

MDS 3.0 RAI Manual (v1.08) Errata (v3) Effective April 1, 2012

Issue IDs	Issue	Resolution				
01	On page 14 of the change table for Chapter 3, Section Q, the screenshot for Q0500 was inserted where Q0490 belongs.	<p>The screenshot of item Q0490 has been replaced on page 14 of the Chapter 3, Section Q change table.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p>Q0490. Resident's Preference to Avoid Being Asked Question Q0500B Complete only if A0310A = 02, 06, or 99</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 2px;">Enter Code</td> <td style="padding: 2px;">Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</td> </tr> <tr> <td style="text-align: center; padding: 2px;"><input type="checkbox"/></td> <td style="padding: 2px;"> 0. No 1. Yes → Skip to Q0600, Referral 8. Information not available </td> </tr> </table> </div>	Enter Code	Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?	<input type="checkbox"/>	0. No 1. Yes → Skip to Q0600, Referral 8. Information not available
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<input type="checkbox"/>	0. No 1. Yes → Skip to Q0600, Referral 8. Information not available					
02	In Chapter 6, pages 6-38 and 6-40, the Special Care High and Special Care Low RUG calculation worksheets still refer to item K0500 and does not reflect the new K0510 item.	<p>This discrepancy has been reconciled in the RAI Manual on the appropriate RUG calculation worksheets on pages 6-38 and 6-40.</p> <p>Also, please note that the following information applies with regard to determination of RUG classification:</p> <p>Special Care High:</p> <ol style="list-style-type: none"> 1. Assessments with an assessment reference date (ARD) before April 1, 2012 will use K0500A (Parenteral/IV feeding) and K0500B (Feeding tube) to determine RUG classification. 2. Assessments with an ARD on or after April 1, 2012 will use K0510A1 (Parenteral/IV feeding while NOT a resident), or K0510A2 (Parenteral/IV feeding while a resident), and K0510B1 (Feeding tube while NOT a resident) or K0510B2 (Feeding tube while a resident) to determine RUG classification. <p>Special Care Low:</p> <ol style="list-style-type: none"> 1. Assessments with an ARD before April 1, 2012 will use K0500B (Feeding tube). 2. Assessments with an ARD after April 1, 2012 will use K0510B1 (Feeding tube while NOT a resident) or K0510B2 (Feeding tube while a resident) to determine RUG classification. 				

Issue IDs	Issue	Resolution
03	<p>The term “mental retardation” appears three times in Appendix C, when it should have been changed to “intellectual disability”.</p> <p>CAAs 2, 7 and 12 refer to item A1550 using the language “Mental retardation/developmental disability,” instead of “Intellectual disability/developmental disability”.</p> <p>In Chapter 3 Section A, on pages A-19 and A-20, the title for A1550 needs to change from “Intellectual Disability/Developmental Delay (ID/DD) Status” to “Intellectual Disability/Developmental Disability (ID/DD) Status.”</p> <p>In Chapter 3, Section A, on page A-19, the Item Rational includes the terms “intellectual or developmental delay disabilities”. The word “delay” should be deleted.</p>	<p>In Appendix C, CAAs 2, 7 and 12, (on pages C-10, C-30 and C-51) any use of “Mental retardation/developmental disability,” has been replaced by “Intellectual disability/developmental disability”.</p> <p>In Chapter 3, Section A, on pages A-16, A-17, A-18, we have replaced all instances of “Intellectual Disability/Developmental Delay (ID/DD)” with “Intellectual Disability/Developmental Disability (ID/DD).”</p> <p>In Chapter 3, Section A, on pages A-19 and A-20, the title for A1550 has been changed from “Intellectual Disability/Developmental Delay (ID/DD) Status.” to “Intellectual Disability/Developmental Disability (ID/DD) Status.”</p> <p>In Chapter 3 Section A, on page A-19, the Item Rationale has been changed from “To document conditions associated with intellectual or developmental delay disabilities.” to “To document conditions associated with intellectual or developmental disabilities.”</p>
04	<p>On page E-7 of Appendix E, Example 2, the sample calculation contains typographical errors that alter the result of the calculation.</p> <p>Line item 2 reads: “Multiply this sum by 1.111. In the example, $9 \times 1.286 = 11.250$.”</p> <p>This is incorrect. The sum should be 12, not 9, and the multiplier should be 1.111 not 1.286.</p>	<p>Appendix E, page E-7, Example 2 computation in step #2 has been amended as follows:</p> <p>2. Multiply the sum by 1.111(See bullet 5 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 12. Therefore, the calculation is: $12 \times 1.111 = 13.332$.</p>

Issue IDs	Issue	Resolution
05	<p>On page E-7 of Appendix E, Example 3, the sample calculation contains typographical errors that alter the result of the calculation.</p> <p>Line item 2 reads: "Multiply this sum by 1.111. In the example, $9 \times 1.286 = 11.250$."</p> <p>This is incorrect. The sum should be multiplied by 1.250.</p>	<p>Appendix E, page E-7, Example 3, computation in step #2 has been amended as follows:</p> <p>2. Multiply the sum by 1.250 (See bullet 6 on page E-5 for calculation of multiplier). In the example, the sum of non-missing values is 9. Therefore, the calculation is: $9 \times 1.250 = 11.250$.</p>
06	<p>In Chapter 4, page 4-8, the link to the State Operations Manual (SOM) contains a typographical error and therefore does not link properly to the webpage.</p> <p>Currently, it reads http://www.cms.gov/Manuals/IOM/list.asp.</p> <p>There is an additional "." After "cms" that needs to be removed.</p>	<p>The link in Chapter 4, page 4-8 will be replaced with the following: http://www.cms.gov/Manuals/IOM/list.asp.</p>

Issue IDs	Issue	Resolution
07	<p>The April 2012 MDS Item Set instructs providers to enter the number of days each of the medications listed were received in the last 7 days in Item N0410, as does the screen shot of item N0410 on page N-4 of the MDS 3.0 RAI Manual (v1.08).</p> <p>However, the Coding Instructions on pages N-5 and N-6, instruct providers to enter checkmarks instead of days for each medication listed. Each of these coding instructions needs to be changed to days vs. checkmarks.</p> <p>On page N-6, “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). Option Z no longer exists on the current item set.</p>	<p>The Coding Instructions in Section N, pages N-5 and N-6 have been amended as follows:</p> <p>N0410 A, Antipsychotic: Record the number of days an 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).</p> <p>N0410 B, Antianxiety: Record the number of days an antianxiety 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).</p> <p>N0410 C, Antidepressant: Record the number of days an antidepressant 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).</p> <p>N0410 D, Hypnotic: Record the number of days a 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).</p> <p>N0410 E, Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an 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.</p> <p>N0410 F, Antibiotic: Record the number of days antibiotic 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).</p> <p>N0410 G, Diuretic: Record the number of days a diuretic 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).</p>

**Track Changes
from Chapter 3 Section Q V1.05
to Chapter 3 Section Q V1.08**

			<p>determined to be feasible; skip to item Q0600 (Referral).</p> <ul style="list-style-type: none"> Code 2: if discharge to the community is determined to be not feasible; skip to the next active assessment section (Section V or X). <p>Coding Tips</p> <ul style="list-style-type: none"> 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. The nursing home interdisciplinary team should not assume that any particular resident is unable to be discharged. The nursing home should code Q0400B as 2 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. 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. If the nursing facility staff has already developed a complete discharge plan, 0400A would be coded as Yes and skip to Q0600.
3	Q0490	Q-12 & Q-13	<p>Q0490: Resident's Preference to Avoid Being Asked Question Q0500B</p> <p><i>For Quarterly, Correction to Quarterly, and Non-OBRA Assessments. (A0310A=02, 06, 99)</i></p> <div data-bbox="695 1472 1414 1570" style="border: 1px solid black; padding: 5px;"> <p>Q0490. Resident's Preference to Avoid Being Asked Question Q0500B Complete only if A0310A = 02, 06, or 99</p> <p>Enter Code <input type="checkbox"/> Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?</p> <p>0. No 1. Yes → Skip to Q0600, Referral 8. Information not available</p> </div> <p>Item Rationale</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>

CATEGORY IV: SPECIAL CARE HIGH RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A, B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score ≥ 5
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

- (1) K0700A is 51% or more of total calories OR
- (2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

CATEGORY V: SPECIAL CARE LOW

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score ≥ 5
I5200, ADL Score	Multiple sclerosis, with ADL score ≥ 5
I5300, ADL Score	Parkinson's disease, with ADL score ≥ 5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1, K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:

(1) K0700A is 51% or more of total calories OR

(2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:

M1200A,B# Pressure relieving chair and/or bed

M1200C Turning/repositioning

M1200D Nutrition or hydration intervention

M1200E Ulcer care

M1200G Application of dressings (not to feet)

M1200H Application of ointments (not to feet)

#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to Category VI now.

2. COGNITIVE LOSS/DEMENTIA

Review of Indicators of Cognitive Loss/Dementia

		Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
✓	Reversible causes of cognitive loss	
☐	<ul style="list-style-type: none"> • Delirium (C1300) CAA triggered (Immediate follow-up required. Perform the Delirium CAA to determine possible causes, contributing factors, etc., and go directly to care planning for those issues. Then continue below.) 	
✓	Neurological factors	
☐	<ul style="list-style-type: none"> • Intellectual disability/developmental disability. (A1550) 	
☐	<ul style="list-style-type: none"> • Alzheimer's Disease or other dementias (I4200, I4800) 	
☐	<ul style="list-style-type: none"> • Parkinson's Disease (I5300) 	
☐	<ul style="list-style-type: none"> • Traumatic brain injury (I5500) 	
☐	<ul style="list-style-type: none"> • Brain tumor (clinical record) 	
☐	<ul style="list-style-type: none"> • Normal pressure hydrocephalus 	
☐	<ul style="list-style-type: none"> • Other (clinical record, I8000) 	
✓	Observable characteristics and extent of this resident's cognitive loss	
	<ul style="list-style-type: none"> • Analyze component of Brief Interview for Mental Status (BIMS) (C0200-C0500) (V0100D) 	
☐	<ul style="list-style-type: none"> • If unable to complete BIMS, analyze components of Staff Assessment for Mental Status (C0700, C0800, C0900,C1000) 	
☐	<ul style="list-style-type: none"> • Identify components of Delirium assessment (C1300) that are present and not new onset or worsening 	
☐	<ul style="list-style-type: none"> • Confusion, disorientation, forgetfulness (observation, clinical record) (C0200, C0300, C0400, C0500,C0700, C0800, C0900, C1300, C1600) 	
☐	<ul style="list-style-type: none"> • Decreased ability to make self understood (B0700) or to understand others (B0800) 	
☐	<ul style="list-style-type: none"> • Impulsivity (observation, clinical record) 	
☐	<ul style="list-style-type: none"> • Other (observation, clinical record) 	

	Diseases and conditions that may impede ability to interact with others	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
✓		
☐	• Delirium (C1300, C1600 = 1, Delirium CAA)	
☐	• Intellectual disability/developmental disability. (A1550)	
☐	• Alzheimer's disease (I4200)	
☐	• Aphasia (I4300)	
☐	• Other dementia (I4800)	
☐	• Depression (I5800)	
✓	Health status factors that may inhibit social involvement	
☐	• Decline in activities of daily living (G0110)	
☐	• Health problem, such as falls (J1700, J1800), pain (J0300, J0800), fatigue, etc.	
☐	• Mood (D0200A1, D0300, D0500A1, D0600) or behavior (E0200) problem that impacts interpersonal relationships or that arises because of social isolation (See Mood State and Behavioral Symptoms CAAs)	
☐	• Change in communication (B0700, B0800), vision (B1000), hearing (B0200), cognition (C0100, C0600)	
☐	• Medications with side effects that interfere with social interactions, such as incontinence, diarrhea, delirium, or sleepiness	
✓	Environmental factors that may inhibit social involvement	
☐	• Use of physical restraints (P0100)	
☐	• Change in residence leading to loss of autonomy and reduced self-esteem (A1700)	
☐	• Change in room assignment or dining location or table mates	
☐	• Living situation limits informal social interaction, such as isolation precautions (O0100M)	

✓	Functional problems that affect ability to eat	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Swallowing problem (K0100)	
<input type="checkbox"/>	• Arthritis (I3700)	
<input type="checkbox"/>	• Contractures (G0400)	
<input type="checkbox"/>	• Functional limitation in range of motion (G0400)	
<input type="checkbox"/>	• Partial or total loss of arm movement (G0400A)	
<input type="checkbox"/>	• Hemiplegia/hemiparesis (I4900)(G0400 A and B = 1)	
<input type="checkbox"/>	• Quadriplegia/paraplegia (I5100/I5000) (G0400 A and/or B =2)	
<input type="checkbox"/>	• Inability to perform ADLs without significant physical assistance (G0110)	
<input type="checkbox"/>	• Inability to sit up (G0300)	
<input type="checkbox"/>	• Missing limb(s) (G0600D)	
<input type="checkbox"/>	• Vision problems (B1000)	
<input type="checkbox"/>	• Decreased ability to smell or taste food	
<input type="checkbox"/>	• Need for special diet or altered consistency which might not appeal to resident	
<input type="checkbox"/>	• Recent decline in Activities of Daily Living (ADLs) (G0110-G0600)	

✓	Cognitive, mental status, and behavior problems that can interfere with eating	
<input type="checkbox"/>	• Review Cognitive Loss CAA	
<input type="checkbox"/>	• Alzheimer's Disease (I4200)	
<input type="checkbox"/>	• Other dementia (I4800)	
<input type="checkbox"/>	• Intellectual disability/developmental disability (A1550)	
<input type="checkbox"/>	• Paranoid fear that food is poisoned	
<input type="checkbox"/>	• Requires frequent/constant cueing	
<input type="checkbox"/>	• Disruptive behaviors (E0200)	
<input type="checkbox"/>	• Indicators of psychosis (E0100)	
<input type="checkbox"/>	• Wandering (E0900)	
<input type="checkbox"/>	• Pacing (E0200)	
<input type="checkbox"/>	• Throwing food (E0200C)	
<input type="checkbox"/>	• Resisting care (E0800)	
<input type="checkbox"/>	• Very slow eating	
<input type="checkbox"/>	• Short attention span	
<input type="checkbox"/>	• Poor memory (C0500, C0700-C0900)	
<input type="checkbox"/>	• Anxiety problems (I5700)	

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 intellectually disabled/developmentally disabled adult resident who has never had an occupation, record as "none."

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code <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)/developmental disability (DD), 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 or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a significant change in status MDS assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.¹

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

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

- 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 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 or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to RR 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 ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.
- Code 9, not a Medicaid-certified unit: if bed is not in a Medicaid-certified nursing home. Skip to A1550, Conditions Related to ID/DD Status. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.
 - Note that the requirement is based on the certification of the part of the nursing home the resident will occupy. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building.

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

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ Check all that apply	
<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)/Developmental Disability : if resident has been diagnosed with intellectual disability/developmental disability.
- Code C, Other related conditions: if resident has been diagnosed with other related conditions.

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

A1550. Conditions Related to ID/DD Status	
If the resident is 22 years of age or older, complete only if A0310A = 01	
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05	
↓ Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely	
	ID/DD With Organic Condition
<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
	ID/DD Without Organic Condition
<input type="checkbox"/>	E. ID/DD with no organic condition
	No ID/DD
<input type="checkbox"/>	Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental 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 Disability (ID/DD) Status (cont.)

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

DEFINITION

OTHER ORGANIC CONDITION RELATED TO ID/DD

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

A1600: 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"/>
	Month		Day
		-	<input type="text"/>
			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 <input type="checkbox"/> 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:

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 the **sum** by 1.111(See bullet 5 on page E-5 for calculation of multiplier). In the example, the **sum** of non-missing values is 12. Therefore, the calculation is: $12 \times 1.111 = 13.332$
3. Round the result to the nearest integer. In the example, 13.332 rounds to 13.
4. Place the rounded result of 13 in D0600.

Example 3: Two Missing Values in Column 2

The following example shows how to score the resident interview when two of the items in Column 2 have missing values:

Item	Value
D0500A2	0
D0500B2	1
D0500C2	2
D0500D2	2
D0500E2	-
D0500F2	0
D0500G2	1
D0500H2	-
D0500I2	2
D0500J2	1
D0600	11

In this example, two of the items in Column 2 have missing values: D0500E2 and D0500H2 are equal to dash. The other 8 items have non-missing values. D0600 is computed as follows:

1. Compute the sum of the 8 items with non-missing values. This sum is 9.
2. Multiply the **sum** by 1.250 (See bullet 6 on page E-5 for calculation of multiplier). In the example, the **sum** of non-missing values is 9. Therefore, the calculation is: $9 \times 1.250 = 11.250$.
3. Round the result to the nearest integer. In the example, 11.250 rounds to 11.
4. Place the rounded result in D0600

RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents. By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes. Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.

- The MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- The MDS is not a diagnostic tool or treatment selection guide
- The MDS does not identify causation or history of problems

Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision making processes to analyze and address MDS findings and CAAs. Table 2 provides a framework for a more complete approach to clinical problem solving and decision making essential to the appropriate care of individuals with multiple and/or complex illnesses and impairments.

4.7 The RAI and Care Planning

As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(k)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at:

<http://www.cms.gov/Manuals/IOM/list.asp>.

Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see 42 CFR 483.20(k), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.

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

- N0410A, Antipsychotic: Record the number of days an 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).
- N0410B, Antianxiety: Record the number of days an antianxiety 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).
- N0410C, Antidepressant: Record the number of days an antidepressant 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.)

- N0410D, Hypnotic: Record the number of days a 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).
- N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an 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.
- N0410F, Antibiotic: Record the number of days antibiotic 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).
- N0410G, Diuretic: Record the number of days a diuretic 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).

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.

DEFINITION

SLEEP HYGIENE

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