschar), Code 0 and skip to M0300G (Unstageable: Deep tissue).</del></li> <li>— <del>M0300G1 (Unstageable: Deep tissue), Code 0 and skip to M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar).</del></li> <li>— <del>M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is NOT completed, as the resident has a Stage 2 pressure ulcer.</del></li> <li>— <del>M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).</del></li> <li>— <del>M0800 (Worsening in pressure ulcer status</del></li> </ul>
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**Track Changes  
from Chapter 3 Section M V1.07  
to Chapter 3 Section M V1.08**

			<p>since prior assessment (OBRA, PPS, or Discharge)), M0800A, Code 0; M0800B, Code 0; M0800C, Code 0. This item is completed because the Discharge assessment is NOT the first assessment since the most recent entry of any kind (admission/entry or reentry). Therefore, A0310E=0. M0800A is coded 0 because the Stage 2 pressure ulcer has not worsened since the prior assessment (14 Day PPS).</p> <p>— M0900A (Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge?)), Code 1. This item is completed because the Discharge assessment is NOT the first assessment since the most recent entry of any kind (admission/entry or reentry). Therefore, A0310E=0. M0900A is coded 1 because there was a Stage 2 pressure ulcer present on the prior assessment (14 Day PPS). M0900B (Stage 2), M0900C (Stage 3), and M0900D (Stage 4) are all Coded 0 because the Stage 2 pressure ulcer is not completely resurfaced with epithelial tissue and there are no healed pressure ulcers at any other Stage.</p> <p>— M1030 (Number of Venous and Arterial ulcers), Code 0.</p> <p><b>Scenarios for Pressure Ulcer Coding (cont.)</b></p> <p>— M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).</p> <p>— M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (Ulcer care) are all checked.</p> <ul style="list-style-type: none"> <li>• <b>Rationale:</b> On Discharge, the resident's assessment was still that the Stage 2 pressure ulcer was present, all supportive care was being provided, there were no new pressure ulcers, wound had not yet healed, and there were no new skin problems or treatments. M0800A (Stage 2) is coded as 0 on the Discharge Assessment because the Stage 2 pressure ulcer that is present at the time of this assessment was not at a lesser stage on the prior assessment (14 Day PPS). M0900A (Were</li> </ul>
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**Track Changes**  
**from Chapter 3 Section M V1.07**  
**to Chapter 3 Section M V1.08**

pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge?)) is coded as a 1 because the Stage 2 pressure ulcer was present on the prior assessment (14 Day PPS).

## Scenarios for Pressure Ulcer Coding (cont.)

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input checked="" type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above
M0150. Risk of Pressure Ulcers	
Enter Code	Is this resident at risk of developing pressure ulcers?
1	0. No 1. Yes
M0210. Unhealed Pressure Ulcer(s)	
Enter Code	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
1	0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number	A. Number of Stage 1 pressure ulcers
0	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	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
1	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3
Enter Number	2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:
	<div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">-</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">-</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">2</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">1</div> <div style="border: 1px solid black; padding: 2px; display: inline-block;">0</div> <div style="margin: 0 5px;">Month Day Year</div>
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
0	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4
Enter Number	2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	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
Enter Number	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing
Enter Number	2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	
M0300 continued on next page	

## Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device
0	1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
Enter Number	2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	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
Enter Number	2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution
Enter Number	1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Enter Number	2. Number of these unstageable pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission
0	

# Track Changes from Chapter 3 Section M V1.07 to Chapter 3 Section M V1.08

			<div> <b>M0700. Most Severe Tissue Type for Any Pressure Ulcer</b>  Select the best description of the most severe type of tissue present in any pressure ulcer bed  Enter Code <input type="text" value="1"/>  1. <b>Epithelial tissue</b> - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin  2. <b>Granulation tissue</b> - pink or red tissue with shiny, moist, granular appearance  3. <b>Slough</b> - yellow or white tissue that adheres to the ulcer bed in strings or thick dumps, or is mucinous  4. <b>Necrotic tissue (Eschar)</b> - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin  </div> <div> <b>M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)</b>  Complete only if A0310E = 0  Indicate the number of current pressure ulcers that were <b>not present or were at a lesser stage</b> on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0  Enter Number <input type="text" value="0"/> <b>A. Stage 2</b>  Enter Number <input type="text" value="0"/> <b>B. Stage 3</b>  Enter Number <input type="text" value="0"/> <b>C. Stage 4</b> </div> <div> <b>M0900. Healed Pressure Ulcers</b>  Complete only if A0310E = 0  Enter Code <input type="text" value="1"/> <b>A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?</b>  0. <b>No</b> → Skip to M1030, Number of Venous and Arterial Ulcers  1. <b>Yes</b> → Continue to M0900B, Stage 2  Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0  Enter Number <input type="text" value="0"/> <b>B. Stage 2</b>  Enter Number <input type="text" value="0"/> <b>C. Stage 3</b>  Enter Number <input type="text" value="0"/> <b>D. Stage 4</b> </div>
			<div> <b>M1030. Number of Venous and Arterial Ulcers</b>  Enter Number <input type="text" value="0"/> Enter the total number of venous and arterial ulcers present  </div> <div> <b>M1040. Other Ulcers, Wounds and Skin Problems</b>  Check all that apply  ↓  <b>Foot Problems</b>  <input type="checkbox"/> <b>A. Infection of the foot (e.g., cellulitis, purulent drainage)</b>  <input type="checkbox"/> <b>B. Diabetic foot ulcer(s)</b>  <input type="checkbox"/> <b>C. Other open lesion(s) on the foot</b>  <b>Other Problems</b>  <input type="checkbox"/> <b>D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)</b>  <input type="checkbox"/> <b>E. Surgical wound(s)</b>  <input type="checkbox"/> <b>F. Burn(s) (second or third degree)</b>  <input type="checkbox"/> <b>None of the Above</b>  <input checked="" type="checkbox"/> <b>Z. None of the above were present</b> </div> <div> <b>M1200. Skin and Ulcer Treatments</b>  Check all that apply  ↓  <input checked="" type="checkbox"/> <b>A. Pressure reducing device for chair</b>  <input checked="" type="checkbox"/> <b>B. Pressure reducing device for bed</b>  <input checked="" type="checkbox"/> <b>C. Turning/repositioning program</b>  <input type="checkbox"/> <b>D. Nutrition or hydration intervention to manage skin problems</b>  <input checked="" type="checkbox"/> <b>E. Ulcer care</b>  <input type="checkbox"/> <b>F. Surgical wound care</b>  <input type="checkbox"/> <b>G. Application of nonsurgical dressings (with or without topical medications) other than to feet</b>  <input type="checkbox"/> <b>H. Applications of ointments/medications other than to feet</b>  <input type="checkbox"/> <b>I. Application of dressings to feet (with or without topical medications)</b>  <input type="checkbox"/> <b>Z. None of the above were provided</b> </div>

## Scenarios for Pressure Ulcer Coding (cont.)

**Track Changes**  
**from Chapter 3 Section N V1.07**  
**to Chapter 3 Section N V1.08**

Chapter	Section	Page	Change
3	N0300	N-1	Replaced screen shot.
OLD			
<div> <div>N0300. Injections</div> <div> <div>Enter Days</div> <div><input type="text"/></div> </div> <div>Record the number of days that injections of any type were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received</div> </div>			
NEW			
<div> <div>N0300. Injections</div> <div> <div>Enter Days</div> <div><input type="text"/></div> </div> <div>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 N0410, Medications Received</div> </div>			
3	N0300	N-1	<b>Steps for Assessment</b> <ol style="list-style-type: none"> <li>Review the resident's medication administration records for the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> </ol>
3	N0300	N-1	<b>Coding Instructions</b> <p><i>Record the number of days during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.</i></p>
3	N0300	N-2	<b>Coding Tips and Special Populations</b> <ul style="list-style-type: none"> <li>If an antigen or vaccination is provided on <del>4</del><b>one</b> day, and another vaccine provided on the next day, the number of days the resident received injections would be <b>coded as 2 days</b>.</li> <li>If two injections were administered on the same day, the number of days the resident received injections would be <b>coded as 1 day</b>.</li> </ul> <b>Examples</b> <p>Example #1  Rationale: The resident received injections on 3 <b>separate</b> days during the 7-day look-back period.</p> <p>Example #2  Coding: N0300 would be coded 1.  Rationale: The resident received injections on <del>4</del><b>one</b> day during the 7-day look-back period.</p>

**Track Changes  
from Chapter 3 Section N V1.07  
to Chapter 3 Section N V1.08**

3	N0350	N-2	Replaced screen shot.						
OLD									
<table><tr><th colspan="2">N0350. Insulin</th></tr><tr><td>Enter Days <input type="text"/></td><td>A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/reentry if less than 7 days</td></tr><tr><td>Enter Days <input type="text"/></td><td>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/reentry if less than 7 days</td></tr></table>				N0350. Insulin		Enter Days <input type="text"/>	A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/reentry if less than 7 days	Enter Days <input type="text"/>	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/reentry if less than 7 days
N0350. Insulin									
Enter Days <input type="text"/>	A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/reentry if less than 7 days								
Enter Days <input type="text"/>	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/reentry if less than 7 days								
NEW									
<table><tr><th colspan="2">N0350. Insulin</th></tr><tr><td>Enter Days <input type="text"/></td><td>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</td></tr><tr><td>Enter Days <input type="text"/></td><td>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</td></tr></table>				N0350. Insulin		Enter Days <input type="text"/>	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 <input type="text"/>	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
N0350. Insulin									
Enter Days <input type="text"/>	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 <input type="text"/>	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								
3	N0350	N-3	<div>Steps for Assessment</div> <div>1. Review the resident’s medication administration records for the 7-day look-back period (or since admission/reentry or reentry if less than 7 days).</div> <div>Coding Instructions for N0350A</div> <div><ul style="list-style-type: none"><li>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.</li></ul></div> <div>Coding Instructions for N0350B</div> <div><ul style="list-style-type: none"><li>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 and Medicare) changed the resident’s insulin orders.</li></ul></div> <div>Coding Tips and Special Populations</div> <div><ul style="list-style-type: none"><li>A sliding scale dosage schedule that is written to cover different dosages depending on lab values does not does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.</li></ul></div>						

**Track Changes  
from Chapter 3 Section N V1.07  
to Chapter 3 Section N V1.08**

3	N0410	N-4	Replaced screen shot.
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**OLD**

N0400. Medications Received	
↓ Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days	
<input type="checkbox"/>	A. Antipsychotic
<input type="checkbox"/>	B. Antianxiety
<input type="checkbox"/>	C. Antidepressant
<input type="checkbox"/>	D. Hypnotic
<input type="checkbox"/>	E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
<input type="checkbox"/>	F. Antibiotic
<input type="checkbox"/>	G. Diuretic
<input type="checkbox"/>	Z. None of the above were received

**NEW**

N0410. Medications Received	
Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days	
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	A. Antipsychotic
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	B. Antianxiety
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	C. Antidepressant
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	D. Hypnotic
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	E. Anticoagulant (warfarin, heparin, or low-molecular weight heparin)
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	F. Antibiotic
Enter Days <input style="width: 30px; height: 20px;" type="text"/>	G. Diuretic

**Track Changes  
from Chapter 3 Section N V1.07  
to Chapter 3 Section N V1.08**

3	N0410	N-4	<p>Replaced definition box. OLD</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>DEFINITIONS</b></p> <p><b>ADVERSE CONSEQUENCE</b> An unpleasant symptom or event that is due to or associated with a medication, such as impairment or decline in an individual's mental or physical condition or functional or psycho-social status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease).</p> <p><b>NON-PHARMACOLOGICAL INTERVENTION</b> Approaches to care that do not involve medication, generally directed towards stabilizing or improving a resident's mental, physical and/or psychosocial well-being.</p> </div>	<p>NEW</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>DEFINITIONS</b></p> <p><b>ADVERSE CONSEQUENCE</b> 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).</p> <p><b>NON-PHARMACOLOGICAL INTERVENTION</b> Approaches that do not involve the use of medication to address a medical condition.</p> </div>
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**Track Changes  
from Chapter 3 Section N V1.07  
to Chapter 3 Section N V1.08**

3	N0410	N-5	<p>Replaced definition box.</p> <div> <div>OLD</div> <div> <p><b>DEFINITIONS</b></p> <p><b>DOSE</b></p> <p>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.”</p> <p><b>MONITORING</b></p> <p>The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal. Monitoring can detect any complications or adverse consequences of the condition or of the treatments; and support decisions about modifying, discontinuing, or continuing any interventions.</p> </div> <div> <p><b>NEW</b></p> <p><b>DEFINITIONS</b></p> <p><b>DOSE</b></p> <p>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.”</p> <p><b>MONITORING</b></p> <p>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.</p> </div> </div>
3	N0410	N-5	<p><b>Steps for Assessment</b></p> <ol style="list-style-type: none"> <li>1. Review the resident’s medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> </ol> <p><b>Coding Instructions</b></p> <ul style="list-style-type: none"> <li>• Check A, antipsychotic: if antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days)</li> <li>• Check B, antianxiety: if anxiolytic medication was received by the resident at any time during the</li> </ul>

**Track Changes  
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			<p>7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</p> <ul style="list-style-type: none"> <li>• Check C, antidepressant: if antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> </ul>
3	N0410	N-6	<ul style="list-style-type: none"> <li>• Check D, hypnotic: if hypnotic medication was received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> <li>• Check E, anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): if anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.</li> <li>• Check F, antibiotic: if antibiotics were received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> <li>• Check G, diuretic: if diuretics were received by the resident at any time during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> <li>• Check Z, none of the above were received: if none of the medications in Item N04010 were received during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> </ul>
3	N0410	N-6	<p><b>Coding Tips and Special Populations</b></p> <ul style="list-style-type: none"> <li>• Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly <b>only</b> if they are given during the 7-day look-back period (or since admission/<del>reentry</del> <b>or reentry</b> if less than 7 days).</li> </ul>
3	N0410	N-7	<ul style="list-style-type: none"> <li>• During the first year in which a resident on a psychopharmacological medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or</li> </ul>

**Track Changes  
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to Chapter 3 Section N V1.08**

			perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications can be found in the <b>State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities</b> (the <b>State Operations Manual</b> can be found at <a href="http://www.cms.gov/Manuals/IOM/list.asp">http://www.cms.gov/Manuals/IOM/list.asp</a> ).
3	N0410	N-7	<div>Replaced definition box.</div> <div> <div>OLD</div> <div> <b>DEFINITIONS</b>             GRADUAL DOSE REDUCTION (GDR) The step-wise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.         </div> </div> <div> <div>NEW</div> <div> <b>DEFINITION</b>   <b>GRADUAL DOSE REDUCTION (GDR)</b> 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.         </div> </div>
3	N0410	N-7	<div>Replaced definition box.</div> <div> <div>OLD</div> <div> <b>DEFINITIONS</b>   <b>MEDICATION INTERACTION</b>            The impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a 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.         </div> </div> <div> <div>NEW</div> <div> <b>DEFINITION</b>   <b>MEDICATION INTERACTION</b>            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.         </div> </div>
3	N0410	N-8	— Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the <b>State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities</b> [the <b>State Operations Manual</b> can be found at <a href="http://www.cms.gov/Manuals/IOM/list.asp">http://www.cms.gov/Manuals/IOM/list.asp</a> ]), which

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			may
3	N0410	N-8	<p><b>Example</b></p> <ul style="list-style-type: none"> <li>• Temazepam 15 mg PO QHS PRN: Received at bedtime <del>HS</del> on Tuesday and Wednesday only.</li> </ul> <p>Coding: The following <del>Medications</del> item (<del>Medications in N0400</del> <b>N0410</b>), would be checked as follows:</p> <p>A. antipsychotic, resperidone is an antipsychotic drug,  B. antianxiety, lorazepam is an antianxiety drug, and D. hypnotic, temazepam is a hypnotic drug. Please note: if a resident is receiving drugs in all of these three classes, simultaneously, there must be a clear clinical indication for the use of these drugs. Administration of these types of drugs, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.</p>
3	N0410	N-9	<p>Additional information on psychopharmacologic medications can be found in the <b>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)</b> (or subsequent editions)  (<a href="http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1">http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1</a>), and the <b>State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities</b> [the <b>State Operations Manual</b> can be found at (<a href="http://www.cms.gov/Manuals/IOM/list.asp">http://www.cms.gov/Manuals/IOM/list.asp</a>)].</p>

**Track Changes**  
**from Chapter 3 Section O V1.07**  
**to Chapter 3 Section O V1.08**

Chapter	Section	Page	Change
3	O0250	O-7	<ul style="list-style-type: none"> <li>The Influenza season varies annually. Information about 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:  <a href="http://www.cdc.gov/flu/weekly/fluactivitysurv.htm">http://www.cdc.gov/flu/weekly/fluactivitysurv.htm</a> ,  <a href="http://www.cdc.gov/flu/weekly/usmap.htm">http://www.cdc.gov/flu/weekly/usmap.htm</a>. Facilities can also contact their local health department website for their local Influenza surveillance information. The Influenza season ends when Influenza is no longer active in your geographic area.</li> <li>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.</li> </ul>
3	O0400	O-14	Replaced screen shot.

OLD

**O0400. Therapies**

**A. Speech-Language Pathology and Audiology Services**

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

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

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 O0400B, Occupational Therapy

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

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

**B. Occupational Therapy**

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

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

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 O0400C, Physical Therapy

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

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

**C. Physical Therapy**

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

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

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 O0400D, Respiratory Therapy

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

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

O0400 continued on next page

# **Track Changes** **from Chapter 3 Section O V1.07** **to Chapter 3 Section O V1.08**

**NEW**

## **00400. Therapies**

### **A. Speech-Language Pathology and Audiology Services**

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Days

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

**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

**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 00400A5, Therapy start date

**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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

### **B. Occupational Therapy**

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Days

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

**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

**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 00400B5, Therapy start date

**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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

### **C. Physical Therapy**

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Minutes

Enter: Number of Days

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

**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

**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 00400C5, Therapy start date

**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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year			

00400 continued on next page

**Track Changes  
from Chapter 3 Section O V1.07  
to Chapter 3 Section O V1.08**

3	O0400	O-15	Replaced screen shot.
<b>OLD</b>			
<div> <div> <b>O0400. Therapies - Continued</b> </div> <div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> </div> <div> <div><b>D. Respiratory Therapy</b></div> <div> 1. <b>Total minutes</b> - 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 </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> <div><b>E. Psychological Therapy</b> (by any licensed mental health professional)</div> <div> 1. <b>Total minutes</b> - 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 </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> <div><b>F. Recreational Therapy</b> (includes recreational and music therapy)</div> <div> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0500, Restorative Nursing Programs </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> </div> </div>			
<b>NEW</b>			
<div> <div> <b>O0400. Therapies - Continued</b> </div> <div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> <div> Enter Number of Minutes  <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> <div> Enter Number of Days  <input type="text"/> </div> </div> <div> <div><b>D. Respiratory Therapy</b></div> <div> 1. <b>Total minutes</b> - 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 </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> <div><b>E. Psychological Therapy</b> (by any licensed mental health professional)</div> <div> 1. <b>Total minutes</b> - 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 </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> <div><b>F. Recreational Therapy</b> (includes recreational and music therapy)</div> <div> 1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0450, Resumption of Therapy </div> <div> 2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days </div> </div> </div>			
3	O0400	O-17	<ul style="list-style-type: none"> <li><b>Therapy Start Date:</b> <ol style="list-style-type: none"> <li>Look at the date at A1600.</li> <li>Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.</li> <li>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</li> </ol> </li> </ul>

**Track Changes  
from Chapter 3 Section O V1.07  
to Chapter 3 Section O V1.08**

			recent therapy regimen.
3	O0400	O-18	Page length change.
3	O0400	O-19	Page length change.
3	O0400	O-20	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 four 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.
3	O0400	O-21	Page length change.
3	O0400	O-22	Page length change.
3	O0400	O-23	Page length change.
3	O0400	O-24	Page length change.
3	O0400	O-25	Page length change.
3	O0400	O-26	Page length change.
3	O0400	O-27	Page length change.
3	O0400	O-28	Page length change.

**Track Changes**  
**from Chapter 3 Section O V1.07**  
**to Chapter 3 Section O V1.08**

3 | 00400 | O-29 | Replaced screen shot.  
 OLD

**00400. Therapies**

**A. Speech-Language Pathology and Audiology Services**

Enter Number of Minutes

1 9 0

Enter Number of Minutes

7 0

Enter Number of Minutes

7 5

Enter Number of Days

5

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
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
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 00400B, Occupational Therapy

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

1 0 - 0 6 - 2 0 0 8  
 Month Day Year

- - - - -  
 Month Day Year

**B. Occupational Therapy**

Enter Number of Minutes

9 3

Enter Number of Minutes

0

Enter Number of Minutes

8 0

Enter Number of Days

5

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
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
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 00400C, Physical Therapy

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

1 0 - 0 9 - 2 0 0 8  
 Month Day Year

- - - - -  
 Month Day Year

**C. Physical Therapy**

Enter Number of Minutes

2 4 7

Enter Number of Minutes

1 0 0

Enter Number of Minutes

0

Enter Number of Days

5

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
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
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 00400D, Respiratory Therapy

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

1 0 - 0 7 - 2 0 0 8  
 Month Day Year

- - - - -  
 Month Day Year

00400 continued on next page

**Track Changes**  
**from Chapter 3 Section O V1.07**  
**to Chapter 3 Section O V1.08**

**NEW**

**00400. Therapies**

<p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">190</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">70</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">75</div></p> <p>Enter Number of Days  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">5</div></p>	<p><b>A. Speech-Language Pathology and Audiology Services</b></p> <ol style="list-style-type: none"> <li>1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li>2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li>3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to 00400A5, Therapy start date</p> <ol style="list-style-type: none"> <li>4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li>5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">10</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">06</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">2011</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> <li>6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> </ol>
<p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">113</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">0</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">80</div></p> <p>Enter Number of Days  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">5</div></p>	<p><b>B. Occupational Therapy</b></p> <ol style="list-style-type: none"> <li>1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li>2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li>3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to 00400B5, Therapy start date</p> <ol style="list-style-type: none"> <li>4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li>5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">10</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">09</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">2011</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> <li>6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> </ol>
<p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">287</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">100</div></p> <p>Enter Number of Minutes  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">0</div></p> <p>Enter Number of Days  <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 40px; text-align: center;">5</div></p>	<p><b>C. Physical Therapy</b></p> <ol style="list-style-type: none"> <li>1. <b>Individual minutes</b> - record the total number of minutes this therapy was administered to the resident <b>individually</b> in the last 7 days</li> <li>2. <b>Concurrent minutes</b> - record the total number of minutes this therapy was administered to the resident <b>concurrently with one other resident</b> in the last 7 days</li> <li>3. <b>Group minutes</b> - record the total number of minutes this therapy was administered to the resident as <b>part of a group of residents</b> in the last 7 days</li> </ol> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to 00400C5, Therapy start date</p> <ol style="list-style-type: none"> <li>4. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</li> <li>5. <b>Therapy start date</b> - record the date the most recent therapy regimen (since the most recent entry) started  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">10</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">07</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">2011</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> <li>6. <b>Therapy end date</b> - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing  <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> <div>-</div> <div style="border: 1px solid black; padding: 2px; text-align: center;">-</div> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Month</span><span>Day</span><span>Year</span> </div> </li> </ol>

00400 continued on next page

**Track Changes**  
**from Chapter 3 Section O V1.07**  
**to Chapter 3 Section O V1.08**

3	00400	O-30	Replaced screen shot.
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**OLD**

00400. Therapies - Continued			
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">5</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;">0</div>	<p><b>D. Respiratory Therapy</b></p> <p>1. <b>Total minutes</b> - 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</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;">0</div>	<p><b>E. Psychological Therapy</b> (by any licensed mental health professional)</p> <p>1. <b>Total minutes</b> - 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</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;">3</div>	<p><b>F. Recreational Therapy</b> (includes recreational and music therapy)</p> <p>1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0500, Restorative Nursing Programs</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		

**NEW**

00400. Therapies - Continued			
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">5</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;">0</div>	<p><b>D. Respiratory Therapy</b></p> <p>1. <b>Total minutes</b> - 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</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;"></div>	<p><b>E. Psychological Therapy</b> (by any licensed mental health professional)</p> <p>1. <b>Total minutes</b> - 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</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		
<p>Enter Number of Minutes</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">9</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; text-align: center;">0</div> </div> <p>Enter Number of Days</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; width: 20px; text-align: center;">3</div>	<p><b>F. Recreational Therapy</b> (includes recreational and music therapy)</p> <p>1. <b>Total minutes</b> - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0450, Resumption of Therapy</p> <p>2. <b>Days</b> - record the <b>number of days</b> this therapy was administered for <b>at least 15 minutes</b> a day in the last 7 days</p>		

**Track Changes  
from Chapter 3 Section O V1.07  
to Chapter 3 Section O V1.08**

3	O0500	O-31	Replaced screen shot.																												
OLD																															
<table><tr><th colspan="2">O0500. Restorative Nursing Programs</th></tr><tr><td colspan="2">Record the <b>number of days</b> 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)</td></tr><tr><th>Number of Days</th><th>Technique</th></tr><tr><td><input type="checkbox"/></td><td>A. Range of motion (passive)</td></tr><tr><td><input type="checkbox"/></td><td>B. Range of motion (active)</td></tr><tr><td><input type="checkbox"/></td><td>C. Splint or brace assistance</td></tr><tr><th>Number of Days</th><th>Training and Skill Practice In:</th></tr><tr><td><input type="checkbox"/></td><td>D. Bed mobility</td></tr><tr><td><input type="checkbox"/></td><td>E. Transfer</td></tr><tr><td><input type="checkbox"/></td><td>F. Walking</td></tr><tr><td><input type="checkbox"/></td><td>G. Dressing and/or grooming</td></tr><tr><td><input type="checkbox"/></td><td>H. Eating and/or swallowing</td></tr><tr><td><input type="checkbox"/></td><td>I. Amputation/prostheses care</td></tr><tr><td><input type="checkbox"/></td><td>J. Communication</td></tr></table>				O0500. Restorative Nursing Programs		Record the <b>number of days</b> 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	<input type="checkbox"/>	A. Range of motion (passive)	<input type="checkbox"/>	B. Range of motion (active)	<input type="checkbox"/>	C. Splint or brace assistance	Number of Days	Training and Skill Practice In:	<input type="checkbox"/>	D. Bed mobility	<input type="checkbox"/>	E. Transfer	<input type="checkbox"/>	F. Walking	<input type="checkbox"/>	G. Dressing and/or grooming	<input type="checkbox"/>	H. Eating and/or swallowing	<input type="checkbox"/>	I. Amputation/prostheses care	<input type="checkbox"/>	J. Communication
O0500. Restorative Nursing Programs																															
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<input type="checkbox"/>	J. Communication																														
NEW																															
<table><tr><th colspan="2">O0500. Restorative Nursing Programs</th></tr><tr><td colspan="2">Record the <b>number of days</b> 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)</td></tr><tr><th>Number of Days</th><th>Technique</th></tr><tr><td><input type="checkbox"/></td><td>A. Range of motion (passive)</td></tr><tr><td><input type="checkbox"/></td><td>B. Range of motion (active)</td></tr><tr><td><input type="checkbox"/></td><td>C. Splint or brace assistance</td></tr><tr><th>Number of Days</th><th>Training and Skill Practice In:</th></tr><tr><td><input type="checkbox"/></td><td>D. Bed mobility</td></tr><tr><td><input type="checkbox"/></td><td>E. Transfer</td></tr><tr><td><input type="checkbox"/></td><td>F. Walking</td></tr><tr><td><input type="checkbox"/></td><td>G. Dressing and/or grooming</td></tr><tr><td><input type="checkbox"/></td><td>H. Eating and/or swallowing</td></tr><tr><td><input type="checkbox"/></td><td>I. Amputation/prostheses care</td></tr><tr><td><input type="checkbox"/></td><td>J. Communication</td></tr></table>				O0500. Restorative Nursing Programs		Record the <b>number of days</b> 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	<input type="checkbox"/>	A. Range of motion (passive)	<input type="checkbox"/>	B. Range of motion (active)	<input type="checkbox"/>	C. Splint or brace assistance	Number of Days	Training and Skill Practice In:	<input type="checkbox"/>	D. Bed mobility	<input type="checkbox"/>	E. Transfer	<input type="checkbox"/>	F. Walking	<input type="checkbox"/>	G. Dressing and/or grooming	<input type="checkbox"/>	H. Eating and/or swallowing	<input type="checkbox"/>	I. Amputation/prostheses care	<input type="checkbox"/>	J. Communication
O0500. Restorative Nursing Programs																															
Record the <b>number of days</b> 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																														
<input type="checkbox"/>	A. Range of motion (passive)																														
<input type="checkbox"/>	B. Range of motion (active)																														
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Number of Days	Training and Skill Practice In:																														
<input type="checkbox"/>	D. Bed mobility																														
<input type="checkbox"/>	E. Transfer																														
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<input type="checkbox"/>	H. Eating and/or swallowing																														
<input type="checkbox"/>	I. Amputation/prostheses care																														
<input type="checkbox"/>	J. Communication																														
3	O0600	O-39	<div>Coding Tips and Special Populations</div> <ul style="list-style-type: none"><li>Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working</li></ul>																												

**Track Changes  
from Chapter 3 Section O V1.07  
to Chapter 3 Section O V1.08**

			in collaboration with the physician as allowable by state law. <del>Cannot be an employee of the facility.</del>
3	O0700	O-40	<b>Coding Tips and Special Populations</b> <ul style="list-style-type: none"> <li>Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law. <del>Cannot be an employee of the facility.</del></li> </ul>

**Track Changes  
from Chapter 3 Section Q V1.05  
to Chapter 3 Section Q V1.08**

Chapter	Section	Page	Change								
3	Q	Q-1	<b>Intent:</b> 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 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach to insure 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 least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.								
3	Q0100	Q-1	Replaced screen shot								
OLD											
<table><tr><th colspan="2">Q0100. Participation in Assessment</th></tr><tr><td>Enter Code <input type="checkbox"/></td><td>A. Resident participated in assessment 0. No 1. Yes</td></tr><tr><td>Enter Code <input type="checkbox"/></td><td>B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other</td></tr><tr><td>Enter Code <input type="checkbox"/></td><td>C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative</td></tr></table>				Q0100. Participation in Assessment		Enter Code <input type="checkbox"/>	A. Resident participated in assessment 0. No 1. Yes	Enter Code <input type="checkbox"/>	B. Family or significant other participated in assessment 0. No 1. Yes 9. No family or significant other	Enter Code <input type="checkbox"/>	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. No guardian or legally authorized representative
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3	Q0100	Q-1	<h3>Health-related Quality of Life</h3> <ul style="list-style-type: none"><li>Residents who actively participate in the assessment process and in developing the care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.</li></ul>								

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Chapter	Section	Page	Change
			<p><b>DEFINITION</b></p> <p>RESIDENT'S PARTICIPATION IN ASSESSMENT</p> <p>The resident actively engages in interviews and conversations <del>as necessary</del> 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 perspective during assessment.</p>
3	Q0100	Q-1 & Q-2	<p><b>Planning for Care</b></p> <ul style="list-style-type: none"> <li>• <del>Each</del> The 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 §483.15 Quality of Life).</li> <li>• During <del>the</del> care planning meetings, <del>if the resident is present, he or she</del> should be made comfortable and verbal communication should be directly with him or her.</li> <li>• <del>Many</del> Residents should be asked about inviting family members, significant others, and/or guardians/legally authorized representatives to participate, and if they desire that they <del>want their family or significant other(s) to be involved in the assessment process.</del></li> <li>• If the individual resident is unable to understand the process, his or her family member, significant other, and/or guardian/legally authorized representative,</li> </ul>

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Chapter	Section	Page	Change
			<p>who represents the individual, should be invited to attend the assessment process whenever possible.</p> <ul style="list-style-type: none"> <li>When the resident is unable to participate in the assessment process, <del>a</del> family members, <del>or</del> significant others, and/or guardian/<del>or</del> legally authorized representatives can provide <del>valuable</del> information about the resident's needs, goals, and priorities.</li> </ul>
3	Q0100	Q-2	<p><b>Steps for Assessment</b></p> <ol style="list-style-type: none"> <li>Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.</li> <li>Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.</li> </ol>
3	Q0100	Q-3	<ul style="list-style-type: none"> <li>Code 9, no family or significant other available: <b>None of the above—resident has no</b> if there is <del>no</del> family or significant other.</li> </ul>
3	Q0100	Q-3	<p><b>Coding Instructions for Q0100C</b></p> <ul style="list-style-type: none"> <li>Code 9, no guardian or legally authorized representative available: <b>if there is no None of the above—resident has no</b> guardian or legally authorized representative.</li> </ul>
3	Q0100	Q-3	<ul style="list-style-type: none"> <li>While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, <del>if the resident is uncertain about his or her goals,</del> the response selected must reflect the resident's perspective if he or she is able to express it.</li> <li>No family or significant other available means <b>the individual</b> resident has no family or significant other, not that they were not consulted.</li> </ul>
3	Q0300	Q-3	<p><b>Q0300: Resident's Overall Expectation</b>  <i>Complete only when A0310E=1. (First assessment on admission/entry or reentry.)</i></p>

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3	Q0300	Q-3	Replaced screen shot.
OLD			
<div> <div>Q0300. Resident's Overall Expectation</div> <div>Complete only if A0310E = 1</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <b>A. Resident's overall goal established during assessment process</b> <ol style="list-style-type: none"> <li>1. Expects to be <b>discharged to the community</b></li> <li>2. Expects to <b>remain in this facility</b></li> <li>3. Expects to be <b>discharged to another facility/institution</b></li> <li>9. <b>Unknown or uncertain</b></li> </ol> </div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <b>B. Indicate information source for Q0300A</b> <ol style="list-style-type: none"> <li>1. <b>Resident</b></li> <li>2. If not resident, then <b>family or significant other</b></li> <li>3. If not resident, family, or significant other, then <b>guardian or legally authorized representative</b></li> <li>9. <b>None of the above</b></li> </ol> </div> </div>			
NEW			
<div> <div>Q0300. Resident's Overall Expectation</div> <div>Complete only if A0310E = 1</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <b>A. Select one for resident's overall goal established during assessment process</b> <ol style="list-style-type: none"> <li>1. Expects to be <b>discharged to the community</b></li> <li>2. Expects to <b>remain in this facility</b></li> <li>3. Expects to be <b>discharged to another facility/institution</b></li> <li>9. <b>Unknown or uncertain</b></li> </ol> </div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <b>B. Indicate information source for Q0300A</b> <ol style="list-style-type: none"> <li>1. <b>Resident</b></li> <li>2. If not resident, then <b>family or significant other</b></li> <li>3. If not resident, family, or significant other, then <b>guardian or legally authorized representative</b></li> <li>9. <b>Unknown or uncertain</b></li> </ol> </div> </div>			
3	Q0300	Q-4	<b>Item Rationale</b> <p>This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her 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 long-term care needs. <b>Additional assessment information may be needed to determine whether the resident requires additional community services and supports.</b></p>
3	Q0300	Q-4 & Q-5	<b>Steps for Assessment</b> <ol style="list-style-type: none"> <li>1. Ask the resident about his or her overall expectations <b>to be sure that</b> after he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices.</li> <li>2. Ask the resident to consider <b>his or her</b> current <b>health/clinical</b> status, expectations regarding improvement or worsening, <b>and social supports, and opportunities to obtain services and supports in the</b></li> </ol>

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			<p><b>community.</b></p> <p><del>3. 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 his or her 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.</del></p> <p><b>4.3.</b> If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.</p> <p><del>5.4.</del> The resident's <b>stated</b> goals should be recorded here. <b>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.</b></p> <p><del>3.5.</del> <b>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 his or her 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.</b></p> <p><del>6. If the resident is unable to understand the question or to discuss his or her goals, then the goals for the resident, as perceived by the family, significant other, guardian, or legally authorized representative should be recorded.</del></p> <p>6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.</p> <p>7. <b>In some guardianship situations, the decision-making authority regarding the individual's care is vested in</b></p>
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			the guardian. But this should not create a presumption that the resident is not able to comprehend and communicate their wishes.
3	Q0300	Q-5	<p><b>Coding Instructions for Q0300A</b></p> <p><i>Record the resident's expectations as expressed, <del>whether they are realistic or not realistic.</del> by her or him. It is important to document their expectations.</i></p>
3	Q0300	Q-5	<ul style="list-style-type: none"> <li>• Code 1, expects to be discharged to the community: if the resident is <del>in the nursing home for rehabilitation, skilled nursing care, or respite care</del> and indicates an expectation to return home, to assisted living, or to another community setting.</li> <li>• Code 2, expects to remain in this facility: if the resident is <del>in the nursing home for rehabilitation or skilled nursing care</del> and indicates that <del>after this care is complete,</del> he or she expects to remain in the nursing home.</li> <li>• 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 <b>do not exist or</b> are not available to participate in the discussion.</li> </ul>
3	Q0300	Q-5	<p><b>Coding Tips</b></p> <ul style="list-style-type: none"> <li>• This item is 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 <b>expectations</b> <del>options</del>; not whether or not the staff considers them to be <del>good or poor options</del> realistic or not.</li> <li>• Q0300A, Code 1 "expects to be discharged to the community" may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid 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).</li> </ul>

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			<ul style="list-style-type: none"> <li>Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a <b>response</b> based on a specific advance <b>directive</b> care order, such as e.g., "do not resuscitate" (DNR).</li> </ul>
3	Q0300	Q-6	<p><b>Coding Instructions for Q0300B</b></p> <ul style="list-style-type: none"> <li>Code 9, <b>unknown or uncertain</b> (none of the above): if the resident cannot respond and the family or significant other, or guardian or legally authorized representative <b>does not exist or</b> cannot be contacted or is unable to respond (Q0300A = 9).</li> </ul>
3	Q0300	Q-6	<p><b>Examples</b></p> <ol style="list-style-type: none"> <li>Mrs. F. is a 55-year-old married woman who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. She was admitted to the nursing home 1 week ago for rehabilitation, <b>specifically</b> particularly for transfer, gait training, and wheelchair mobility training. Mrs. F. is extremely motivated to return home. Her husband is supportive and has been busy adapting their home to promote her independence. Her goal is to return home once she has completed rehabilitation.</li> </ol>
3	Q0300	Q-7	<ol style="list-style-type: none"> <li>Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, <b>and</b> the level of care that she needs, <b>and other work and family responsibilities,</b> <del>we feel that</del> we cannot adequately meet her needs <b>at home</b>. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort <b>and for us to spend as much time as we can with her.</b>" The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days <b>and that the family does not have the capacity to provide all the care the resident needs.</b></li> </ol>
3	Q0300	Q-8	<ol style="list-style-type: none"> <li>Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years</li> </ol>

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			<p>ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.</p> <p>Coding: Q0300A would be coded 1, expects to be discharged to the community (small group homes are considered to be community setting).</p> <p>Q0300B would be coded 1, Resident. <del>3, guardian or legally authorized representative.</del></p> <p>Rationale: Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded, but is unable to make decisions about her medical and other care needs. When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed decided that it is in Ms. K.'s best interest to be transferred to a group home. This information should also be recorded in the individual's clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)</p>
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3	Q0400	Q-8	Replaced screen shot
<div> <div>OLD</div> <div> <div>Q0400. Discharge Plan</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <div>A. Is there an active discharge plan in place for the resident to return to the community?</div> <div> <div>0. No</div> <div>1. Yes → Skip to Q0600, Referral</div> </div> </div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <div>B. What determination was made by the resident and the care planning team regarding discharge to the community?</div> <div> <div>0. Determination not made</div> <div>1. Discharge to community determined to be feasible → Skip to Q0600, Referral</div> <div>2. Discharge to community determined to be not feasible → Skip to next active section (V or X)</div> </div> </div> </div> </div>			
<div> <div>NEW</div> <div> <div>Q0400. Discharge Plan</div> <div> <div>Enter Code</div> <div><input type="checkbox"/></div> </div> <div> <div>A. Is active discharge planning already occurring for the resident to return to the community?</div> <div> <div>0. No</div> <div>1. Yes → Skip to Q0600, Referral</div> </div> </div> </div> </div>			
3	Q0400	Q-8 & Q-9	<div>Item Rationale</div> <div>Health-related Quality of Life</div> <ul style="list-style-type: none"> <li>Returning home or to a non-institutional setting can be very important to the a resident's health and quality of life.</li> <li>For residents who that have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow them to return to a community setting.</li> <li>Being discharged from the nursing home without an adequate discharge plan planning occurring (planning and implementation of a plan before discharge) could result in the resident's decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.</li> </ul> <div>Planning for Care</div> <ul style="list-style-type: none"> <li>ManySome nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.</li> <li>Important progress has been made so that individuals have more choices, care options, and</li> </ul>

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			<p>available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U. S. Supreme Court <b>decision in</b> <i>Olmstead v. L.C.</i> <b>ruling</b>, which states that residents needing <b>long term</b> <del>long-term</del> <b>care services and supports</b> have a right to receive services in the least restrictive and most integrated setting.</p> <ul style="list-style-type: none"> <li>Each situation is unique to the resident, his/her family, and/or guardian/<b>legally authorized representative</b>. A referral to the Local Contact Agency (LCA) may be appropriate for <b>many</b> <del>some</del> individuals, <del>such as those with Alzheimer's disease, who could be maintained in their</del> <b>community</b> <del>own</del> homes <b>of their choice</b> for long periods of time, depending on the residential setting and support services available. <del>Others may not be able to be discharged and be determined as not feasible by the interdisciplinary team because the intense level of services and supports that are needed are not available in the community, and the individual does not have family or other relationships that could support them. For</del> <b>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.</b></li> <li>Discharge instructions should include at a minimum: <ul style="list-style-type: none"> <li>the individual's preferences and needs for care and supports: <ul style="list-style-type: none"> <li>arrangements for housing; <del>and</del></li> <li><b>arrangements for transportation to follow-up appointments; and</b></li> </ul> </li> </ul> </li> </ul>
3	Q0400	Q-10	<p>— Section Q has <del>been</del> broadened <b>the scope of</b> <del>beyond</del> the traditional <b>boundary definition</b> of discharge</p>

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			<p>planning for sub-acute residents to encompass long stay residents, <del>including the elderly, disabled, intellectually challenged, and younger nursing home residents.</del> In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, <del>employment,</del> <b>transportation, employment if desired,</b> and social engagement opportunities.</p> <ul style="list-style-type: none"> <li><del>o The nursing home staff must not make an interdisciplinary determination that discharge is not feasible without consulting the resident if the resident can be interviewed.</del> The NF 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 transition services planning. They 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 by a state's on-line/website or by other state-approved processes. 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.</li> <li>o Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, <b>guardian, or significant others</b> 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 <del>individual</del> resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.</li> <li>o Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now more readily available <del>and will grow over time.</del> Resource availability and eligibility coverage varies across <b>States and</b> local communities <del>and States, and may be barriers to some residents being able to return to the</del></li> </ul>
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			<p>community.</p> <ul style="list-style-type: none"> <li>o Should <b>a planned relocation not occur, it might</b> <del>it occur, an unsuccessful transition may</del> create stress and disappointment for the resident and family that will require support and nursing home care planning interventions.</li> </ul>
3	Q0400	Q-11	<p><b>Steps for Assessment</b></p> <ol style="list-style-type: none"> <li>1. A review should be conducted of the care plan, the medical record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy <b>to consider the resident's discharge planning needs.</b></li> <li>2. If the resident is unable to communicate his or her 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. <del>Determining whether discharge to the community is feasible requires consultation with the family or guardian if they are available.</del></li> <li>3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and <del>there are not individual resident needs that the NF/SNF does not have the capability to</del> <b>address a resident's needs and arrange for that resident to discharge back to the community, it may not be necessary for a referral to the LCA may not be necessary. This should be decided on a case-by-case basis.</b> Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them.</li> <li>4. Record the resident's expectations as expressed/communicated, whether <b>you assess that</b> they are realistic or not realistic.</li> <li>5. If the resident's <b>discharge needs cannot be met by the nursing facility, is being discharged,</b> an evaluation of the <del>site-community living situation</del> <b>to evaluate whether it can meet the resident's needs</b> should be conducted by the <b>LCA, along with</b> <del>or</del> <b>other community providers who will</b></li> </ol>

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			<p>be providing the transition and other community based services to determine the safety of the resident's surroundings and the need for assistive/adaptive devices, medical supplies, and equipment and other services.</p> <p>6. The resident, his or her interdisciplinary team, and local contact agency LCA (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance) and make appropriate referrals.</p> <p>7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered assessed prior to discharge to identify the options available to the individual determine where the resident will be discharged (e.g., home, assisted living, board and care, or group living homes, etc.).</p> <p>8. Determine if there will be A determination of family involvement, capability, and support after discharge should also be made.</p>
3	Q0400	Q-12	<p><b>Coding Instructions for Q0400A, Is There an Active Discharge planning already occurring in Place for the Resident to Return to the Community?</b></p> <ul style="list-style-type: none"> <li>• Code 0, no: if there is not an active discharge planning already occurring in place for the resident to return to the community.</li> <li>• Code 1, yes: if there is an active discharge planning already occurring in place for the resident to return to the community; skip to Referral item (Q0600).</li> </ul>
3	Q0400	Q-12	<p><b>Coding Instructions for Q0400B, What Determination Was Made by the Resident and the Care Planning Team Regarding Discharge to the Community?</b></p> <ul style="list-style-type: none"> <li>• Code 0: if a determination is not made by the resident and the care planning team regarding discharge to the community.</li> <li>• Code 1: if discharge to the community is</li> </ul>

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			<p>determined to be feasible; skip to item Q0600 (Referral).</p> <ul style="list-style-type: none"><li><del>Code 2: if discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X).</del></li></ul> <p><b>Coding Tips</b></p> <ul style="list-style-type: none"><li><del>This item is individualized and resident driven, and the interdisciplinary team must interview residents and/or their family members, whenever possible, and determine their preferences and agreement.</del></li><li><del>The nursing home interdisciplinary team should not assume that any particular resident is unable to be discharged. The nursing home should code Q0400B as <b>2</b> after they have fully explored the resident's preferences and possible home and community based services/options available to the resident. Most likely, this would require consultation with community resource experts at the LCA.</del></li><li><del>If the care planning team determines that the resident's discharge to the community is not feasible (answer B =2), there is an existing skip pattern that directs the assessor to skip to Section V or Section X.</del></li><li><del>If the nursing facility staff has already developed a complete discharge plan, 0400A would be coded as Yes and skip to Q0600.</del></li></ul>								
3	Q0490	Q-12 & Q-13	<p><b>Q0490: Resident's Preference to Avoid Being Asked Question Q0500B</b></p> <p><i>For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)</i></p> <div><p><b>Q0500. Return to Community</b></p><table><tr><td>Enter Code</td><td>B. Ask the resident (or family or significant other if resident is unable to 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?"</td></tr><tr><td><input type="checkbox"/></td><td>0. No</td></tr><tr><td></td><td>1. Yes</td></tr><tr><td></td><td>9. Unknown or uncertain</td></tr></table></div> <p><b>Item Rationale</b></p> <p>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</p>	Enter Code	B. Ask the resident (or family or significant other if resident is unable to 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?"	<input type="checkbox"/>	0. No		1. Yes		9. Unknown or uncertain
Enter Code	B. Ask the resident (or family or significant other if resident is unable to 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?"										
<input type="checkbox"/>	0. No										
	1. Yes										
	9. Unknown or uncertain										

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			<p>Q0500B until their next annual 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 Q0550 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 Q0600, Referral.</p> <p>Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s).</p> <p><u>If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.</u></p> <p><b>Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</b></p> <ul style="list-style-type: none"> <li>• Code 0, no: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again.</li> <li>• Code 1, yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments. <u>Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, Referral.</u></li> </ul> <p><u>If this is a comprehensive assessment, proceed to the next item Q0500B.</u></p> <ul style="list-style-type: none"> <li>• Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment.</li> </ul> <p><b>Coding Tips</b></p> <ul style="list-style-type: none"> <li>• 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 Q0550.</li> </ul> <p><u>If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item</u></p>
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			<b>Q0550A.</b>
3	Q0490	Q-13	<p><b>Examples</b></p> <ol style="list-style-type: none"> <li>Ms. G is a 45-year-old woman, 300 lbs., <b>pounds</b>, who is cognitively intact. She has CHF and shortness of breath requiring oxygen <del>at night</del> <b>at all times</b>. Ms. G also requires <b>2 person</b> assistance with bathing and transfers to the commode. <del>She has resided at the nursing home for 3 years. Her nursing home admission was a result of the fact that her family and friends, who visited regularly, could not care for her at home. Although she expresses interest in talking to someone about returning to the community, the interdisciplinary team is uncertain whether there would be sufficient community resources available and whether her family would agree to the discharge.</del> <b>She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.</b> <p style="margin-left: 40px;">Coding: <del>Q0400B</del> <b>Q0490</b> would be coded 1, <del>discharge to the community is determined to be feasible; skip to item Q0600 (Referral)</del> <b>Yes, skip to Q0600; because this is a quarterly assessment.</b></p> <p><b><u>If this is a comprehensive assessment, then proceed to the next item Q0500B.</u></b></p> <p style="margin-left: 40px;">Rationale: <del>Ms. G expresses the desire to talk to someone about the return to the community and the local contact agency representative can help address the interdisciplinary team's legitimate concerns about available and sufficient community resources particularly accessible and affordable housing and to talk to the resident's family.</del> <b>On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to</b></p> </li> </ol>

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			<p>community living (No on Q0550A).</p> <p>2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer’s disease. She has no family, and has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.</p> <p>Coding: <del>Q0400B</del> Q0490 would be coded 21, discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X) Yes, skip to Q0600; Unless this is a comprehensive assessment, then proceed to the next item Q0500B.</p> <p>Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.</p>
3	Q0500	Q-14	Replaced screen shot.

OLD

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	<b>A. Has the resident been asked about returning to the community?</b> 0. No 1. Yes - previous response was "no" 2. Yes - previous response was "yes" → Skip to Q0600, Referral 3. Yes - previous response was "unknown"
Enter Code <input type="checkbox"/>	<b>B. Ask the resident (or family or significant other if resident is unable to respond): "Do you want to talk to someone about the possibility of returning to the community?"</b> 0. No 1. Yes 9. Unknown or uncertain

NEW

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	<b>B. Ask the resident (or family or significant other if resident is unable to 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?"</b> 0. No 1. Yes 9. Unknown or uncertain

3	Q0500	Q-14	<p>Item Rationale</p> <p>The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local</p>
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			<p>contact agency to support the resident's expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term <b>services and supports</b> <del>care</del> in the least restrictive setting possible. CMS has found that in many cases individuals requiring long term <del>care</del> services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.</p>
3	Q0500	Q-14	<p><b>Health-related Quality of Life</b></p> <ul style="list-style-type: none"> <li>Returning home or to a non-<b>institutional</b> setting can be very important to the resident's health and quality of life.</li> <li>The goal is to obtain the <b>informed choice and preferences</b> expressed <del>interest of</del> <b>by</b> the resident and to provide information about <b>available community supports and services</b> <del>focus on the resident's preferences.</del></li> </ul>
3	Q0500	Q-14	<p><b>Planning for Care</b></p> <ul style="list-style-type: none"> <li><del>Many</del> <b>Some</b> nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-<b>institutional</b> setting.</li> </ul>
3	Q0500	Q-15	<p><b>Steps for Assessment: Interview Instructions</b></p> <ol style="list-style-type: none"> <li>At the initial admission assessment and in subsequent follow-up assessments (as applicable), <del>determine if the resident has been asked about returning to the community</del> <b>make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents.</b></li> <li><del>If the resident has not been asked about returning to the community or if the resident has been asked and his or her previous response was no or unknown, make the</del></li> </ol>

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			<p><del>resident comfortable by assuring him or her that this is a routine question that is asked of all residents.</del></p> <p>32. Ask the resident if he or she would like to speak with someone about the possibility of returning to live 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 leave the nursing home 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 he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at any time.</p> <p>43. 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. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input. 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 his/her mind at any time.</p> <p>54. If the resident is unable to communicate his or her 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 is not available, a guardian or legally authorized representative, if one exists, can provide the information.</p>
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			<p>65. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her 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.</p>
3	Q0500	Q-15 & Q-16	<p><b>Coding Instructions for Q0500A, Has the Resident Been Asked about Returning to the Community?</b></p> <ul style="list-style-type: none"> <li>• <del>Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she has not been asked about the possibility of returning to the community.</del></li> <li>• <del>Code 1, yes—previous response was no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community and the previous response was no.</del></li> <li>• <del>Code 2, yes—previous response was yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community and the previous response was yes. If Code 2 is entered, skip to Q0600 (Referral).</del></li> <li>• <del>Code 3, yes—previous response was unknown: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she was previously asked about the possibility of returning to the community but the previous response is unknown.</del></li> </ul> <p><b>Coding Instructions for Q0500B, Ask the Resident (or Family or Significant Other if Resident Is Unable to Respond): “Do You Want to Talk to Someone about the Possibility of Returning to the Community?”</b> Ask the resident (or family or significant other or</p>

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			<p>guardian or legally authorized representative 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?”</p> <ul style="list-style-type: none"> <li>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.</li> </ul>
3	Q0500	Q-16	<p><b>Coding Tips</b></p> <ul style="list-style-type: none"> <li>A “yes—previous response was yes” response to item Q0500A Q0500B will trigger follow-up care planning and contact with the designated local contact agency about the resident’s request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires.</li> <li>Some residents will have a very clear expectation and some may have changed change their expectations over time. Other Residents may also be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a critical necessary step. It is important to clarify the resident’s discharge needs and expectations, determine what the SNF/NF usually provides does and can arrange, and in some instances to determine whether their preferences are or are not feasible obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24-hour care issues, etc.</li> <li>Current return to community questions may upset residents who that cannot understand what the question means go home and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the</li> </ul>

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			resident does not understand Q0500B, a family member, significant other, guardian, and/or legally appointed decision-maker for that individual could be asked the question.
3	Q0500	Q-17	<p><b>Examples</b></p> <p>Example #1 Coding: <del>Q0500A would be coded 0, no.</del> Q0500B would be coded 1, yes. Rationale: <del>Q0500A would be coded as no because Mr. B. had not been asked previously about returning to the community.</del> Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.</p> <p>Example #2 Coding: <del>Q0500A would be coded 0, no.</del> Q0500B would be coded 1, yes. Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.</p> <p>Example #3 Coding: <del>Q0500A would be coded 1, yes—previous response was no.</del> Q0500B would be coded 0, no. Rationale: <del>Mr. D. had been previously asked if he wanted to talk to someone about returning to the community. He had responded no.</del> During this assessment, he was asked again about returning to the community and he again responded no.</p>
3	Q0550	Q-18 & Q-19	<b>Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again</b>


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			<div data-bbox="690 241 1448 424" data-label="Form"> <p><b>Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again</b></p> <p>Enter Code <input type="checkbox"/> <b>A. Does the resident (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)</b>  0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment  1. Yes  8. Information not available</p> <p>Enter Code <input type="checkbox"/> <b>B. Indicate information source for Q0550A</b>  1. Resident  2. If not resident, then family or significant other  3. If not resident, family or significant other, then guardian or legally authorized representative  8. No information source available</p> </div> <div data-bbox="683 426 922 468" data-label="Section-Header"> <p><b>Item Rationale</b></p> </div> <div data-bbox="683 499 1458 976" data-label="Text"> <p>Some individuals, such as those with cognitive impairments, mental illness, or end-stage life 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 individual 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.</p> </div> <div data-bbox="683 999 1458 1339" data-label="Section-Header"> <p><b>Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments (rather than being asked yearly only on comprehensive assessments)?</b></p> </div> <div data-bbox="732 1350 1458 1890" data-label="List-Group"> <ul style="list-style-type: none"> <li>• Code 0, no: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.</li> <li>• Code 1, yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.</li> <li>• Code 9, information not available: if the resident cannot respond and the family or significant</li> </ul> </div>
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			<p>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.</p> <p><b>Coding Instructions for Q0550B, Indicate information source for Q0550A</b></p> <ul style="list-style-type: none"> <li>• Code 1, Resident: if resident responded to Q0550A.</li> <li>• Code 2, If not resident, then family or significant other.</li> <li>• Code 3, If not resident, family or significant other, then guardian or legally authorized representative.</li> </ul> <p>Code 8, No information source 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.</p> <p><b>Example</b></p> <p>1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her <b>and</b> she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.</p> <p>Coding: Q0550A would be coded 1, Yes. Q0550B would be coded 1.</p> <p>Rationale: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.</p>
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3	Q0600	Q-19	Replaced screen shot.
OLD			
<div> <div>Q0600. Referral</div> <div> <div>Enter Code</div> <div> <input type="checkbox"/> </div> </div> <div> <b>Has a referral been made to the local contact agency?</b>            0. <b>No</b> - determination has been made by the resident and the care planning team that contact is not required            1. <b>No</b> - referral not made            2. <b>Yes</b> </div> </div>			
NEW			
<div> <div>Q0600. Referral</div> <div> <div>Enter Code</div> <div> <input type="checkbox"/> </div> </div> <div> <b>Has a referral been made to the Local Contact Agency?</b> (Document reasons in resident's clinical record)            0. <b>No</b> - referral not needed            1. <b>No</b> - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)            2. <b>Yes</b> - referral made            </div> </div>			
3	Q0600	Q-19	<b>Health-related Quality of Life</b> <ul style="list-style-type: none"> <li>Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.</li> </ul>
3	Q0600	Q-20	<b>Planning for Care</b> <ul style="list-style-type: none"> <li>Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.</li> </ul>
3	Q0600	Q-20	<b>Steps for Assessment: Interview Instructions</b> <ol style="list-style-type: none"> <li>If Item Q0400A is coded 1, yes, then complete this item.</li> <li>If Item <del>Q0400B</del> Q0490B is coded 1, yes, then complete this item.</li> <li>If Item <del>Q0500A</del> Q0500B is coded 2, <del>yes</del> previous response was yes, then complete this item.</li> </ol>
3	Q0600	Q-20	<b>Coding Instructions</b> <ul style="list-style-type: none"> <li>Code 0, no: Referral not needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family,</li> </ul>

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			<p>etc., responded no to Q0500B.</p> <ul style="list-style-type: none"><li>Code 1, no: Referral is or may be needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) <del>and the care planning team</del> that the designated local contact agency needs to be contacted but the referral has not <del>made been</del> <b>initiated at this time</b>. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.</li><li>Code 2, yes: <b>Referral made</b>; if referral was made to the local contact agency. For example, the resident responded yes to <del>Q0500A</del> <b>Q0500B</b>. The facility care planning team was notified and initiated contact with the local contact agency.</li></ul>		
3	Q0600	Q-20	<p>Added resource center information (in table)</p> <table><tr><td><b>Local Contact Agency (LCA) Point of Contact List</b></td></tr><tr><td>See <a href="http://www.cms.gov/CommunityServices/downloads/State_by_%20State_POC_list.pdf">www.cms.gov/CommunityServices/downloads/State by %20State_POC_list.pdf</a> for listings.</td></tr></table>	<b>Local Contact Agency (LCA) Point of Contact List</b>	See <a href="http://www.cms.gov/CommunityServices/downloads/State_by_%20State_POC_list.pdf">www.cms.gov/CommunityServices/downloads/State by %20State_POC_list.pdf</a> for listings.
<b>Local Contact Agency (LCA) Point of Contact List</b>					
See <a href="http://www.cms.gov/CommunityServices/downloads/State_by_%20State_POC_list.pdf">www.cms.gov/CommunityServices/downloads/State by %20State_POC_list.pdf</a> for listings.					
3	Q0600	Q-21	<p><b>Coding Tips</b></p> <ul style="list-style-type: none"><li>State Medicaid Agencies have designated <b>Local Contact Agencies</b> and a State point of contact (POC) <b>to coordinate efforts to implement</b> <del>for</del> Section Q <del>implementation and are responsible to coordinate efforts to</del> designate LCAs for their State’s skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate.</li><li>Several resources are available at the Return to Community web site at: <a href="http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage">http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage</a>. — The State-by-State <b>POC</b> list for <b>MDS 3.0</b></li></ul>		

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from Chapter 3 Section Q V1.05  
to Chapter 3 Section Q V1.08**

			<p><del>Section Q including State's Local Contact Agencies and</del> <b>of Local Contact Agencies and POC</b> Section Q Coordinator Information.</p> <p>— MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.</p> <p>— The Section Q Pilot Test Results report describes the <del>implementation activities of the States that pilot tested Section Q and the need to establish collaborative arrangements at the local level</del> <b>results of user testing of the new items in Section Q.</b></p> <ul style="list-style-type: none"> <li>• Resource availability and eligibility coverage varies across <b>States and</b> local communities and <del>States and these</del> may present barriers to allowing some resident's return to their community. The nursing home and local agency <del>staffs</del> <b>staff members</b> should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.</li> <li>• Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.</li> <li>• The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.</li> <li>• The <del>nursing home and</del> local contact agency team must explore community care options/supports and conduct appropriate care planning to determine if transitions <b>back to the community is possible.</b></li> <li>• Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, insufficient financial resources, problems with caregiving supports, community resource gaps, etc., preventing discharge to the community.</li> <li>• <b>When Q0600 is answered 1, No, 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</b></li> </ul>
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**Track Changes  
from Chapter 3 Section Q V1.05  
to Chapter 3 Section Q V1.08**

			an opportunity to discuss returning to the community.
3	Q0600	Q-22	<p><b>Examples</b></p> <p>1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was “Yes” to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son’s school and use <del>handicapped</del> accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops and appliances—accessible housing.</p> <p style="padding-left: 40px;">Coding: <del>Q0500A</del> Q0500B would be coded 21, yes—[Skip to Q0600].</p> <p style="padding-left: 40px;">Q0600 would be coded 2, yes.</p> <p style="padding-left: 40px;">Rationale: <del>Q0400A would be coded yes, previous response was yes because Mr. S asked to be referred to the LCA and no referral was made.</del> The social worker or discharge planner would make a referral to the designated local contact agency for their state area and Q0600 would be coded as 2, yes.</p> <p>2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B and yet there has not been time to contact her family or to ask Ms. V. about how realistic going home would be for her at this time. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed and feasible for Ms. V.</p> <p style="padding-left: 40px;">Coding: Q0600 would be coded 1, no.</p> <p style="padding-left: 40px;">Rationale: Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community and yet there is insufficient time for</p>

**Track Changes  
from Chapter 3 Section Q V1.05  
to Chapter 3 Section Q V1.08**

			<p>the nursing home staff to talk to her and her family to determine whether the referral is possible and realistic. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600A Q0600 would be coded as no- “referral not made is or may be needed.” 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 local contact agency.</p>
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**Track Changes**  
**from Chapter 3 Section V V1.04**  
**to Chapter 3 Section V V1.08**

Chapter	Section	Page	Change
3	-	V-1	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.
3	V0100	V-2	Replaced screen shot.

OLD

**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- 06

Enter Code <input type="text"/> <input type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment</b> (A0310A value from prior assessment) 01. <b>Admission</b> assessment (required by day 14) 02. <b>Quarterly</b> review assessment 03. <b>Annual</b> assessment 04. <b>Significant change in status</b> assessment 05. <b>Significant correction to prior comprehensive</b> assessment 06. <b>Significant correction to prior quarterly</b> assessment 99. <b>Not OBRA required</b> assessment
Enter Code <input type="text"/> <input type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment</b> (A0310B value from prior assessment) 01. <b>5-day</b> scheduled assessment 02. <b>14-day</b> scheduled assessment 03. <b>30-day</b> scheduled assessment 04. <b>60-day</b> scheduled assessment 05. <b>90-day</b> scheduled assessment 06. <b>Readmission/return</b> assessment 07. <b>Unscheduled assessment used for PPS</b> (OMRA, significant or clinical change, or significant correction assessment) 99. <b>Not PPS</b> assessment
	<b>C. Prior Assessment Reference Date</b> (A2300 value from prior assessment) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Enter Score <input type="text"/> <input type="text"/>	<b>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score</b> (C0500 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	<b>E. Prior Assessment Resident Mood Interview (PHQ-9®) Total Severity Score</b> (D0300 value from prior assessment)
Enter Score <input type="text"/> <input type="text"/>	<b>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score</b> (D0600 value from prior assessment)

**Track Changes  
from Chapter 3 Section V V1.04  
to Chapter 3 Section V V1.08**

NEW			
<b>V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment</b> Complete only if A0310E = 0 and if the following is true for the <b>prior assessment</b> : A0310A = 01- 06 or A0310B = 01- 06			
Enter Code <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)</b> 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 <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)</b> 01. 5-day scheduled assessment 02. 14-day scheduled assessment 03. 30-day scheduled assessment 04. 60-day scheduled assessment 05. 90-day scheduled assessment 06. Readmission/return assessment 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) 99. None of the above		
<b>C. Prior Assessment Reference Date (A2300 value from prior assessment)</b> <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 1.2em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 1.2em;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em; margin-top: 2px;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>			
Enter Score <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)</b>		
Enter Score <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)</b>		
Enter Score <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	<b>F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)</b>		
3	V0100	V-3	<p><b>Coding Instructions for V0100B</b></p> <p><b>Note:</b> 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 (<del>not</del> <b>None of the above</b>), then the value for V0100B must be 01 through 07, indicating a PPS assessment. If the value of V0100B is 99 (<b>None of the above</b> <del>not a PPS assessment</del>), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.</p>

**Track Changes**  
**from Chapter 3 Section V V1.04**  
**to Chapter 3 Section V V1.08**

3	V0200	V-4	Replaced screen shot.
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OLD

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 <u>Addressed in Care Plan</u> 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 <u>Location and Date of CAA Information</u> 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. Addressed in Care Plan	Location and Date of CAA Information
	↓ Check all that apply ↓		
01. Delirium	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	
09. Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
10. Activities	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dehydration/Fluid Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	
15. Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	
16. Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychotropic Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
18. Physical Restraints	<input type="checkbox"/>	<input type="checkbox"/>	
19. Pain	<input type="checkbox"/>	<input type="checkbox"/>	
20. Return to Community Referral	<input type="checkbox"/>	<input type="checkbox"/>	
B. Signature of RN Coordinator for CAA Process and Date Signed			
1. Signature		2. Date	
		<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>	
C. Signature of Person Completing Care Plan and Date Signed			
1. Signature		2. Date	
		<div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: small;"> <span>Month</span> <span>Day</span> <span>Year</span> </div>	

**Track Changes  
from Chapter 3 Section V V1.04  
to Chapter 3 Section V V1.08**

NEW

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 <u>Care Planning Decision</u> 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 <u>Location and Date of CAA Documentation</u> 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	<input type="checkbox"/>	<input type="checkbox"/>	
02. Cognitive Loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
03. Visual Function	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL Functional/Rehabilitation Potential	<input type="checkbox"/>	<input type="checkbox"/>	
06. Urinary Incontinence and Indwelling Catheter	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	
09. Behavioral Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
10. Activities	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	
12. Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	
13. Feeding Tube	<input type="checkbox"/>	<input type="checkbox"/>	
14. Dehydration/Fluid Maintenance	<input type="checkbox"/>	<input type="checkbox"/>	
15. Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	
16. Pressure Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	
17. Psychotropic Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
18. Physical Restraints	<input type="checkbox"/>	<input type="checkbox"/>	
19. Pain	<input type="checkbox"/>	<input type="checkbox"/>	
20. Return to Community Referral	<input type="checkbox"/>	<input type="checkbox"/>	
B. Signature of RN Coordinator for CAA Process and Date Signed			
1. Signature		2. Date <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 2px;"> <span>Month</span><span>Day</span><span>Year</span> </div>	
C. Signature of Person Completing Care Plan Decision and Date Signed			
1. Signature		2. Date <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <div style="display: flex; justify-content: space-around; font-size: small; margin-top: 2px;"> <span>Month</span><span>Day</span><span>Year</span> </div>	

**Track Changes**  
**from Chapter 3 Section V V1.04**  
**to Chapter 3 Section V V1.08**

3	V0200	V-5	<ul style="list-style-type: none"> <li>For each triggered care area, Column B “Care Planning Decision—<del>Addressed in Care Plan</del>” 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—<del>Addressed in Care Plan</del>” 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.</li> </ul>
3	V0200	V-5	<p><b>V0200B2, Date</b></p> <ul style="list-style-type: none"> <li>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 14<sup>th</sup> 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 <del>Full</del> <b>Comprehensive</b> assessment. This date is considered the date of completion for the RAI.</li> </ul>
3	V0200	V-6	<p><b>Coding Instructions for V0200C, Signature of Person Completing Care Plan Decision and Date Signed</b></p>
3	V0200	V-6	<p><b>V0200C2, Date</b></p> <ul style="list-style-type: none"> <li>The date on which a staff member completes the <del>care planning decision</del> <b>Care Planning Decision</b> 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.</li> </ul>
3	V0200	V-6	<p><b>Clarifications:</b></p> <p>4. Dash fill all of the “Care Planning Decision<del>Addressed in Care Plan</del>” items in V0200A, Column B, which indicates that the decisions are unknown.</p>

**Track Changes**  
**from Chapter 3 Section X V1.04**  
**to Chapter 3 Section X V1.08**

Chapter	Section	Page	Change						
3	-	X-1	<p><b>Intent:</b> The purpose of Section X is to <del>indicate whether an MDS record is a new record to be added to the QIES ASAP system or a</del> identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error, request to modify or inactivate a record already present in the database. This information is provided in the first item in the section (X0100). If this is a new record, then all items in this section except the first item are skipped. If this is a request to modify or inactivate an existing record, then the other items in this section must be completed. 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 Sectoin 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 National MDS Database.</p>						
3	X0100	X-2 & X-3	Page length change.						
3	X0100	X-2 & X-3	<p><del>X0100: Type of Record</del></p> <div><p><b>X0100. Type of Record</b></p><table><tr><td>Enter Code</td><td>1. Add new record → Skip to Z0100, Medicare Part A Billing</td></tr><tr><td><input type="checkbox"/></td><td>2. Modify existing record → Continue to X0150, Type of Provider</td></tr><tr><td></td><td>3. Inactivate existing record → Continue to X0150, Type of Provider</td></tr></table></div> <p><del>Coding Instructions for X0100, Type of Record</del></p> <ul style="list-style-type: none"><li><del>Code 1, Add new record: if this is a new record that has not been previously submitted and accepted in the QIES ASAP system. If this item is coded as 1, then the remainder of Section X is skipped and the assessor should proceed to Section Z, Assessment Administration.</del></li><li><del>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 the QIES ASAP system and a “fatal” error will be reported to the facility on the Final Validation Report.</del></li><li><del>Code 2, Modify existing record: if this is a request to modify the MDS items for a record that</del></li></ul>	Enter Code	1. Add new record → Skip to Z0100, Medicare Part A Billing	<input type="checkbox"/>	2. Modify existing record → Continue to X0150, Type of Provider		3. Inactivate existing record → Continue to X0150, Type of Provider
Enter Code	1. Add new record → Skip to Z0100, Medicare Part A Billing								
<input type="checkbox"/>	2. Modify existing record → Continue to X0150, Type of Provider								
	3. Inactivate existing record → Continue to X0150, Type of Provider								

**Track Changes**  
**from Chapter 3 Section X V1.04**  
**to Chapter 3 Section X V1.08**

Chapter	Section	Page	Change
			<p>already has been submitted and accepted in the QIES ASAP system.</p> <p>If this item is coded as 2, then the remaining items in Section X and the items in all other MDS sections must be completed.</p> <p>When a modification request is submitted, the QIES ASAP System will take the following steps:</p> <ol style="list-style-type: none"> <li>1. The system will attempt to locate the existing record in the QIES ASAP database for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.</li> <li>2. If the existing record is not found, the submitted modification record will be rejected and not accepted in the QIES ASAP system. A “fatal” error will be reported to the facility on the Final Validation Report.</li> <li>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 the QIES ASAP system. The “fatal” error(s) will be reported to the facility on the Final Validation Report.</li> </ol> <p><b>X0100: Type of Record (cont.)</b></p> <ol style="list-style-type: none"> <li>4. If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP database. The prior record will be moved to a history file in the QIES ASAP database.</li> </ol> <p>• <b>Code 3, Inactivate existing record:</b> if this is a request to inactivate a record that already has been submitted and accepted in the QIES ASAP system.</p> <p>If this item is coded as 3, then the remaining items in Section X must be completed and all other MDS sections are skipped.</p> <p>When an inactivation request is submitted, the QIES ASAP system will take the following steps:</p> <ol style="list-style-type: none"> <li>1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the</li> </ol>

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			<p>resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.</p> <p>2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a “fatal” error will be reported to the facility on the Final Validation Report.</p> <p>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 the QIES ASAP system.</p> <p>4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file.</p> <p><b>Identification of Record to be Modified/Inactivated</b></p> <p>The Section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information <b>EXACTLY</b> 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.</p> <p>Example: A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record. When the encoder “data entered” the prior assessment for Joan L. Smith, he typed “John” by mistake. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under <u>Identification of Record to be Modified/Inactivated</u>. 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, the QIES ASAP system would not locate the prior assessment.</p> <p>———— The correction to the name from “John” to “Joan” will be made by recording “Joan”</p>

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			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 to the QIES ASAP system which causes the desired correction to be made.
3	X0600	X-4	Replaced screen shot.

OLD

X0600. Type of Assessment 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. Not OBRA required assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. 5-day scheduled assessment

02. 14-day scheduled assessment

03. 30-day scheduled assessment

04. 60-day scheduled assessment

05. 90-day scheduled assessment

06. Readmission/return assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. Not PPS assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA

0. No

1. Start of therapy assessment

2. End of therapy assessment

3. Both Start and End of therapy assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2

0. No

1. Yes

Enter Code

F. Entry/discharge reporting

01. Entry record

10. Discharge assessment-return not anticipated

11. Discharge assessment-return anticipated

12. Death in facility record

99. Not entry/discharge record

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NEW

<div> <div>Enter Code <input type="text"/></div> <div>Enter Code <input type="text"/></div> <div>Enter Code <input type="text"/></div> <div>Enter Code <input type="text"/></div> <div>Enter Code <input type="text"/></div> </div> <div> <p><b>X0600. Type of Assessment</b> on existing record to be modified/inactivated</p> <p><b>A. Federal OBRA Reason for Assessment</b></p> <p>01. Admission assessment (required by day 14)</p> <p>02. Quarterly review assessment</p> <p>03. Annual assessment</p> <p>04. Significant change in status assessment</p> <p>05. Significant correction to prior comprehensive assessment</p> <p>06. Significant correction to prior quarterly assessment</p> <p>99. None of the above</p> <p><b>B. PPS Assessment</b></p> <p><u>PPS Scheduled Assessments for a Medicare Part A Stay</u></p> <p>01. 5-day scheduled assessment</p> <p>02. 14-day scheduled assessment</p> <p>03. 30-day scheduled assessment</p> <p>04. 60-day scheduled assessment</p> <p>05. 90-day scheduled assessment</p> <p>06. Readmission/return assessment</p> <p><u>PPS Unscheduled Assessments for a Medicare Part A Stay</u></p> <p>07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)</p> <p><u>Not PPS Assessment</u></p> <p>99. None of the above</p> <p><b>C. PPS Other Medicare Required Assessment - OMRA</b></p> <p>0. No</p> <p>1. Start of therapy assessment</p> <p>2. End of therapy assessment</p> <p>3. Both Start and End of therapy assessment</p> <p>4. Change of therapy assessment</p> <p><b>D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2</b></p> <p>0. No</p> <p>1. Yes</p> <p><b>F. Entry/discharge reporting</b></p> <p>01. Entry tracking record</p> <p>10. Discharge assessment-return not anticipated</p> <p>11. Discharge assessment-return anticipated</p> <p>12. Death in facility tracking record</p> <p>99. None of the above</p> </div>			
3	X0600	X-5	Page length change.
3	X0600	X-6	<p><b>Coding Instructions for X0600F, Entry/discharge reporting</b></p> <p>01. Entry tracking record</p> <p>10. Discharge assessment-return not anticipated</p> <p>11. Discharge assessment-return anticipated</p> <p>12. Death in facility tracking record</p> <p>99. None of the above entry/discharge</p> <ul style="list-style-type: none"> <li>Note that the Entry/discharge code in X0600F does not have to match the current value of A0310F on a modification request. The entries may be different if the modification is correcting the Entry/discharge reason for completing the assessment or tracking record.</li> </ul>
3	X0600	X-7	Page length change.
3	X0900	X-8	<p><b>X0900: Reasons for Modification</b></p> <p>The items in this section indicate the possible reasons for the</p>

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			modification request of the record in the QIES ASAP database. Check all that apply. These items should only be completed when A0050X0100 = 2, indicating a modification request. If A0050X0100 = 3, indicating an inactivation request, these items should be skipped.
3	X0900	X-8	Replaced screen shot.
<div>OLD</div> <div> <div>X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)</div> <div> <div>↓ Check all that apply</div> <div> <input type="checkbox"/> A. Transcription error <input type="checkbox"/> B. Data entry error <input type="checkbox"/> C. Software product error <input type="checkbox"/> D. Item coding error <input type="checkbox"/> E. End of Therapy - Resumption (EOT-R) date <input type="checkbox"/> Z. Other error requiring modification  If "Other" checked, please specify: _____ </div> </div> </div>			
<div>NEW</div> <div> <div>X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)</div> <div> <div>↓ Check all that apply</div> <div> <input type="checkbox"/> A. Transcription error <input type="checkbox"/> B. Data entry error <input type="checkbox"/> C. Software product error <input type="checkbox"/> D. Item coding error <input type="checkbox"/> E. End of Therapy - Resumption (EOT-R) date <input type="checkbox"/> Z. Other error requiring modification  If "Other" checked, please specify: _____ </div> </div> </div>			
3	X0900	X-9	<b>Coding Instructions for X0900E, End of Therapy-Resumption (EOT-R) date</b> <ul style="list-style-type: none"> <li>Check the box if the error in the prior QIES ASAP record was caused by an erroneous End of Therapy-Resumption (EOT-R) date.</li> </ul>
3	X0900	X-9	<b>Coding Instructions for X0900Z, Other Error Requiring Modification</b> <ul style="list-style-type: none"> <li>Check the box if any errors in the prior QIES ASAP record were caused by other types of errors not included in Items X0900A through X0900DE.</li> </ul>
3	X1050	X-9	<b>X1050: Reasons for Inactivation</b> <p>The items in this section indicate the possible reasons for the inactivation request. Check all that apply. These items should only be completed when A0050X0100 = 3, indicating an inactivation request. If A0050X0100 = 2, indicating a modification request, these items should be skipped.</p>

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3	X1050	X-9	Replaced screen shot.
<p>OLD</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>X1050. Reasons for Inactivation</b> - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)</p> <p>↓ Check all that apply</p> <div style="display: flex; border-bottom: 1px solid black;"> <div style="width: 40px; text-align: center; border-right: 1px solid black;"><input type="checkbox"/></div> <div>A. Event did not occur</div> </div> <div style="display: flex; border-bottom: 1px solid black;"> <div style="width: 40px; text-align: center; border-right: 1px solid black;"><input type="checkbox"/></div> <div>Z. Other error requiring inactivation</div> </div> <p style="margin-left: 40px;">If "Other" checked, please specify: _____</p> </div>			
<p>NEW</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>X1050. Reasons for Inactivation</b> - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)</p> <p>↓ Check all that apply</p> <div style="display: flex; border-bottom: 1px solid black;"> <div style="width: 40px; text-align: center; border-right: 1px solid black;"><input type="checkbox"/></div> <div>A. Event did not occur</div> </div> <div style="display: flex; border-bottom: 1px solid black;"> <div style="width: 40px; text-align: center; border-right: 1px solid black;"><input type="checkbox"/></div> <div>Z. Other error requiring inactivation</div> </div> <p style="margin-left: 40px;">If "Other" checked, please specify: _____</p> </div>			
3	X0600	X-10	Page length change.
3	X1100	X-11	<p><b>Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion</b></p> <ul style="list-style-type: none"> <li>If you are completing an inactivation is being completed, you need to complete Z0400 must also be completed.</li> </ul>

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Chapter	Section	Page	Change
3	Z0300	Z-5	Replaced screen shot.
<div> <div>OLD</div> <div> <div>Z0300. Insurance Billing</div> <div> <div>A. RUG Case Mix group:</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> </div> <div> <div>B. RUG version code:</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> </div> </div> </div>			
<div> <div>NEW</div> <div> <div>Z0300. Insurance Billing</div> <div> <div>A. RUG billing code:</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> </div> <div> <div>B. RUG billing version:</div> <div> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div> </div> </div> </div>			
3	Z0300	Z-5	<p><b>Coding Instructions for Z0300A, RUG Case Mix Group <del>billing</del> code</b></p> <ul style="list-style-type: none"> <li>If the other payer has selected a standard RUG model, this item may be populated automatically by the software data entry product. Otherwise, enter the <del>ease-mix</del> <b>billing</b> code in the space provided. This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs.</li> </ul> <p><b>Coding Instructions for Z0300B, RUG Version Code <del>billing</del> version</b></p> <ul style="list-style-type: none"> <li>If the other payor has selected a standard RUG model, this item may be populated automatically by the software data entry product. Otherwise, enter an appropriate <b>billing</b> version <del>code</del> in the spaces provided. This is the <b>billing</b> version <del>code</del> appropriate to the <del>ease-mix</del> <b>billing</b> code in Item Z0300A.</li> </ul>

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Chapter	Section	Page	Change
4	4.3	4-2	<p><b>4.3 What Are the Care Area Assessments (CAAs)?</b></p> <p>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, <b>Care Area Assessments (CAAs)</b> are <del>previous MDS versions provided Resident Assessment Protocols (RAPs) that were triggered</del> <b>responses to items coded on the MDS</b> by MDS item responses specific to a resident's <del>that alerted the assessor to the resident's possible problems, needs or strengths. For the MDS 3.0, the RAPs have been replaced by Care Area Assessments (CAAs). CAAs are identified by responses to items coded on the MDS.</del> 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.</p>
4	4.3	4-3	<p><b>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 <del>Full</del> Comprehensive).</b> 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.</p>

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Chapter	Section	Page	Change
4	4.5	4-6	<p>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 <del>decision-making</del> <b>decision making</b> (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.</p>
4	4.5	4-7	<p>Written documentation of the CAA findings and <del>decision-making</del> <b>decision making</b> 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.</p> <p>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—<del>Addressed in Care Plan</del>" whether the triggered care area is addressed in the care plan.</p>

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Chapter	Section	Page	Change
4	4.7	4-10	<p>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 <del>well-developed</del> <b>well developed</b> and executed assessment and care plan:</p> <ul style="list-style-type: none"> <li>Reflects the resident/resident representative input and goals for health care;</li> </ul>
4	4.8	4-11	<p>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 <del>cross-reference</del> <b>cross reference</b> 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.</p> <p>4) The RN coordinator is required to sign and date the <b>Care Area Assessment (CAA)</b> Summary <del>form</del> 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).</p>
4	4.8	4-12	<p>9) 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 <del>form</del> 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.</p>
4	4.9	4-15	<p>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</p>

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			<p>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.</p>
4	4.9	4-15	<p>Key components of the care plan may include; but are not limited to the following:</p>
4	4.10	4-18	<p><b>3. Visual Function</b></p> <p>The aging process leads to a decline in visual acuity; f. 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.</p>
4	4.10	4-20	<p>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; f. For example, touch, facial expressions, eye contact,</p>

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			<p>hand movements, tone of voice, and posture.</p> <p><b>5. ADL Functional/Rehabilitation Potential</b></p> <p>The ADL Functional/Rehabilitation CAA addresses the resident's <del>self-sufficiency</del> <b>self sufficiency</b> in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toileting, changing position in bed, 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.</p>
4	4.10	4-23	<p><b>6. Urinary Incontinence and Indwelling Catheter</b></p> <p>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. <del>It is often</del> <b>Often, it is</b> 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 <del>lifethreatening</del> <b>life threatening</b> infections</p>
4	4.10	4-24	<p>Change in table:</p> <p><b>6. Resident has moisture associated skin damage as indicated by:</b></p> <p style="text-align: center;"><b>M1040H = 1</b></p>
4	4.10	4-24	<p>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<del>;</del>, the potential for removal of the catheter<del>;</del>, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral</p>

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			erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.
4	4.10	4-25	<p><b>8. Mood State</b></p> <p>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 <del>be</del> 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.</p>
4	4.10	4-26	Page length change.
4	4.10	4-27	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.
4	4.10	4-27	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,
4	4.10	4-30	<p>Changes in table:</p> <p>6. Resident received antianxiety medication <b>on one or more of the</b> <del>during the</del> last 7 days or since admission/<b>entry or</b> <del>reentry if less than 7 days</del> as indicated by:</p> <p style="text-align: center;"><del>N0400B</del><b>N04010B</b> &gt;= 1 <b>AND N0410B</b> &lt;= 7</p> <p>7. Resident received antidepressant medication <b>on one or more of</b> <del>during the</del> last 7 days or since admission/<b>entry or</b> <del>reentry if less than 7 days</del> as indicated by:</p> <p style="text-align: center;"><del>N0400B</del><b>N04010C</b> &gt;= 1 <b>AND N0410C</b> &lt; 7</p>

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4	4.10	4-30	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 <del>persons</del> <b>residents</b> 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.
4	4.10	4-31	<p>Changes in table:</p> <p>2. Body mass index (BMI) is too low or too high as indicated by:</p> <p style="text-align: center;"><b>BMI &lt; 18.5000 OR BMI &gt; 24.9000</b></p> <p>3. Any weight loss as indicated by a value of 1 or 2 as follows:</p> <p style="text-align: center;"><b>K0300 = 1 OR K0300 = 2</b></p> <p>4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:</p> <p style="text-align: center;"><b>K0310 = 1 OR K0310 = 2</b></p> <p>4.5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p style="text-align: center;"><b><del>K0500A</del>K0510A1 = 1 OR K0510A2 = 1</b></p> <p>5.6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p style="text-align: center;"><b><del>K0500C</del>K0510C1 = 1 OR K0510C2 = 1</b></p> <p>6.7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p style="text-align: center;"><b><del>K0500D</del>K0510D1 = 1 OR K0510D2 = 1</b></p> <p>7.8. 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:</p>
4	4.10	4-31 & 4-32	<p><b>13. Feeding Tubes</b></p> <p>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</p>

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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 <del>(for example, in individuals with advanced dementia)</del> , 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.
4	4.10	4-32	<p>Changes in table:</p> <p>1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p><del>K0500B</del> <b>K0510B = 1 OR K0510B2 = 1</b></p>
4	4.10	4-33	<p>Changes in table:</p> <p>7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p><del>K0500A</del> <b>K0510A1 = 1 OR K0510A2 = 1</b></p> <p>8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:</p> <p><del>K0500B</del> <b>K0510B1 = 1 OR K0510B2 = 1</b></p>
4	4.10	4-33 & 4-34	<p><b>15. Dental Care</b></p> <p>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.</p> <p>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 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 of the resident's issues and/or conditions.</p>
4	4.10	4-35	The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure

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			<p>ulcers(s) and to identify any related causes and/or contributing and/or 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.</p> <p><b>17. Psychotropic Medication Use</b></p> <p>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 (<del>medications that are</del>, 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</p>
4	4.10	4-36	<p>Changes in table:</p> <ol style="list-style-type: none"> <li>1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry to resident in last 7 days or since admission as indicated by:  <del>N0400A</del> <b>N0410A&gt; = 1 AND N0410A&lt;=7</b></li> <li>2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry to resident in last 7 days or since admission as indicated by:  <del>N0400B</del> <b>N0410B&gt; = 1 AND N0410B&lt;7</b></li> <li>3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry in last 7 days or since admission as indicated by:  <del>N0400C</del> <b>N0410C&gt; = 1 AND N0410C&lt;7</b></li> <li>4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry in last 7 days or since admission as indicated by:  <del>N0400D</del> <b>N0410D&gt; = 1 AND N0410D&lt;7</b></li> </ol>
4	4.10	4-36	<p>The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's</p>

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			medication, <del>(in consultation with the physician and the consultant pharmacist)</del> , and to identify any adverse consequences, as well as any related possible causes and/or contributing <del>and/or</del> 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.
4	4.10	4-37	The physical restraint CAA identifies residents who are physically restrained <b>during the look-back period</b> . When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. <del>This CAA is triggered when a resident used a physical restraint during the look-back period.</del>
4	4.10	4-38	<b>19. Pain</b>  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; e.g., <b>For example</b> , 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.
4	4.10	4-39 & 4-40	<b>20. Return to Community Referral</b>  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. <del>The</del> <b>This</b> ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments <b>(Federal and State)</b> have a responsibility to enforce and support these choices.  An individual in a nursing home with adequate <del>decision-making</del> <b>decision making</b> capacity can choose to leave the facility and/or request to talk to someone about returning to the community at any time. The return to community referral <b>portion of MDS 3.0</b> uses a person-centered approach to ensure that all individuals <b>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.</b> The CAA associated with this

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			<p>portion of MDS 3.0 CAA 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 service settings for receipt of services.</p> <p>Individual choices related to returning to the 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, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care interventions, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.</p>
4	4.10	4-40	<p>Change to table:</p> <ol style="list-style-type: none"> <li>Referral is or may be needed but has not been made to local contact agency as indicated by:</li> </ol>
4	4.10	4-40	<p>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 his or her highest level of functioning and the involvement of the designated 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 his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.</p>

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5	5.1	5-1	<a href="http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp">http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp</a> <a href="http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp">http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp</a>
5	5.6	5-9	The correction process is more complicated for a nursing home OBRA comprehensive or quarterly assessments with <b>any significant errors</b> identified after the end of the 7-day encoding and editing period but before the records <del>has</del> <b>have</b> been accepted into the QIES ASAP system. 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 insure 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.
5	5.7	5-11	2. Complete the required Correction Request Section X items and include with the corrected record. Item <del>X0100</del> <b>A0050</b> should have a value of 2, indicating a modification request. 2. Complete the required Correction Request Section X items and include with the corrected record. Item <del>X0100</del> <b>A0050</b> should have a value of 2, indicating a modification request. 2. Complete the required Correction Request Section X items and include with the corrected record. Item <del>X0100</del> <b>A0050</b> should have a value of 2, indicating a modification request.
5	5.7	5-12	<b>Inactivation Requests</b> An Inactivation should be used when a record has been accepted into the QIES ASAP system 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 <del>X0100</del> <b>A0050</b> = 3) <b>must</b> be completed when any of the following items are inaccurate: Type of Provider (Item A0200), Type of Assessment (A0310), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.

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5	5.7	5-13	Page length change.

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6	6.4	6-10	1. When rehabilitation therapy begins during the middle of a Medicare Part A stay, a Start of Therapy OMRA may optionally be performed <b>with an ARD set for</b> within 5 to 7 days after the earliest <u>start of therapy</u> date (items O0400A5, O0400B5, or O0400C5). The Start of Therapy OMRA changes the RUG payment rate previously established by a previous PPS assessment from the earliest start of therapy date through the end of the standard payment period. <b>Consider Example 1.</b>
6	6.4	6-10 & 6-11	3. When all rehabilitation therapy ends, an End of Therapy OMRA must be performed <b>with an ARD set for</b> within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. <b>Example 3</b> presents the most common situation.
6	6.4	6-11 & 6-12	<ul style="list-style-type: none"> <li>EXAMPLE 5. The End of Therapy OMRA assessment is performed with <b>an</b> ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 28 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 25 through Day 30. The Medicare <b>Non-Therapy</b> RUG (Z150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.</li> <li>EXAMPLE 6. The End of Therapy OMRA has an ARD on Day 26 with the last day of therapy being Day 24. The PPS 30-Day assessment is then performed <b>with an ARD</b> on Day 27 (the first day of the ARD window) to establish payment with the Medicare RUG (Z0100A) for Days 31-60. Therapy then resumes at the prior level and</li> </ul>

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			<p>the EOT-R items (O0450A, and O0450B) indicate a resumption of therapy date of Day 28. The EOT OMRA would establish payment at a Medicare Non-Therapy RUG (Z0150A) for Days 25-27 and Resumption of Therapy reporting would reestablish payment from Day 28 through Day 30 (the end of the payment period) at the same Medicare RUG (Z0100A) provided on the resident's most recent PPS assessment used to establish payment prior to Day 25. The PPS 30-day assessment would then set the payment at the Medicare RUG (Z0100A) for the standard Day 31 to 60 payment period.</p>
6	6.4	6-12 & 6-13	<p>The first Change of Therapy OMRA evaluation occurs on Day 7 after the most recent assessment ARD (except in cases where the last assessment is an EOT-R, as outlined in Chapter 2) and the provision of therapy services are evaluated for the first <del>Change of Therapy</del> <b>COT</b> OMRA observation period (Day 1 through Day 7 after the assessment ARD). If the provision of therapy services during this 7 day period no longer reflects the RUG-IV classification category on the most recent PPS assessment (as described in Chapter 2), then a Change of Therapy OMRA must be performed with the ARD on Day 7 of the COT observation period.</p> <p>If the provision of therapy services are <del>reflected by</del> <b>reflective</b> <del>the</del> <b>of the</b> most recent PPS assessment RUG category classification, a <del>Change in Therapy</del> <b>Change of Therapy</b> OMRA is not performed <del>on Day 7</del> and changes in the provision of therapy services would next be evaluated on Day 14 after the most recent assessment ARD using the second <del>Change of Therapy OMRA</del> <b>COT</b> observation period (Day 8 through Day 14 after the assessment ARD). If a different RUG-IV classification category results for Day 14, then a Change of Therapy OMRA must be performed with an ARD on Day 14, which is Day 7 of that COT observation period, and <b>payment is set retroactively back to the beginning of that COT observation period.</b></p> <p>If the provision of therapy services are <del>reflected by</del> <b>reflective</b> <del>the</del> <b>of the</b> most recent PPS assessment RUG category classification, a <del>Change in Therapy</del> <b>Change of Therapy</b> OMRA is not performed <b>with an ARD</b> on Day 14 and the evaluation of the change in therapy services provided would next be evaluated on Day 21 after the most recent assessment ARD using the third <del>Change of Therapy</del> <b>COT</b> OMRA observation</p>

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			<p>period (Day 15 through Day 21 after the assessment ARD). This process continues until <b>the next scheduled or unscheduled PPS assessment used for payment.</b> <del>a new scheduled or unscheduled PPS assessment is performed.</del> When a new PPS assessment is performed (Change of Therapy OMRA, any other unscheduled PPS assessment, or scheduled PPS assessment), then the COT OMRA evaluation process restarts <b>the day following the ARD of that intervening assessment.</b> If at any point, rehabilitation therapy ends before the last day of a <del>Change of Therapy OMRA</del> <b>COT</b> observation period and an End of Therapy OMRA is <del>required</del> <b>performed with an ARD set for on or prior to Day 7 of the COT observation period,</b> then the change of therapy evaluation process ends until the next PPS assessment <b>used for payment which reflecting the utilization of skilled therapy services.</b> <del>includes the resident receiving skilled therapy services again.</del></p> <p>7. Example 7 presents a case where a Change <del>in</del> <b>Therapy of Therapy</b> OMRA is performed.</p> <ul style="list-style-type: none"> <li>EXAMPLE 7. The 30-day assessment is performed with the ARD on Day 30, and the provision of therapy services are evaluated on Day 37. It is determined that the therapy services provided were <del>reflected by</del> <b>reflective of</b> the RUG-IV classification category on the most recent PPS assessment and therefore, no Change of Therapy OMRA is performed <del>on</del> <b>with an ARD set for</b> Day 37. When the provision of therapy services are next evaluated on Day 44, it is determined that a different Rehabilitation category results and a <del>Change in Therapy of Therapy</del> <b>Change of Therapy of Therapy</b> OMRA is performed with <b>an ARD set for on</b> Day 44. The Change of Therapy OMRA will change the RUG payment beginning on Day 38 (the first day of the <del>Change of Therapy OMRA</del> <b>COT</b> observation period). The Change of Therapy OMRA evaluation process then restarts with this Change of Therapy OMRA.</li> </ul> <p>8. If a new PPS assessment <b>used for payment</b> occurs <b>with an ARD set for on or prior to</b> <del>before</del> the last day of a <del>Change of Therapy OMRA</del> <b>COT</b> observation period, then a Change of Therapy OMRA is not <del>performed</del> <b>required</b> for that observation period. Example 8</p>

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			<p>illustrates this case.</p> <ul style="list-style-type: none"> <li>EXAMPLE 8. An SCSA is performed with <b>an</b> <del>ARD on</del> <b>of</b> Day 10. An evaluation for the Change of Therapy OMRA would occur on Day 17 but the 14-Day assessment intervenes with ARD on Day 15. A Change of Therapy OMRA is not performed <del>on</del> <b>with an ARD on</b> Day 17. Rather, the COT OMRA evaluation process is restarted with the 14-day assessment with ARD on Day 15. Day 1 of the next COT observation period is Day 16 and the new COT OMRA evaluation would be done on Day 22.</li> </ul> <p>9. Example 9 illustrates that the COT OMRA evaluation process ends when all rehabilitation therapy ends before the end of a <del>Change in Therapy OMRA</del> <b>COT</b> observation period.</p> <ul style="list-style-type: none"> <li>EXAMPLE 9. The 14-Day assessment is performed with the ARD on Day 14. The first COT OMRA evaluation would normally happen on Day 21. However, all therapy ends on Day 20. The ARD for an EOT OMRA is set for Day 21 to reflect the discontinuation of therapy services. No <del>Change in</del> <b>of</b> Therapy OMRA is performed <b>with an ARD</b> on Day 21 and the change <del>in</del> <b>of</b> therapy evaluation process is discontinued.</li> </ul>
6	6.6	6-26	<p><b>STEP # 2</b></p> <p>Calculate the total minutes for occupational therapy as follows:</p> <p>Add the individual minutes (O0400B1) and one-half of the concurrent minutes (O0400B2). If classification is for Medicare for FY2011 add all of the group minutes (O0400B3) and record as Total Minutes. Otherwise beginning with FY 2012, add <del>alone</del> <b>one</b>-quarter of the group minutes and record as Total Minutes. Total Minutes* = _____</p>
6	6.6	6-31	<p><b>STEP # 3</b></p> <ul style="list-style-type: none"> <li><b>Ultra High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied)</li> </ul>

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			<ol style="list-style-type: none"> <li>1. In the past 7 days: Total Therapy Minutes (calculated on page 6-<del>19</del><b>25 - 6-28</b>) of 720 minutes or more</li> <li>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del><b>see</b> page 6-<del>19</del><b>24</b>) of 144 minutes or more</li> </ol>
6	6.6	6-32 & 6-33	<ul style="list-style-type: none"> <li>• <b>Very High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied) <ol style="list-style-type: none"> <li>1. In the last 7 days: Total Therapy Minutes (calculated on page 6-<del>19</del><b>25 - 6-28</b>) of 500 minutes or more <b>and</b> At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days</li> <li>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del><b>see</b> page 6-<del>24</del><b>19</b>) of between 100 and 143 minutes</li> </ol> </li> <li>• <b>High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied) <ol style="list-style-type: none"> <li>1. In the last 7 days: Total Therapy Minutes (calculated on page 6-<del>19</del><b>25 - 6-28</b>) of 325 minutes or more <b>and</b> At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days</li> <li>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del><b>see</b> page 6-<del>24</del><b>19</b>) of between 65 and 99 minutes</li> </ol> </li> <li>• <b>Medium Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied) <ol style="list-style-type: none"> <li>1. In the last 7 days: Total Therapy Minutes (calculated on page 6-<del>19</del><b>25 - 6-28</b>) of 150 minutes or more <b>and</b> At least 5 days of any combination of the three</li> </ol> </li> </ul>

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			<p>disciplines (O0400A4 plus O0400B4 plus O0400C4)</p> <p>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del> <del>see</del> page 6-24 <b>19</b>) of between 30 and 64 minutes</p> <ul style="list-style-type: none"> <li>• <b>Low Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied): <ul style="list-style-type: none"> <li>1. In the last 7 days: Total Therapy Minutes (calculated on page 6-19 <b>25 - 6-28</b>) of 45 minutes or more <b>and</b> At least 3 days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4) <b>and</b> Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day</li> <li>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del> <del>see</del> page 6-24 <b>19</b>) of between 15 and 29 minutes</li> </ul> </li> </ul>
6	6.6	6-34 to 6-36	<p><b>STEP # 1</b></p> <p>A. <b>Ultra High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied)</p> <ul style="list-style-type: none"> <li>1. In the last 7 days: Total Therapy Minutes (calculated on page 6-19 <b>25 - 6-28</b>) of 720 minutes or more <b>and</b> One discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days <b>and</b> A second discipline (O0400A4, O0400B4 or O0400C4) for at least 3 days</li> <li>2. <b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on</del> <del>see</del> page 6-24 <b>19</b>) of 144 minutes or more</li> </ul>

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			<p><b>B. Very High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied)</p> <ol style="list-style-type: none"> <li>In the last 7 days: Total Therapy Minutes (calculated on page 6-19<del>25</del> - 6-28) of 500 minutes or more <b>and</b> At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days</li> <li><b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (calculated on <del>see</del> page 6-21<del>19</del>) of between 100 and 143 minutes</li> </ol> <p><b>C. High Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied)</p> <ol style="list-style-type: none"> <li>In the last 7 days: Total Therapy Minutes (calculated on page 6-19<del>25</del> - 6-28) of 325 minutes or more <b>and</b> At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days</li> <li><b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (calculated on <del>see</del> page 6-21<del>19</del>) of between 65 and 99 minutes</li> </ol> <p><b>D. Medium Intensity Criteria</b> (the resident qualifies if either [1] or [2] is satisfied)</p> <ol style="list-style-type: none"> <li>In the last 7 days: Total Therapy Minutes (calculated on page 6-19<del>25</del> - 6-28) of 150 minutes or more <b>and</b> At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4)</li> <li><b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (calculated on <del>see</del> page 6-21<del>19</del>) of between 30 and 64 minutes</li> </ol> <p><b>E. Low Intensity Criteria</b> (the resident qualifies if either</p>

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Chapter	Section	Page	Change
			<p>[1] or [2] is satisfied):</p> <ol style="list-style-type: none"> <li>In the last 7 days: Total Therapy Minutes (calculated on page 6-<del>19</del>25 - 6-28) of 45 minutes or more <b>and</b> At least 3 days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4) <b>and</b> Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day</li> <li><b>If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is “Yes”:</b> Medicare Short Stay Average Therapy Minutes (<del>calculated on see</del> page 6-2119) of between 15 and 29 minutes</li> </ol>
6	6.8	6-52 & 6-53	<p><b>Late Assessment</b></p> <p>The SNF must complete a late assessment if the SNF fails to set the ARD within the defined ARD window for a scheduled Medicare-required assessment (including the grace days) or an OMRA when the resident is still on Part A coverage. The ARD can be no earlier than the day the omission was identified. If the ARD on the late assessment is set prior to the end of the payment period <b>for which the Medicare-required assessment would have been effective,</b><del>for the Medicare-required assessment that was missed,</del> the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment. For example, a Medicare-required 30-day assessment with an ARD of Day 41 would be paid the default rate for Days 31 through 40 and at the HIPPS classification from the assessment beginning on Day 41.</p> <p>If the ARD of the late assessment is set after the end of the payment period for <b>which the Medicare-required assessment would have been effective</b> <del>that was missed</del> and the resident is still on Part A, the provider must still complete an assessment. The ARD can be no earlier than the day the omission was identified. The SNF must bill all covered days for that payment period at the default rate regardless of the HIPPS code calculated from the late assessment. For</p>

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Chapter	Section	Page	Change
			<p>example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace the next regularly scheduled Medicare-required assessment. The SNF would then need to complete the 30-day Medicare-required assessment that covers Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services.</p> <p><b>Missed Assessment</b></p> <p>If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and <b>the resident is no longer a SNF Part A resident, and</b> as a result a Medicare-required assessment does not exist in the QIES ASAP for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP. When an assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the RUG category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.</p>

**Track Changes  
from Appendix A V1.07  
to Appendix A V1.08**

Chapter	Section	Page	Change		
3	Appendix A	A-6	<b>Down Syndrome</b>		A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, <del>mental retardation</del> <b>intellectual disability</b> , low muscle tone, and other possible effects.
3	Appendix A	A-13	<b>Most Recent Medicare Stay</b>		<p><del>For an admission: day 1 of Medicare Part A stay.</del></p> <p><del>For a reentry: day 1 of Medicare Part A coverage after returning to facility following a discharge return anticipated and resident returns within 30 days.</del></p> <p><b>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.</b></p>
3	Appendix A	A-14	<b>Nursing Monitoring</b>		<b>Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).</b>

**Track Changes  
from Appendix C V1.07  
to Appendix C V1.08**

Chapter	Section	Page	Change	
Appendix C	-	C-3	Step 9: Information in the <i>Supporting Documentation</i> column can be used to populate the <i>Location and Date of CAA Information-Documentation</i> column in Section V, Item V0200A (CAA Results) – for e.g. “See Delirium CAA 4/30/11, H&P dated 4/18/11.”	
Appendix C	1.	C-7	<input type="checkbox"/>	• Receiving diuretics or drugs that may cause electrolyte imbalance (medication administration record) (N04010G)
Appendix C	1.	C-7	<input type="checkbox"/>	• Drugs with anticholinergic properties (for example, some antipsychotics (N0400AN0410A), antidepressants (N0400CN0410C), antiparkinsonian drugs, antihistamines)
Appendix C	1.	C-7	<input type="checkbox"/>	• Benzodiazepines, especially long-acting agents (N04010B)
Appendix C	1.	C-7	<input type="checkbox"/>	• Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0400BN0410B)
Appendix C	3.	C-15	<input type="checkbox"/>	• Antipsychotics (N04010A)
Appendix C	3.	C-15	<input type="checkbox"/>	• Antidepressants (N04010C)
Appendix C	3.	C-15	<input type="checkbox"/>	• Hypnotics (N04010D)
Appendix C	4.	C-17	<input type="checkbox"/>	• Antipsychotics (N04010A)
Appendix C	4.	C-17	<input type="checkbox"/>	• Antianxiety (N04010B)
Appendix C	4.	C-17	<input type="checkbox"/>	• Antidepressants (N04010C)
Appendix C	4.	C-17	<input type="checkbox"/>	• Hypnotics (N04010D)
Appendix C	4.	C-17	<input type="checkbox"/>	• Gentamycin (N04010F) (medication administration record)
Appendix C	4.	C-17	<input type="checkbox"/>	• Tobramycin (N04010F) (medication administration record)
Appendix C	5.	C-21	<input type="checkbox"/>	• Nutritional problems (K05010A1, K0510A2) (clinical record and Nutrition CAA)
Appendix C	5.	C-22	<input type="checkbox"/>	• Psychoactive medications (N04010A-D)
Appendix C	6.	C-26	<input type="checkbox"/>	• Diuretics(N04010G)– can cause urge incontinence
Appendix C	6.	C-26	<input type="checkbox"/>	• Sedative hypnotics (N04010B, N0400DN0410D)
Appendix C	6.	C-26	<input type="checkbox"/>	—Antipsychotics (N04010A) —Antidepressants (N04010C)
Appendix C	8.	C-34	<input type="checkbox"/>	• Antibiotics (N04010F)
Appendix C	8.	C-34	<input type="checkbox"/>	• Antipsychotics (N04010A)

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Chapter	Section	Page	Change	
Appendix C	10.	C-42	<input type="checkbox"/>	• Use of psychoactive medications ( <del>N0400A</del> <del>N0410A-</del> <del>N0400D</del> <del>N0410D</del> )
Appendix C	11.	C-46	<input type="checkbox"/>	• Antipsychotics ( <del>N0400A</del> <del>N0410A</del> )
Appendix C	11.	C-46	<input type="checkbox"/>	• Antianxiety agents ( <del>N0400B</del> <del>N0410B</del> )
Appendix C	11.	C-46	<input type="checkbox"/>	• Antidepressants ( <del>N0400C</del> <del>N0410C</del> )
Appendix C	11.	C-46	<input type="checkbox"/>	• Hypnotics ( <del>N0400D</del> <del>N0410D</del> )
Appendix C	11.	C-46	<input type="checkbox"/>	• Diuretics (N04010G) (from medication administration record)
Appendix C	12.	C-53	<input type="checkbox"/>	• Weight gain (K0310)
Appendix C	12.	C-53	<input type="checkbox"/>	• Antipsychotics ( <del>N0400A</del> <del>N0410A</del> )
Appendix C	12.	C-53	<input type="checkbox"/>	• Diuretics (N04010G)
Appendix C	13.	C-56	<input type="checkbox"/>	• Weight check at least monthly (K0300, K0310)
Appendix C	13.	C-56	<input type="checkbox"/>	• Regular changing and replacement of PEG tubes and J-tubes, per physician order and facility protocol (K05010B1, K0510B2)
Appendix C	13.	C-56	<input type="checkbox"/>	• Significant weight gain (K0310)
Appendix C	14.	C-59	<input type="checkbox"/>	• Weight gain (K0310)
Appendix C	14.	C-60	<input type="checkbox"/>	• Newly taking a diuretic or recent increase in diuretic dose (N04010G) (medication records)
Appendix C	15.	C-62	<input type="checkbox"/>	— Antipsychotics ( <del>N0400A</del> <del>N0410A</del> ) — Antidepressants ( <del>N0400C</del> <del>N0410C</del> ) — Antianxiety agents ( <del>N0400B</del> <del>N0410B</del> ) — Sedatives/hypnotics ( <del>N0400D</del> <del>N0410D</del> ) — Diuretics (N04010G)
Appendix C	16.	C-65	<input type="checkbox"/>	• Maceration — Persistently wet, especially from fecal incontinence, wound drainage, or perspiration — Moisture associated skin damage (M1040H)
Appendix C	16.	C-66	<input type="checkbox"/>	• Incontinence (H0300, H0400, M1040H) (see Incontinence CAA)
Appendix C	16.	C-66	<input type="checkbox"/>	• Antipsychotics ( <del>N0400A</del> <del>N0410A</del> )
Appendix C	16.	C-66	<input type="checkbox"/>	• Antianxiety agents ( <del>N0400B</del> <del>N0410B</del> )
Appendix C	16.	C-66	<input type="checkbox"/>	• Antidepressants ( <del>N0400C</del> <del>N0410C</del> )
Appendix C	16.	C-66	<input type="checkbox"/>	• Hypnotics ( <del>N0400D</del> <del>N0410D</del> )
Appendix C	16.	C-67	<input type="checkbox"/>	• Recent weight gain (K0310)

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to Appendix C V1.08**

Chapter	Section	Page	Change	
Appendix C	17.	C-69	<input type="checkbox"/>	• Antipsychotic (N0400A <b>N0410A</b> )
Appendix C	17.	C-69	<input type="checkbox"/>	• Antianxiety (N0400B <b>N0410B</b> )
Appendix C	17.	C-69	<input type="checkbox"/>	• Antidepressant (N0400C <b>N0410C</b> )
Appendix C	17.	C-69	<input type="checkbox"/>	• Sedative/Hypnotic (N0400D <b>N0410D</b> )
Appendix C	17.	C-70	<input type="checkbox"/>	• Weight gain ( <b>K0310</b> , clinical record)
Appendix C	17.	C-72	<input type="checkbox"/>	• Constipation/fecal impaction (H0600, clinical record)
Appendix C	18.	C-74	<input type="checkbox"/>	• Parenteral/IV feeding (K05010A1, <b>K0510A2</b> )
Appendix C	18.	C-74	<input type="checkbox"/>	• Feeding tube (K05100B1, <b>K0510B2</b> )
Appendix C	18.	C-76	<input type="checkbox"/>	• <b>Moisture associated skin damage (M1040H)</b>
Appendix C	19.	C-78	<input type="checkbox"/>	• Skin/Wound — Pressure ulcer (section M) — Other ulcers, wounds, incision, skin problems (M1040) — <b>Moisture associated skin damage (M1040H)</b>
Appendix C	General Resources	C-84	<ul style="list-style-type: none"> <li>Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines:  <a href="http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html">http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html</a>  <a href="http://www.cdc.gov/HAI/settings/ltc_settings.html">http://www.cdc.gov/HAI/settings/ltc_settings.html</a>; </li> </ul>	
Appendix C	General Resources	C-84	<ul style="list-style-type: none"> <li>Improving Nursing Home Culture (CMS Special Study):  <a href="http://www.qualitypartnersri.org/2/Site/CustomFiles/Qty-DocMgr/ImprovingNursingHomeCultureFinalReport.pdf">http://www.qualitypartnersri.org/2/Site/CustomFiles/Qty-DocMgr/ImprovingNursingHomeCultureFinalReport.pdf</a>  <a href="http://www.healthcentricadvisors.org/images/stories/documents/inhc.pdf">http://www.healthcentricadvisors.org/images/stories/documents/inhc.pdf</a> </li> </ul>	
Appendix C	General Resources	C-84	<ul style="list-style-type: none"> <li>Quality Improvement Organizations:  <a href="https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&amp;name=QIO%20Listings">https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&amp;name=QIO%20Listings</a>;  <a href="http://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1144767874793">http://www.qualitynet.org/dcs/ContentServer?c=Page&amp;pagename=QnetPublic%2FPage%2FQnetTier2&amp;cid=1144767874793</a> </li> </ul>	

**Track Changes  
from Appendix D V1.02  
to Appendix D V1.08**

Chapter	Section	Page	Change
Appendix D	-	D-2	<ul style="list-style-type: none"> <li>• <b>Explain the purpose of the questions to the resident.</b> <ul style="list-style-type: none"> <li>— End by explaining that <del>their</del> <b>his or her</b> answers will help the care team develop a care plan that is appropriate for the resident.</li> </ul> </li> </ul>
Appendix D	-	D-3	<p><b>Example:</b> Read the item (or part of the item) to the resident, then <del>say</del> <b>ask</b>, “Do you have this at all?” If yes, then <b>ask</b>, “Do you have it every day?” If no, then <b>ask</b>, “Did you have it at least half the days in the past 2 weeks?”</p>
Appendix D	-	D-3	<ul style="list-style-type: none"> <li>• <b>Clarify using echoing.</b> If the resident appears to understand but is having difficulty selecting an answer, try clarifying <del>his or her</del> <b>his or her</b> response by first echoing what <del>he or she</del> <b>they</b> told you and then repeating the related response options.</li> </ul>
Appendix D	-	D-3	<ul style="list-style-type: none"> <li>• <b>Record the resident’s response</b>, not what you believe <del>he or she</del> <b>they</b> should have said.</li> </ul>
Appendix D	-	D-4	<ul style="list-style-type: none"> <li>— If the resident remains agitated or overly emotional and does not want to continue, respond to <del>his or her</del> <b>his or her</b> <del>their</del> <b>s</b> 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.</li> </ul>

**Track Changes  
from Appendix E V1.07  
to Appendix E V1.08**

Chapter	Section	Page	Change
Appendix E	D0600	E-7	2. Multiply this sum by 1.111. In the example, <del>12 x 1.111</del> <del>=13.332</del> <b>9 x 1.286 = 11.250.</b>

**Track Changes  
from Appendix G V1.02  
to Appendix G V1.08**

Chapter	Section	Page	Change
Appendix G	All	G-1	Centers for Disease Control and Prevention: <u>The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases</u> , <del>11th</del> 12th ed. Available from <del>http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htm</del> <a href="http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters">http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters</a>
Appendix G	All	G-2	Centers for Medicare & Medicaid Services: <u>Minimum Data Set (MDS) 3.0 Provider User's Guide</u> . Available from <del>https://www.qtso.com/mds30.html</del> <a href="https://www.qtso.com/">https://www.qtso.com/</a>
Appendix G	All	G-2	<u>Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh)</u> . CMS NH QIOSC Contract. Providence, RI. 2006. Available from <a href="http://healthcentricadvisors.org/images/stories/documents/inhc.pdf">http://healthcentricadvisors.org/images/stories/documents/inhc.pdf</a> .
Appendix G	All	G-3	<del>Quality Partners of Rhode Island: The Holistic Approach to Transformational Change (HATCh)</del> . CMS NH QIOSC Contract. Providence, RI. 2006. Available from <a href="http://www.qualitypartnersri.org">http://www.qualitypartnersri.org</a> .
Appendix G	All	G-3	U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: <u>Healthy People 2012</u> . Available from <del>http://www.healthypeople.gov/</del> <a href="http://www.healthypeople.gov/2020/default.aspx">http://www.healthypeople.gov/2020/default.aspx</a>