

MDS 3.0 RAI User's Manual (v1.15R) Errata (v1)

Effective December 15, 2017

Issue ID	Issue	Resolution
1	In Chapter 3, page I-9, under "Coding Tips" in I: Active Diagnoses in the Last 7 Days, clarification was needed regarding the coding of UTI, when the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility.	<p>In Chapter 3, page I-9, under "Coding Tips" in I: Active Diagnoses in the Last 7 Days, a third bullet has been added:</p> <ul style="list-style-type: none"> - If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.
2	In Chapter 3, page I-9, under "Coding Tips" in I: Active Diagnoses in the Last 7 Days, clarification was needed regarding completion of item I2300 Urinary Tract Infection (UTI).	<p>In Chapter 3, page I-9, under "Coding Tips" in I: Active Diagnoses in the Last 7 Days, a fourth bullet has been added:</p> <ul style="list-style-type: none"> - When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).
3	In Chapter 3, pages I-9–I-11, page length changed due to revised content.	Replacement pages are provided in this file.
4	In Chapter 3, page N-8, under "Coding Tips and Special Populations" in N0410: Medications Received, information was needed regarding transdermal patches.	<p>In Chapter 3, page N-8, under "Coding Tips and Special Populations" in N0410: Medications Received, a new first bullet has been added:</p> <ul style="list-style-type: none"> • A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal

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		<p>patches would be considered long-acting medications for the purpose of coding the MDS, and only the days the staff attaches the patch to the skin are counted for the MDS. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0410H Opioid would be coded 3, because the application occurred on 3 days during the look-back period.</p>
5	<p>In Chapter 3, page N-9, page length changed because of revised content.</p>	<p>A replacement page is provided in this file.</p>
6	<p>In Chapter 3, page N-10, under the third bullet in the first example, the medication “risperidone” was spelled incorrectly.</p>	<p>In Chapter 3, page N-10, under the third bullet in the first example, the spelling of the medication “risperidone” has been corrected.</p> <ul style="list-style-type: none"> • Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only. Coding: Medications in N0410, would be coded as follows: A. Antipsychotic = 3, risperidone is an antipsychotic medication, B. Antianxiety = 7, lorazepam is an antianxiety medication, and D. Hypnotic = 2, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.
7	<p>In Chapter 3, page N-11, in the “Example” section, the explanation accompanying the list of resources and tools needed to be updated.</p>	<p>In Chapter 3, page N-11, in the “Example” section, the explanation accompanying the list of resources and tools has been replaced with revised text, as follows:</p>

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		<p>This list is not all inclusive. CMS is not responsible for the content or accessibility of the pages found at these sites. URL addresses were current as of the date of this publication.</p> <p>The above resource list is not all-inclusive, and use of these resources is not required for MDS completion. The resources are being provided as a convenience, for informational purposes only, and CMS is not responsible for their accessibility, content, or accuracy. Providers are responsible for coding each medication's pharmacological/therapeutic classification accurately. Caution should be exercised when using lists of medication categories, and providers should always refer to the details concerning each medication when determining its medication classification.</p> <p>NOTE: References to non-CMS sources do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services and were current as of the date of this publication.</p>
8	In Chapter 3, page N-11, the links to resources and tools for information on medications needed to be updated.	<p>In Chapter 3, page N-11, the following link was deleted from the resources and tools list:</p> <ul style="list-style-type: none"> • DrugLib.com Index of Drugs by Category, http://www.druglib.com/drugindex/category/
9	In Chapter 3, page N-12, page length changed because of revised content.	A replacement page is provided in this file.
10	In Chapter 3, page N-13, under "Coding Tips and Special Populations," the coding tip regarding inclusion of medications by pharmacological classification or therapeutic category was relocated from page N-17 to	<p>In Chapter 3, page N-13, under "Coding Tips and Special Populations," information has been added to the N0450A coding instructions:</p> <p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be

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	Coding Tips and Special Populations (N0450A) on page N-13.	recorded in this section, regardless of why the medication is being used.
11	In Chapter 3, page N-13, under “Coding Tips and Special Populations,” bullet points were relocated from “Coding Tips and Special Populations” to “Coding Tips and Special Populations (N0450B and N0450C).”	<p>In Chapter 3, pages N-13–N-14, under “Coding Tips and Special Populations,” information has been added to the N0450B and N0450C coding instructions:</p> <p>Coding Tips and Special Populations (N0450B and N0450C)</p> <ul style="list-style-type: none"> • Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated (see F758 in Appendix PP of the State Operations Manual). • Do not include gradual dose reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident’s acute care stay prior to admission to the facility). • Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication to another. • In cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C. • If multiple dose reductions have been attempted since admission OR since initiation of the antipsychotic medication,

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		<p>record the date of the most recent reduction attempt in N0450C.</p> <ul style="list-style-type: none"> Federal requirements regarding GDRs are found at 42 CFR 483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.
12	<p>In Chapter 3, page N-13, under “Coding Tips and Special Populations (N0450B and N0450C),” clarification was needed when coding Gradual Dose Reduction attempts in N0450B and N0450C.</p>	<p>In Chapter 3, pages N-13–N-14, under “Coding Tips and Special Populations (N0450B and N0450C),” additional bullet points have been added:</p> <ul style="list-style-type: none"> In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted. If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C. If the resident received a dose or doses of an antipsychotic medication that was not part of a documented GDR attempt, such as if the resident received a dose or doses of the medication PRN or one or two doses were ordered for the resident for a specific day or procedure, these are not coded as a GDR attempt in N0450B and N0450C. Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual

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		<p>dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication.</p> <ul style="list-style-type: none"> The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic medication.
13	In Chapter 3, page N-14, the header “Coding Tips and Special Populations” omitted information specifying the item numbers to which the section applies.	<p>In Chapter 3, page N-14, the header “Coding Tips and Special Populations” has been revised to include the applicable item numbers:</p> <p>Coding Tips and Special Populations (N0450D and N0450E)</p>
14	In Chapter 3, page N-14, in the bulleted list under “Coding Tips and Special Populations,” some bulleted items were relocated to N-13, “Coding Tips and Special Populations (N0450B and N0450C),” and clarification on what physician documentation to consider when coding GDR attempts in N0450D and N0450E was needed.	<p>In Chapter 3, page N-14, the bulleted list under “Coding Tips and Special Populations (N0450D and N0450E)” has been revised as follows:</p> <ul style="list-style-type: none"> Any medication that has a pharmacological classification or therapeutic category as an antipsychotic medication must be recorded in this section, regardless of why the medication is being used. In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist. In N0450D and N0450E, include physician documentation that a GDR attempt is clinically contraindicated since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted to the facility.

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		<ul style="list-style-type: none"> • Do not include Gradual Dose Reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility). • Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life. • Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated. • Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section. • In cases where a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C, Date of last attempted GDR. • If multiple dose reductions have been attempted since admission/entry or reentry or the prior OBRA assessment, record the date of the most recent reduction attempt in N0450C, Date of last attempted GDR.

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		<ul style="list-style-type: none"> • Federal requirements regarding GDRs are found at 42 CFR §483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.
15	In Chapter 3, page P-5, the “Coding Tips and Special Populations” section in P0100: Physical Restraints needed to include coding information regarding locked/secured areas in which residents have freedom of movement.	<p>In Chapter 3, page P-5, in the “Coding Tips and Special Populations” section in P0100 Physical Restraints, a new fourth bullet has been added:</p> <ul style="list-style-type: none"> • When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section “Considerations Involving Secured/Locked Areas” of F603 in Appendix PP of the State Operations Manual.
16	In Chapter 3, pages P-6–P-8, page length changed because of revised content.	Replacement pages are provided in this file.
17	In Chapter 3, page P-9, under “Planning for Care” in P0200: Alarms, information about evaluating the effect an alarm has on the individual resident was needed.	<p>In Chapter 3, page P-9, under “Planning for Care” in P0200: Alarms, a new fourth bullet has been added:</p> <ul style="list-style-type: none"> • When an alarm is used as an intervention in the resident’s safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident.
18	In Chapter 3, page P-10, under “Coding Tips” in P0200: Alarms, clarification regarding alarm activation was needed.	<p>In Chapter 3, page P-10, under “Coding Tips” in P0200: Alarms, the first bullet has been revised as follows:</p> <ul style="list-style-type: none"> • Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident’s clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the

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		resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
19	In Chapter 3, page P-10, under "Coding Tips" in P0200: Alarms, the reference to "P0200F Other alarm" needed to be revised to "P0200E Wander/elopement alarm."	<p>In Chapter 3, page P-10, under "Coding Tips" in P0200: Alarms, the eighth bullet has been revised as follows:</p> <ul style="list-style-type: none"> • Bracelets or devices worn by or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm F-Other alarm, whether or not the device activates a sound or alerts the staff.
20	In Chapter 3, page P-10, under "Coding Tips" in P0200: Alarms, information was needed about determining whether using an alarm also meets the criteria of a restraint.	<p>In Chapter 3, page P-10, under "Coding Tips" in P0200: Alarms, the following bulleted item has been added:</p> <ul style="list-style-type: none"> • When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section "Determination of the Use of Position Change Alarms as Restraints" of F604 in Appendix PP of the State Operations Manual.

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

- In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.
- Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.
- If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is **not** necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.
- When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).
- **Resources for evidence-based UTI criteria:**
 - Loeb criteria:
https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference
 - Surveillance Definitions of Infections in LTC (updated McGeer criteria):
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/>
 - National Healthcare Safety Network (NHSN):
<https://www.cdc.gov/nhsn/ltc/uti/index.html>

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not

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

recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTIs and many other issues related to infections in LTC.

<http://www.cdc.gov/hai/>

Examples of Active Disease

1. A resident is prescribed hydrochlorothiazide for hypertension. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.

Coding: **Hypertension** item (I0700), would be checked.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for a resident with atrial fibrillation to decrease the risk of embolic stroke. The resident requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

Coding: **Atrial fibrillation** item (I0300), would be checked.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

3. A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

Coding: **Arthritis** item (I3700), would be checked.

Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

4. The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. The resident is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.

Coding: **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be checked.

Rationale: The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

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

Examples of Inactive Diagnoses (do not code)

1. The admission history states that the resident had pneumonia 2 months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look back period.

Coding: **Pneumonia** item (I2000), would not be checked.

Rationale: The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

Coding: **CAD** item (I0400), would not be checked.

Rationale: The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.

Coding: **Hip Fracture** item (I3900), would not be checked.

Rationale: Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

N0410: Medications Received (cont.)

- A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the MDS, and only the days the staff attaches the patch to the skin are counted for the MDS. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0410H Opioid would be coded 3, because the application occurred on 3 days during the look-back period.
- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.
- In circumstances where reference materials vary in identifying a medication’s therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility’s pharmacy or the manufacturer’s website.
- 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.
- 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

DEFINITION

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

DEFINITIONS

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.

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.)

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 psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.
- During the first year in which a resident on a psychoactive 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 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>).
- Prior to discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).
- 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 and duration of use. Certain anticoagulants require monitoring via laboratory results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
 - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>]), which may
 - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
 - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant.

N0410: Medications Received (cont.)

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website <http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/>.
- Opioid medications can be an effective intervention in a resident's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.

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 coded as follows: A. Antipsychotic = 3, risperidone is an antipsychotic medication, B. Antianxiety = 7, lorazepam is an antianxiety medication, and D. Hypnotic = 2, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)** (or subsequent editions) (<https://www.psychiatry.org/psychiatrists/practice/dsm>), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>)].

N0410: Medications Received (cont.)

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- GlobalRPh Drug Reference, <http://globalrph.com/drug-A.htm>
- USP Pharmacological Classification of Drugs, <http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6>. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for “USP Medicare Model Guidelines (With Example Part D Drugs)”
- Medline Plus, <https://www.nlm.nih.gov/medlineplus/druginformation.html>

The above resource list is not all-inclusive, and use of these resources is not required for MDS completion. The resources are being provided as a convenience, for informational purposes only, and CMS is not responsible for their accessibility, content, or accuracy. Providers are responsible for coding each medication’s pharmacological/therapeutic classification accurately. Caution should be exercised when using lists of medication categories, and providers should always refer to the details concerning each medication when determining its medication classification.

NOTE: References to non-CMS sources do not constitute or imply endorsement of these organizations or their programs by CMS or the U.S. Department of Health and Human Services and were current as of the date of this publication.

N0450: Antipsychotic Medication Review

N0450. Antipsychotic Medication Review	
Enter Code <input type="checkbox"/>	<p>A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?</p> <p>0. No - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs</p> <p>1. Yes - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?</p> <p>2. Yes - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?</p> <p>3. Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?</p>
Enter Code <input type="checkbox"/>	<p>B. Has a gradual dose reduction (GDR) been attempted?</p> <p>0. No → Skip to N0450D, Physician documented GDR as clinically contraindicated</p> <p>1. Yes → Continue to N0450C, Date of last attempted GDR</p> <p>C. Date of last attempted GDR:</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"/></p> <p style="text-align: center;">Month Day Year</p>
Enter Code <input type="checkbox"/>	<p>D. Physician documented GDR as clinically contraindicated</p> <p>0. No - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs</p> <p>1. Yes - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated</p> <p>E. Date physician documented GDR as clinically contraindicated:</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"/></p> <p style="text-align: center;">Month Day Year</p>

N0450: Antipsychotic Medication Review (cont.)

Item Rationale

Health-related Quality of Life

- The use of unnecessary medications in long term care settings can have a profound effect on the resident's quality of life.
- Antipsychotic medications are associated with increased risks for adverse outcomes that can affect health, safety, and quality of life.
- In addition to assuring that antipsychotic medications are being utilized to treat the resident's condition, it is also important to assess the need to reduce these medications whenever possible.

Planning for Care

- Identify residents receiving antipsychotic medications to ensure that each resident is receiving the lowest possible dose to achieve the desired therapeutic effects.
- Monitor for appropriate clinical indications for continued use.
- Implement a system to ensure gradual dose reductions (GDR) are attempted at recommended intervals unless clinically contraindicated.

Steps for Assessment

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

Coding Instructions for N0450A

- Code 0, no: if antipsychotics were not received: Skip to O0100, Special Treatments, Procedures, and Programs.
- Code 1, yes: if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- Code 2, yes: if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- Code 3, yes: if antipsychotics were received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted?

N0450: Antipsychotic Medication Review (cont.)

Coding Tips and Special Populations

- Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used.

Coding Instructions for N0450B

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

Coding Instructions for N0450C

- **Enter the date of the last attempted Gradual Dose Reduction.**

Coding Tips and Special Populations (N0450B and N0450C)

- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated (see F758 in Appendix PP of the State Operations Manual).
- In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted.
- Do not include gradual dose reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).
- If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C.
- If the resident received a dose or doses of an antipsychotic medication that was not part of a documented GDR attempt, such as if the resident received a dose or doses of the medication PRN or one or two doses were ordered for the resident for a specific day or procedure, these are not coded as a GDR attempt in N0450B and N0450C.
- Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication.

N0450: Antipsychotic Medication Review (cont.)

- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication to another.
- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic medication.
- In cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C.
- If multiple dose reductions have been attempted since admission **OR** since initiation of the antipsychotic medication, record the date of the most recent reduction attempt in N0450C.
- Federal requirements regarding GDRs are found at 42 CFR 483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

Coding Instructions for N0450D

- Code 0, no: if a GDR has not been documented by a physician as clinically contraindicated. Skip to O0100, Special Treatments, Procedures, and Programs.
- Code 1, yes: if a GDR has been documented by a physician as clinically contraindicated. Continue to N0450E, Date physician documented GDR as clinically contraindicated.

Coding Instructions for N0450E

- Enter date the physician documented GDR attempts as clinically contraindicated.

Coding Tips and Special Populations (N0450D and N0450E)

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

P0100: Physical Restraints (cont.)

Coding Instructions

Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:

- Code 0, not used: if the item was not used during the 7-day look-back **or** it was used but did not meet the definition.
- Code 1, used less than daily: if the item met the definition and was used less than daily.
- Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other. These devices, although not coded on the MDS, must be assessed, care-planned, monitored, and evaluated.
- In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use. It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining him or her.
- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section "Considerations Involving Secured/Locked Areas" of F603 in Appendix PP of the State Operations Manual.
- **Bed rails** include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
 - *Bed rails used as positioning devices.* If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A.

P0100: Physical Restraints (cont.)

— *Bed rails used with residents who are immobile.* If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.

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

- **Trunk restraints** include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body.
- **Limb restraints** include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category.
- **Trunk or limb restraints**, if used in both bed and chair, should be marked in both sections.
- **Chairs that prevent rising** include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.
 - For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.
 - For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising.
 - Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
 - Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker

P0100: Physical Restraints (cont.)

via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising.

- **Restraints used in emergency situations.** If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR §§483.10(c)(6) and 483.21(b)(ii)(A)–(F) respectively. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.
 - A resident who is injuring himself/herself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

Additional Information

- **Restraint reduction/elimination.** It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.
- **Restraints as a fall prevention approach.** Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- **Request for restraints.** While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.

According to 42 CFR 483.10(e)(1) and 483.12, “The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident’s medical symptoms.” CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident’s needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state,

P0100: Physical Restraints (cont.)

“...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident’s medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a resident, legal surrogate or representative’s request or approval.” The SOM goes on to state, “While Federal regulations affirm the resident’s right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident’s care and safety, including clinical decisions.”

P0200: Alarms

P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Bed alarm
	<input type="checkbox"/> B. Chair alarm
	<input type="checkbox"/> C. Floor mat alarm
	<input type="checkbox"/> D. Motion sensor alarm
	<input type="checkbox"/> E. Wander/elopement alarm
	<input type="checkbox"/> F. Other alarm

Item Rationale

Health-related Quality of Life

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

P0200: Alarms (cont.)

Planning for Care

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

Steps for Assessment

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

Coding Instructions

Identify all alarms that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:

- Code 0, not used: if the device was not used during the 7-day look-back period.
- Code 1, used less than daily: if the device was used less than daily.
- Code 2, used daily: if the device was used on a daily basis during the look-back period.

Coding Tips

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.

P0200: Alarms (cont.)

- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
- **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in this section.
- Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the resident appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.
- While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.
- Bracelets or devices worn by or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether or not the device activates a sound or alerts the staff.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.
- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section "Determination of the Use of Position Change Alarms as Restraints" of F604 in Appendix PP of the State Operations Manual.