

**Track Changes
from Chapter 3 Section J v1.20.1
to Chapter 3 Section J v1.20.11**

Chapter	Section	Page(s) in version 1.20.11	Change
3	J0100	J-2	Coding Instructions for J0100A, Been on a Scheduled Pain Medication Regimen Received scheduled pain medication regimen? • Code 0, No: if the medical record does not contain documentation that a scheduled pain medication was received. • Code 1, Yes: if the medical record contains documentation that a scheduled pain medication was received.
3	J0100	J-3	Coding Instructions for J0100B, Received PRN pain medications OR was offered and declined? • Code 0, No: if the medical record does not contain documentation that a PRN medication was received or offered. • Code 1, Yes: if the medical record contains documentation that a PRN medication was either received OR was offered but declined. Coding Instructions for J0100C, Received non-medication intervention for pain? • Code 0, No: if the medical record does not contain documentation that a non- medication pain intervention was received. • Code 1, Yes: if the medical record contains documentation that a non-medication pain intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy.

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3	J1100	J-25	4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities. 5. If the resident reports avoiding an activity (e.g., lying flat) due to shortness of breath, do not require the resident to perform the activity.
3	J1800	J-35	Steps for Assessment 1. If this is the first assessment/ since entry/admission or reentry (A0310E = 1 and A1700 = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is not the first assessment/entry or since reentry (A0310E = 0 1 and A1700 = 2), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment the medical record for the time period from the reentry date (A1600) to the ARD. 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.