# Centers For Medicare & Medicaid Services

## Revised

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

## Version 2.0

**December 2002**

**Revised January 2008**

# Centers For Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Updated December 2002 For Use Effective June 15, 2005

**The *Long-Term Care Facility Resident Assessment Instrument User's Manual* for Version 2.0 is published by the Centers For Medicare & Medicaid Services (CMS) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities.**

**This manual replaces CMS's original *Long-Term Care Resident Assessment Instrument User's Manual, Version 2.0,* published October 1995.**

**According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. (Note: The RAI mandated by OBRA is exempt from this requirement.)**

**The valid OMB control number for the Medicare Prospective Payment Form (MPAF) information collection is 0938-0739 and the form has been approved through March 31, 2006. The time required to complete this information collection is estimated to average 90 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.**

**If you have comments concerning the accuracy of the time estimates(s) or suggestions for improving these forms, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.**

## CMS ACKNOWLEDGEMENTS
## 2002 Edition

It's sometimes hard to believe that seven years has passes since the publication of the original RAI Manual in 1995. The Center has a new name, the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) has been implemented, there are specialized MDS instruments for Medicare SNF and swing bed assessments, and we're fully automated with the RAVEN software packages. Over the years, CMS has issued numerous updates and clarifications in the form of Qs & As posted on the CMS website, and will continue to address clinical issues to support providers and enhance the accuracy of MDS coding. One thing for sure, the RAI is always a work in progress.

This version of the manual includes updates and clarifications to the processes and clinical items required for the MDS resident assessments that have occurred during the past seven years. Without the professionalism and tireless efforts of Carol Job, Donna Coszalter, Jan Courtney, Cathy Petko, and Kathy Wade and the staff at Myers and Stauffer, we would not have been able to produce the manual in such a short time frame. We thank you for your insights and patience throughout this process.

In addition, we want to thank our CMS co-authors, Rosemary Dunn, Sheila Lambowitz, Jeane Nitsch, and Mary Pratt. You have given freely of your time, energy and talent, to fully update, and when necessary, expand upon each section of the original RAI User's Manual and make it a more valuable tool for the industry. We could not have completed this work without the support of the entire MDS Coordinating Team who served as editors, critical readers, and researchers. Many thanks to Dana Burley, Rosemary Dunn, Yael Harris, Lisa Hines, Susan Joslin, Sheila Lambowitz, Tina Miller, Jeane Nitsch, and Mary Pratt. We also want to thank Sheryl B. Rosenfield, RNC, Director of Clinical Operations at Zimmet Solomon Health Care Consulting, LLC, for her assistance in developing new case studies and coding examples, and for helping us to integrate reviewer comments into the revised manual.

We want to particulary thank Sue Nonemaker, Cindy Hake and Dana Burley for their years of dedication, the wealth of knowledge each brought to the team, and the passion with which they supported the RAI process. We would be remiss if we also failed to acknowledge the many contributions of Helene Fredeking to the RAI process and other CMS nursing facility efforts. While all four have moved on to other challenges, their constributions to the RAI will always be remembered and greatly appreciated.

Through the years, many other CMS staff members, including Susan Burris, Dorothea Musgrave, Jeane Nitsch and Mary Weakland, have also supported the RAI process, and deserve our special thanks. Finally, a special thank you goes to Tina Miller, co-project officer on the MDS Manual Update project, for her hard work, dedication and full participation in all aspects of the project.

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### 2002 Edition
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Finally, we want to thank our colleagues in the CMS Regional Offices and State agencies for their support and assistance. Throughout the years, we have worked together to identify problems, answer questions, clarify coding requirements, and train providers. They've been our "eyes and ears" in the communities, and we could not have completed this update without their contributions, suggestions, and support.


We hope that you find this revised manual to be a positive resource. Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Also, please email your question to mdsquestions@cms.hs.gov so we can ensure you receive a response to your inquiry. Please continue to check our web site for more information at: **http://cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.**

## CMS ACKNOWLEDGEMENTS
## From the 1995 Edition of the Manual

The RAI Version 2.0 and related training materials were developed under a CMS contract with the Hebrew Rehabilitation Center for Aged (HRCA). John N. Morris and Katharine Murphy, key members of the original RAI design team, had primary responsibility for developing 2.0 and participated in the development of training materials. They were assisted on tasks related to 2.0 by Steven Littlehale, Jon Wolf, Yvonne Anderson, Romanna Michajliw, Wee Lock Ooi, David Levine, and other members of HRCA research and clinical staff. Staff at the Health Insights Research Group (HIRG), including Allan Stegemann, Gloria Smit, Janne Swearengen, and David Zimmerman, also participated in the development of materials for this ***User's Manual*** and had lead responsibility for its production. Sue Frey, Kris Engbring, Patti Beutel, and Mary Ann Sveum contributed to the final production of this ***Manual.***

We also acknowledge the continued thoughtful input into version 2.0 by the principal investigators on the original design team, specifically Catherine Hawes, Charles Phillips, Brant Fries, and Vince Mor. Members of the international community using the MDS also contributed to the development of version 2.0 through their *interRAI* association.

We particularly appreciate the continued involvement and support of the countless professional associations and clinical experts that have been involved in the resident assessment initiative since its onset. They are too numerous to name individually, but special mention must be made of the contributions of individuals representing the key associations with which we have worked on nursing home reform issues: Marcia Richards, American Health Care Association; Evvie Munley, American Association of Homes and Services for the Aging; and Sarah Burger, National Citizens' Coalition for Nursing Home Reform.

State and CMS Regional office personnel have played a key role in working with nursing home staff to implement the RAI. Specifically, we acknowledge the exceptional contributions of Marlene Black (Washington State), Ruth Jacobs-Jackson (California), Sheree Zbylot (Mississippi), Pat Maben (Kansas), Ellen Mullins (Alabama), Diane Carter (Colorado), and Pat Bendert (CMS Region IV - Atlanta), all of who have contributed their own time to serve on workgroups or develop training materials. Betty Cornelius, CMS Project Officer and staff from her Nursing Home Case mix and Quality Demonstration States, have also contributed freely. We particularly appreciate the suggestions of Bob Godbout (Texas), Peter Arbuthnot (Mississippi), and Dave Wilcox (New York) in modifying the MDS 2.0 to make it more computer "friendly."

## CMS ACKNOWLEDGEMENTS
## From the 1995 Edition of the Manual
**(continued)**

Lastly, this work would not have been possible without the continued support of management within the Health Standards and Quality Bureau at CMS. Most specifically, Helene Fredeking, Director of the Division of Long-Term Care Services, has played a key substantive role, as well as garnered necessary resources to support work on this initiative. Katie Phillips has worked closely with the States and Regions on RAI issues for the past several years, and has been deeply involved in developing both the State Operations Manual and pending final regulations on resident assessment. Finally, a major contribution to the original RAI development effort, the revisions associated with version 2.0, and the development of training materials for both versions was made by Sue Nonemaker, CMS Project Officer for both initiatives. She also provided the CMS leadership and coordination necessary to implement the RAI nationally.

**IF YOU HAVE QUESTIONS RELATED TO RESIDENT ASSESSMENT**

Questions related to the RAI should be referred initially to the State (see Appendix A for a list of contact persons, addresses, and phone numbers.) CMS Regional office RAI coordinators are also listed in Appendix A.

Questions that cannot be resolved at the State level or suggestions for improving this ***User's Manual*** should be referred to:

MDS Coordinator
Center on Long-Term Care
Health Standards and Quality Bureau
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

# PREFACE

## From the 1995 Edition of the Manual

The nursing home reform law of OBRA '87 provided an opportunity to ensure good clinical practice by creating a regulatory framework that recognized the importance of comprehensive assessment as the foundation for planning and delivering care to this country's nursing home residents. The Resident Assessment Instrument (RAI) requirements can be viewed as empowering to clinicians in that they provide regulatory support for good clinical practice. The RAI is simply a standardized, new approach for doing what clinicians have always been doing, or should have been doing, related to assessing, planning and providing individualized care. CMS's efforts in developing the RAI and associated policies, therefore, have always been centered on the premise "What is the right thing to do in terms of good clinical practice, and for all nursing home residents?"

This same philosophy has been shared by the other members of the original design team, and the countless individuals representing associations and State governments with which we have worked in partnership in implementing the RAI nationally. I believe that it is this emphasis on interweaving tenets of good clinical practice within a regulatory model, more than any other factor, that has contributed to our successful implementation of the RAI nationally, and more importantly, the successful use of the RAI by individual nursing homes to provide quality care to their residents.

In introducing version 2.0 of the RAI, it is important to note that we always intended that the RAI would be a dynamic tool. In essence, we recognized that we could not simply publish the MDS and RAPs in 1990 and expect that they could serve as a foundation for the delivery of long-term care services without ongoing evaluation and refinement over time. Consequently, with the designation of the original version of the RAI, CMS made a commitment to the providers and consumers of nursing home services that we would sponsor the continued refinement of the RAI. While change is always difficult, this work is necessary in order for the RAI to incorporate state-of-the-art changes in clinical practice and assessment methodologies, as well as accommodate the changing needs of the nursing home population.

CMS began an open and very collaborative process to develop version 2.0 of the RAI in early 1993 by requesting comments on the original version through a notice of proposed rulemaking published in the Federal Register. Working in concert with key members of the original RAI development team, John N. Morris, Ph.D., and Katharine Murphy, R.N., M.S., at Hebrew Rehabilitation Center for Aged in Boston, CMS then began the arduous task of consulting with nursing home staff, State agencies, and national organizations representing the industry, consumers, and professional disciplines. We produced a series of draft documents, and continued our refinements based on comments from individuals and organizations with years of experience in using the original RAI. We made many substantive changes based on the comments of nursing home staff participating in a field test of the new MDS, which focused on ensuring the clinical utility and inter-rater reliability of new MDS items. We also consulted with a number of states and organizations with experience in automating the MDS, in order to make version 2.0 more computer-"friendly."

There were a number of "guiding principles" we used in developing version 2.0 that give insight into the programmatic goals and priorities that shaped the new instrument:

- In keeping with the clinical focus used to design the original MDS, we made only those additions or changes that nursing home staff viewed as providing useful information for care planning. Our primary rule of thumb in deciding whether to add or change an item was "Is this something that clinicians need to know in order to provide care for a nursing home resident?" We also strove to keep this a minimum data set. As we waded through an innumerable number of excellent suggestions for additional items, we would ask ourselves whether the item provided vital information or would simply be "nice to know," and whether or not it was something that was necessary to know for all nursing home residents. This was truly a difficult task and will no doubt result in several unhappy individuals whose suggestions did not survive such scrutiny. As such, the MDS version 2.0 remains a symbol of compromise--probably less information than we might like to have, but clearly an improvement as evidenced by the positive responses of facility staff participating in our field test and the positive comments received from states and associations.

- We also recognized the increasing purposes for which MDS data is being used by both nursing home staff and states. Provided that items met the primary test of supplying necessary information for clinical staff, we chose to add some items that would also support programmatic needs, such as for payment and quality improvement systems. To the extent that such programs could be supported by the clinical information obtained from the MDS, it was felt that this would minimize burden on facilities by reducing the need to report duplicative sets of information. Consequently, in response to the increasing number of states that have already implemented or expressed an interest in using MDS data for a Medicaid case mix reimbursement system, we added those items necessary to calculate Resource Utilization Groups III (RUGs-III). RUGs-III is the payment classification system that was developed for the CMS sponsored "Nursing Home Case mix and Quality" Demonstration. It has already been implemented as the basis for Medicaid payment by the four states participating in the Demonstration, with plans for six states to move to RUGs-III driven payment for Medicare in participating facilities. Designing version 2.0 to support case mix reimbursement systems required the addition of several items from the tool known as the MDS+, which has been used in ten states for Medicaid payment. This was not in opposition to our primary rule of "clinical utility," however, as many of the MDS+ items addressed clinical "holes" in the original MDS (e.g., issues related to restorative nursing care, therapies, skin care, etc.). The incorporation of all "payment" items into the core MDS eliminates the need for states to implement alternate instruments to support payment systems, unless additional items are needed for State-specific payment systems.

- In keeping with the goal of CMS's Health Standards and Quality Bureau (HSQB) to move forward with an MDS-driven quality monitoring and improvement system, we have also added those MDS+ items necessary to generate many of the Quality Indicators (QI's), as developed by the University of Wisconsin under the auspices of the aforementioned Demonstration. This required the addition of a few items to the core MDS. More significantly, this programmatic goal underscores the importance of the quarterly review, as more information, submitted more frequently, will be required to support our future quality monitoring systems. However, it should also be stressed that no items were added to the quarterly review requirement solely to provide QI data. There was significant agreement

within the associations and states with which we consulted that the original quarterly review requirement did not provide facilities with all items necessary to adequately monitor residents' status. In this regard, we also had to compromise and could not accommodate all of the good suggestions we received for adding items to the quarterly review requirement.

- You will notice a number of changes in the new MDS, which are highlighted below:

- The sections have been reordered (e.g., ADLs are now found in Section G). All State RAIs will now have one consistent ordering of sections, with any additional State-specific items found in Section S. Sections T and U have been developed for use in states participating in the Medicare Nursing Home Case mix and Quality Demonstration, and are not a part of the core MDS.

- A number of items and sections have been constructed to facilitate computerization and data entry. There are also new forms designed for this purpose: Basic Assessment Tracking Form, Section AA - Identification Information, which has all key information needed to track residents in data systems; and forms for tracking residents on discharge and reentry into the facility.

- Several new scales have been added to help clinicians better understand a resident's status in a number of areas. For example, there are now scales that measure the alterability and frequency of behavioral symptoms and the frequency and intensity of pain.

- Several items have been added in response to the changing needs of the nursing home population. For example, the increase in subacute, hospice, and short-term stay populations led to the inclusion of items assessing pain, discharge potential, restorative and rehabilitation needs, and infections.

Version 2.0 brings an attempt to streamline the RAP triggers. Analyses of large data sets were conducted to improve the predictive power of the triggers. In more simple terms, which triggers contributed most significantly to the identification of problems warranting care plans? Which trigger items could be eliminated? Along with reducing the number of trigger items overall, we also eliminated the distinction between automatic and potential triggers.

There have also been a number of changes in the RAI utilization guidelines, which is a regulatory term for our instructions on how the instrument must be used. For example, we created a new definition of significant change and modified our guidance on when a significant change reassessment is required, decreased the time for retention of RAI records, and changed the procedures by which errors may be corrected.

We expect the changes within version 2.0 and our policies regarding its use to be only the beginning of our commitment to improving the instrument and facilities' ability to use it effectively. Over the next few months, we will begin a process to review and revise the existing RAPs, as well as to develop new RAPs to address areas of significant clinical importance. We also expect to conduct an ongoing assessment of training needs and to intensify our efforts to produce educational materials for both nursing home staff and surveyors. Over the next few years, we expect to revise all of the RAPs, as well as begin work on the next version of the MDS. We welcome your suggestions on all of these areas and invite you to consider volunteering to participate in developing or reviewing materials in your own area of clinical expertise.

Finally, we thank you for all of your hard work in implementing the RAI and using it to provide quality care to nursing home residents throughout the nation.

Sue Nonemaker, R.N., M.S.
RAI Project Officer
Health Standards and Quality Bureau
Centers for Medicare and Medicaid Services
September 4, 1995

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# CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT

## 1.1 Overview of the Resident Assessment Instrument (RAI)

Providing care to residents with post-acute and long-term care needs is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI helps facility staff to look at residents holistically - as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

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

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, standardized approach for applying a problem identification process in long-term care facilities. **The RAI should not be, nor was it ever meant to be, an additional burden for nursing facility staff**.

All good problem identification models have similar steps:

**a.** **Assessment** - Taking stock of all observations, information and knowledge about a resident; understanding the resident's limitations and strengths; finding out who the resident is.

**b.** **Decision-making** - Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "what's" and "whys" of resident problems.

**c.** **Care Planning** - Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.

**d.** **Implementation** - Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" and "when" of resident care.

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

This is how the problem identification process would look as a pathway. This manual will feature this pathway throughout the chapter discussions.

**Assessment (MDS/other)** → **Decision-Making (RAPs/other)** → **Care Plan Development** → **Care Plan Implementation** → **Evaluation**

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

The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff, across all shifts, are involved in its "hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

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

**Residents Respond to Individualized Care.** While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

**Staff Communication Has Become More Effective.** When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the Resident Assessment Protocols (RAPs)) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

**Resident and Family Involvement in Care Has Increased.** There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.

**Increased Clarity of Documentation.** When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 that made recommendations to improve the quality of care in nursing facilities, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

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

## 1.2 Content of the RAI for Nursing Facilities

The RAI consists of three basic components:

1. **Minimum Data Set (MDS) Version 2.0**,

2. **Resident Assessment Protocols (RAPs)**, and

3. **Utilization Guidelines** specified in State Operations Manual (SOM) Transmittal #272.

Utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS)**. A core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. **A copy of the MDS Version 2.0 can be found at the end of this chapter.**

- **Resident Assessment Protocols (RAPs)**. The RAPs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. RAPs help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAPs are explained in detail in Appendix C. There are four components in the RAPs protocols:

  - ***Triggers*** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation.

  - The ***Trigger Legend*** is a two-page form that summarizes all of the triggers for the 18 RAPs. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.

  - The ***RAPs*** analysis is performed in accordance with the Utilization Guidelines. The indepth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care.

  - The ***RAPs Summary Sheet*** documents the decisions made during this evaluation process on whether or not to proceed to care planning.

- **Utilization Guidelines**. Instructions concerning when and how to use the RAI. Application of the RAPs and the Utilization Guidelines is discussed in detail in Chapter 4.

## 1.3 Additional Uses of the Minimum Data Set

Over the course of time, the role of the MDS has expanded beyond its primary purpose as an assessment tool used to identify resident care problems that are addressed in an individualized care plan. Data collected from MDS assessments is used for the Medicare reimbursement system, many State Medicaid reimbursement systems, and to monitor the quality of care provided to nursing facility residents. The

MDS instrument has also been adapted for the hospital swing bed program. Swing bed providers are required to complete a unique 2-page MDS for the Medicare Prospective Payment System (PPS).

## Medicare and Medicaid Payment Systems

The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. Chapters 2 and 6 provide more detailed information on the Medicare Prospective Payment System, assessment requirements, and payment requirements.

## Monitoring the Quality of Care

MDS assessment data is also used to monitor the quality of care in the nation's nursing facilities. A set of 24 quality indicators (QIs) was developed by researchers to assist State staff to identify potential care problems in a nursing facility. CMS is currently evaluating the usefulness of these indicators and is considering additions and modifications to further enhance the effectiveness of the QI system. The QI data is available to providers to assist them in their ongoing quality improvement activities, to surveyors to assist in identifying potential problem areas that should be addressed during the survey process, and to CMS for long-term quality monitoring and program planning.

Consumers are also able to access information about every Medicare and Medicaid certified nursing facility in the country. The Nursing Home Compare tool available at **www.medicare.gov** provides the following sections of detailed information:

- **About the Nursing Facility:** Including the number of beds and type of ownership.
- **About the Nursing Facility Inspection:** Including health deficiencies found during the most recent State nursing facility survey and from recent substantiated complaint investigations.
- **About Nursing Facility Staff:** Including the average number of hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per resident per day.
- **About the Quality of Care Received at the Facility:** In 2002, CMS began a new program called the Nursing Home Quality Initiative (NHQI). The purpose of this program is to provide consumers with information on the quality of care delivered in nursing facilities to help them make informed decisions. CMS expanded the original quality indicators to a set of 39 quality measures. These quality measure domains include pain and measures for the short-stay and post-acute population. A subset of 10 quality measures are posted on the Nursing Home Compare web site, a CMS developed internet search tool to allow comparisons between nursing facilities. The public reporting initiative was successfully piloted in six states, and, beginning in November 2002, was expanded to all fifty states as well as to U.S. territories that have Medicare or Medicaid certified nursing facilities.

The Nursing Home Compare web site is:

**http://www.medicare.gov/nhcompare/home.asp**.

## 1.4 Suggestions for the Use of this Manual

This manual is designed to meet the needs of nursing facility staff who are both skilled in the use of the RAI process and staff who are just beginning to work with it.

This revised manual includes information about:

- MDS automation
- Reimbursement
- Quality monitoring applications

It also includes new case studies and expanded clarifications for the original item-by-item section information of the October 1995 Version 2.0 Long-Term Care Resident Assessment Instrument User's Manual and "how-to" directions for completing the RAP review process and documentation requirements.

The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

- The resident is an individual with strengths, as well as functional limitations and health problems.
- The RAPs are utilized to identify possible causes for each problem area, and guidance for further assessment and resolution or intervention.
- An interdisciplinary approach to resident care is vital - both in assessment and in developing the resident's care plan.
- Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that is based on specific, individual characteristics.

## 1.5 Clarifications and Revisions to the Manual

Since the publication of the MDS 2.0 manual in October 1995, a number of additional systems and monitoring protocols that use MDS data have been developed and implemented, such as SNF PPS, nursing facility quality of care monitoring, and the public reporting of nursing facility quality of care information.

In addition, CMS established a process for answering questions and clarifying MDS coding instructions for nursing facility staff. CMS posted responses to questions on their web site. These responses are now incorporated into this manual. The instructions in this revised manual incorporate and supercede previous Q&A documents.

CMS recognizes that the publication of this revised manual will not preclude future questions or the need for more clarification about MDS items. Therefore, CMS has developed a procedure to review, respond and distribute clarifications to the MDS coding process.

**STEP 1:** If clinicians have a question about a particular MDS item, they should first review the manual and then contact their State RAI Coordinator for a clarification. If necessary, the State RAI Coordinator will contact the appropriate CMS staff if he/she is not able to answer a specific question.

**STEP 2:** CMS will determine if a clarification about an item is needed and will post new clarifications on the CMS web site. If a clarification is posted on the official CMS web site, then it can be considered policy. CMS will periodically update the manual and incorporate additional clarifications. Clinicians should monitor the CMS website for these clarifications at: **http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.**

## 1.6 Statutory and Regulatory Basis for the RAI in Nursing Facilities

**Minimum Data Set (MDS):** The statutory authority for the MDS Version 2.0 and the Resident Assessment Instrument (RAI) is found in Section 1819(f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements for use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995. Revision #22, issued December 8, 2000, required nursing facilities to implement the September 2000 update of the Resident Assessment Instrument (RAI).

Federal requirements at 42 CFR 483.20(b)(1)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and helps staff to identify health problems. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data from the facility to the State MDS database. (Detailed submission requirements are located in Chapter 5.)

## 1.7 State Designation of the RAI for Nursing Facilities

**All comprehensive RAIs authorized by states include at least the Centers for Medicare & Medicaid Services' (CMS's):**

- **MDS Version 2.0 (with or without optional Sections S, T, U)**
- **Resident Assessment Protocols (RAPs), including**
  - **Triggers**
  - **Trigger Legend**
  - **RAPs Summary Sheet**
- **Utilization Guidelines**

Each state must have CMS approval for the State RAI. CMS's approval of a state's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. CMS's approval of the RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). States must use all Federally required MDS items (see Section 1.9) but have some flexibility in adding one or more optional sections (Sections S, T and U) and in selecting a Quarterly assessment instrument.

In addition to approving the State's RAI, CMS must also pre-approve the Quarterly assessment designated by each state. Effective July 1, 2002, CMS approved the Medicare Prospective Payment Assessment Form (MPAF) for use as a Quarterly assessment. States choosing to use the MPAF form as the State Quarterly assessment do not need prior CMS approval. The state is only required to notify CMS that the MPAF has been designated as the State Quarterly assessment.

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the state can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR 483.20 (b). This applies to either pre-printed forms or computer generated printouts. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions).

Additional information about State specification of the RAI, variations in format and CMS approval of alternative State instruments can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual, Transmittal #272 issued April 1995. Revision #22 issued December 8, 2000 updated RAI requirements and mandated nursing facilities to implement the Version 2.0 September 2000 update of the RAI.

## 1.8 Protecting the Privacy of MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (COP). By regulation at CFR 483.75(L)(2)(3) and 483.75(L)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

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

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. The Privacy Act can be found at **www.usbr.gov/laws/privacy.html.**

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the State MDS database. The notice shown on Page 1-11 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under OBRA or for Medicare payment purposes.

### Contractual Agreements

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

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

**NURSING FACILITIES**
**PRIVACY ACT STATEMENT – HEALTH CARE RECORDS**

*THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.

**Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.**

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators(TPA),employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

# 1.9 The Components of the Minimum Data Set (MDS)

## Minimum Data Set

The MDS is completed on all residents in Medicare or Medicaid certified facilities. A mandated assessment schedule is discussed in Chapter 2. In addition, states may establish additional MDS requirements. For specific information on State requirements, contact your State RAI Coordinator (see Appendix B).

Since the requirements for Medicare PPS went into effect, assessments may be referred to as either a "comprehensive" or "full" assessment. To clarify this terminology, the comprehensive assessment is a clinical assessment that requires the full MDS, RAPs and Utilization Guidelines. Comprehensive assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines. Comprehensive assessments are required within 14 days of the admission, annually, when there has been a significant change in clinical status, and when the facility does a Significant Correction of a Prior Full assessment.

When the term "full assessment" is used, it includes the MDS required items A through R (plus any State-required items). A full assessment is distinguished from a comprehensive assessment (RAI) in that the RAPs and care planning are not completed when the full assessment is completed for a Medicare assessment.

Of course, the facility's right to care plan is not restricted to the RAI mandated requirements. Facilities may expand upon these requirements, when appropriate, to fully assess and care plan for an individual.

The required components of the MDS are as follows:

**SECTION AA - The Basic Assessment Tracking Form**

This form contains Identification Information Items 1-9, which consists of identifying information needed to uniquely identify each resident, the nursing facility in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of the MDS or Tracking form. The information contained on this form must accompany each comprehensive, full, MPAF, or Quarterly assessment, as well as every Distcharge and Reentry Tracking form, submitted electronically to the State MDS database. This includes Federally required assessment records, (e.g., Admission, Annual, Significant Change in Status, and Quarterly assessments), as well as assessments required for Medicare or by the State. This section also contains the Attestation Statement that staff members must sign and date attesting to the accuracy of the portions of the MDS completed by each member of the interdisciplinary team.

**SECTIONS AB, AC, AD - Background (Face Sheet) Information at Admission Form**

This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the time of the resident's initial admission to the nursing facility. A new Face Sheet is also required to be completed, along with an Admission assessment, for an individual who returns

to the facility after a discharge in which return was not anticipated. CMS's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the Admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally required records (those indicated by the codes under AA8a) or the assessments required for Medicare (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

**SECTIONS A-Q - Clinical Assessment**

Sections A-Q contain the clinical data items used to assess residents in the nursing facility. Section A9 is where staff sign that they have completed portions of the assessment and agree to the Attestation Statement.

**SECTION R – Signature and Completion Date**

Section R contains the signature of the RN coordinating the assessment. This is the section that records participation of the resident, family and/or significant other in the assessment process.

**SECTION S - State Section**

Some states have added items to the core MDS that must be completed for each resident when a comprehensive assessment, full, MPAF, or Quarterly is required. Thus, while the basic MDS form is the standard foundation for states, you may find that other items have been added at the end of the form (in Section S) in your state. Contact your State RAI Coordinator for State-specific requirements. A list of State RAI Coordinators is found in the Appendix B.

**SECTION T – Supplement**

Required for all Medicare assessments. Optional at State discretion for all other types of assessments.

**SECTION U – Medications**

Not used by CMS. Can be required by the State.

**SECTION V - Resident Assessment Protocol Summary**

Section V contains the form used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether or not a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A RAP Summary form must be completed each time a comprehensive RAI is required under the Federal schedule. If a care plan is written from a non-triggered RAP, it should be noted on the RAP Summary form.

## Quarterly Assessments

Additionally, states must specify a Quarterly assessment form, for use by facilities that includes at least the items on the CMS-designated form. The Quarterly assessment contains the mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for Quarterly assessments within each State's RAI. Some states have mandated an expanded Optional Quarterly assessment form. CMS has published two optional versions that states may require. A state may also require a full assessment on a quarterly basis. Again, contact your State RAI Coordinator for State specifics. States have the following options for the Quarterly Assessment:

- **Minimum Required MDS Quarterly Assessment**
- **MDS Quarterly Assessment Form Optional Version for RUG-III or Optional Version for RUG-III 1997 Update**
- **Full MDS Assessment**
- **Medicare Prospective Payment Assessment Form (MPAF)**

Copies of the Quarterly assessment options available to the states are included at the end of this Chapter.

## Discharge and Reentry Tracking Forms

Facilities are required to submit the information contained in two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the Discharge Tracking form and the Reentry Tracking form contain Section AA (Identification Information) Items 1-7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The Discharge Tracking form also contains items from Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. The Reentry Tracking form contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms. A detailed discussion of the Discharge and Reentry Tracking process is in Chapter 2.

## Medicare Assessments

Nursing facilities perform a comprehensive MDS assessment when the Medicare assessment is combined with any assessment required for clinical and/or care planning purposes, i.e., all OBRA assessments except the Quarterly. In 2002, a customized version of the MDS form was developed to minimize the facility's data collection requirements. This customized Medicare Prospective Payment System Assessment Form (MPAF) may be used when the assessment is performed solely for payment purposes (see Chapter 2 for details).

## Resident Assessment Protocols (RAPs)

The **triggers** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPs) designated within the State specified RAI. MDS item responses that define triggers are specified in each RAP and on the trigger legend form. Not all items assessed on the MDS are automatic triggers, e.g., use of side rails

at P4. However, the RAP may be used to evaluate those items that are not automatic triggers. Turn to the RAPs (in Appendix C) to review these items and the accompanying RAP Guidelines. Once you are familiar with the RAP triggers and guidelines, the trigger legend form serves as a useful summary of all RAP triggers. The **trigger legend** summarizes which MDS item responses trigger individual RAPs and has been designed as a helpful tool for facilities if they choose to use it. **It is a worksheet, not a required form**, and does not need to be maintained in each resident's clinical record.

The RAPs provide structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the RAP in question? Clinical staffs are responsible for answering questions such as these. The information from the MDS and RAPs forms the basis for individualized care planning. The RAPs Summary form documents the decisions made during this evaluation process whether or not to proceed to care planning.

### Utilization Guidelines

The **Utilization Guidelines** are instructions concerning when and how to use the RAI. Once a RAP has been triggered, use the utilization guidelines to evaluate the problem and determine whether or not you continue to care plan for it. The Utilization Guidelines for Version 2.0 of the RAI were published by CMS in the State Operations Manual[1] Transmittal #272, and are discussed in detail in Chapter 4.

The individual resident's care plan must be evaluated and revised, if appropriate, each time a comprehensive or Quarterly assessment is completed. Facilities may either make changes to the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI, may be documented in the resident's active record. This documentation should include progress notes or facility specific flow sheets.

## 1.10 Applicability of RAI to Facility Residents

The clinical requirements for the resident assessment instrument are found at 42 CFR 483.20 and are applicable to all residents in certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, or payment category.

[1]The SOM is a reference only; it is not necessary for effective use of the RAI. The SOM can be ordered from the National Technical Information Service (NTIS); PB# 95-950007; (703) 487-4650.

An RAI must be completed for any resident residing in the facility **longer than 14 days**, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes a certified Skilled Nursing Facility (SNF) or Nursing Facility (NF) and certified SNFs or NFs in hospitals, regardless of payment source.

- **Hospice Residents.** When an SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between the hospice and long-term care facility staff with the consent of the resident. In these situations, the hospice team should participate in completing the RAI.

- **Short-term stay or respite residents.** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, you must follow the OBRA assessment schedule and tracking document requirements. If the respite resident is in the facility for fewer than 14 days, no assessment is due. Facilities that have short-term or respite residents should follow the instructions in Chapter 2 for completion of assessments and tracking forms.

  Given the nature of short stay or respite admissions, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may not be able to provide information on the resident's Customary Routine). In that case, the "no-information" convention should be used ("-") (See Chapter 3 Section 3.2 for more information). For respite residents who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be discharged to "extended" leave status (Discharged-return anticipated). This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred in the intervening period.

  Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet the resident's needs upon or shortly after admission. In addition, if the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

- **Special populations (e.g. pediatric or residents with a psychiatric diagnosis).** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.

- **Long-Term Care Facilities.** Additional assessments are required for Medicare beneficiaries in a SNF Part A stay. The MDS is used to determine the Resource Utilization Group (RUG-III) that is used to calculate payment under the SNF PPS. See Chapter 2 for detailed information on Medicare assessments.

- **Swing bed facilities.** Swing bed hospitals providing Part A skilled nursing facility-level services were phased into the skilled nursing facility prospective payment system (SNF PPS) starting July 1, 2002. Beginning on the first day of each hospital's cost reporting year on and after July 1, 2002, swing bed hospitals must complete a customized two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. A separate Swing Bed MDS Assessment Training Manual has been developed and can be found on the CMS website at:

**http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp**

Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

## 1.11 Facility Responsibilities for Completing Assessments

**NEWLY CERTIFIED NURSING HOMES**

Nursing homes must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed *as if the beds were already certified.* Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 (of the covered Part A stay) when establishing the Assessment Reference Date for the 5-Day Medicare assessments. For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Assuming a survey where the SNF has been determined to be in substantial compliance, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the survey as Day 1.

If the SNF is already certified and is adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

**CHANGE IN OWNERSHIP**

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment schedule for existing residents continues, and the facility continues to use the existing provider number. For example, if the Admission assessment was done 10 days prior to the change in

ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.

There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases, the beds are no longer certified. Also, there are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures debts, etc. Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See page 1-16 for information regarding newly certified facilities.

**TRANSFERS OF RESIDENTS**

Any time a resident is admitted to a new facility (regardless of whether or not it is a transfer within the same chain), a new comprehensive assessment must be done within 14 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an Admission assessment, and if applicable, a 5-Day Medicare assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new assessment for the purpose of planning care within the facility to which the resident has been transferred. The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper--that is, the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff. States may have other requirements from a payment perspective. Therefore, facilities should contact their survey agency as well for clarification.

When there has been a transfer of residents secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Fiscal Intermediary for guidance.

When the originating facility determines that the resident will not return to the evacuating facility, the provider will discharge the resident. The receiving facility will then admit the resident and the MDS cycle will begin as of the admission date. For questions related to this type of situation, providers should contact their State agency and their Regional Office.

## 1.12 Completion of the RAI

**PARTICIPANTS IN THE ASSESSMENT PROCESS**

Federal regulations[2] require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical

[2] 42 CFR 483.20 (h)--(F 278)

**This page revised—June 2005, April 2004**

backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The RAI must be conducted or coordinated by an RN who signs and certifies the completion of the assessment[3]. If a facility does not have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the RAI. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the MDS and RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.

- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, activities specialists, physical, occupational, or speech therapists, dietitians, and pharmacists.

- Assure that residents and their families are actively involved in the information sharing and decision-making processes.

- Assure that the care planning component is developed with input from all staff.

- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.

[3] 42 CFR 483.20 (i)(1)--(F 278)

- Instruct staff on how to integrate MDS information with existing facility resident assessment and care planning practices.

## 1.13 Sources of Information for Completion of the MDS

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, interacting with the resident and direct care staff validates information in the resident's record.

**The following sources of information must be used in completing the MDS.** Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the resident's record** - Depending on whether or not the assessment is an admission or follow-up assessment, the review could include: preadmission, admission, or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60-day period; and a record of medications administered for the prior 30-day period.

- **Communication with and observation of the resident.**

- **Communication with direct-care staff (e.g., nursing assistants, activity aides) from all shifts.**

- **Communication with licensed professionals** (from all disciplines) who have recently observed, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.

- **Communication with the resident's physician.**

- **Communication with the resident's family** - Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, the resident may request that someone else who is very close to him/her be contacted.

### REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

**At admission**, record review includes an examination of notes written in the first 2 weeks (assuming the full 14-day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and RAPs from another nursing facility if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

**Subsequent reassessments** should focus on recorded information from earlier MDS assessments and Quarterly assessments, written information from the previous 3-month period, and notes made during the prior 30-day period.

**The following are important considerations when reviewing the resident's record:**

- **Review the information documented in the record, keeping in mind the required MDS definitions.** Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the MDS, a resident, who stays "dry" with a catheter may be considered continent).

- **Make sure that the information taken from the record covers the same observation period as that specified by the MDS items.** The MDS refers to specific time frames for each item; for example ADL status is based on resident performance over a 7-day period. To ensure uniformity, the MDS has an Assessment Reference Date (A3a) that establishes a common reference end-point for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the MDS and also to the Item-by-Item instructions in Chapter 3.

- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items.** A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a suggested work tool only.

- **As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.**

## COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, an RN can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confirming staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. For further information on "Interviewing Techniques" see Appendix D.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

Any person completing any MDS section is required to follow the Item-by-Item guidelines in Chapter 3 of this manual that specify sources of information necessary for accurate coding. The process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not personally observe for example a behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

## COMMUNICATION WITH DIRECT CARE STAFF

Direct care staff (e.g., nursing assistants and activity aides) having daily, intimate contact with residents is often the most reliable source of information about the resident. Direct care staff talk with and listen to the residents. They observe and assist the resident's performance of ADLs and involvement in activities. They observe the resident's physical, cognitive and psychosocial status daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- **Be sure to speak with a person who has first-hand knowledge of the resident.** Plan for sufficient time to talk with direct care staff person(s).

- **Start by asking about the resident's performance on ADLs and activities.** What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.

- **Talk with direct care staff across all shifts, if possible.** The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

## COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, dietitians, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns, and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

## COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. At the Quarterly assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

## COMMUNICATION WITH THE RESIDENT'S FAMILY

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas, and customary routine prior to the first nursing facility admission. This information is particularly necessary when the resident is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. Facilities need to respect the cognitively intact resident's right to privacy, and should have permission from the individual for staff to ask questions of family members. In most instances, family will not be the sole source of information but will supplement information from other sources. The assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

## 1.14 CMS Clarification Regarding Documentation Requirements

CMS has always accepted the MDS as a primary data source, and duplicative documentation is not required. However, clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the MDS. Completion of the MDS does not remove the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident. In addition, for the Medicare prospective payment system, documentation must substantiate the resident's need for Part A SNF-level services and his/her response to those services.

Nursing facilities are required to document the resident's care and response to care during the course of the stay, and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment. Always keep in mind that government requirements are not the only or even the major reason for clinical documentation. The MDS has simply codified some documentation requirements into a standard format.

Clinical documentation that contributes to identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. Good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to a SNF resident. For these types of services, the more detailed documentation needed for good resident care also provides all the data needed to code the MDS. The MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the MDS.

In addition, it is important to note that CMS does not impose specific documentation procedures to nursing facilities. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility. These tools may provide more accurate data for MDS reporting and care planning, and may provide real value to the facilities utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State agency and Fiscal Intermediary staff will utilize these data collection tools as part of an MDS validation review. In the absence of this type of documentation, the MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS.

Some states may have regulations that require supporting documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system. If your state requires the MDS to be completed for the Medicaid program, they may have additional documentation requirements. Contact your State agency's Resident Assessment Coordinator or your Medicaid program for State-specific requirements.

## 1.15 RAI Completion Time Frames

### ASSESSMENT COMPLETION TIME FRAMES

Each individual team member who completes a portion of the MDS assessment must sign and certify its accuracy.[4] Each interdisciplinary team member who completes a portion of the MDS assessment signs, dates, and indicates the portion of the assessment he or she completed in AA9. This signature and date should reflect the date of the assessment and may be earlier than the date in R2b. The RN coordinator is required to sign R2b to certify that the MDS is complete.[5] The RN coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. If the RN does all of the MDS, then the nurse alone would sign and be responsible for certifying accuracy and completeness. An assessment that was signed and dated by all assessors, but not by the RN coordinator, because the RN coordinator is no longer at the facility, should be signed and dated (with the date it is actually signed) by the current RN assessment coordinator.

### RAPs COMPLETION TIME FRAMES

An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment. For the admission assessment, the RN coordinator must sign and date the RAP Summary form at VB1 and VB2 within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner. The RN completing the RAP Summary form does not have to be the same RN who completed and signed the MDS assessment.

It is never permissible to certify or backdate RAI forms for another individual on the interdisciplinary team. If an individual who completed a portion of the MDS is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI when these situations occur.

[4] 42 CFR 483.20 (i)(2)--(F 278)

[5] 42 CFR 483.20 (i)(1)--(F 278)

**CARE PLANNING COMPLETION TIME FRAMES**

The facility has 7 days after completing the RAI (RAPs Completion Date (VB2)). The staff member entering the care planning decision information must also sign and date the RAP Summary form at VB3 and VB4, the Care Plan Completion Date.

## 1.16 Attestation Statement of Accuracy

The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for:

- The development of an individualized care plan for the resident occurs directly from responses entered on the MDS,
- Medicare Prospective Payment System,
- State Medicaid reimbursement programs,
- Quality monitoring activities such as the Quality Indicator (QI) Reports, the data driven survey and certification process, and the quality measures used for public reporting,
- Research, and
- Policy development.

Primary responsibility for accuracy lies with the person selecting the MDS item response. Each person completing a section of the MDS is required to sign the Attestation Statement (AA9, AD, and AT7) that reads:

> "I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from Federal funds. I further understand that payment of such Federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

In addition, the RN coordinating the assessment must sign and date the MDS. The signature of the RN attests to the completeness of the document. Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN assessment coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN assessment coordinator is not certifying the accuracy of assessments that were completed by other health professionals.

## 1.17 Correcting The MDS

Once completed, edited, and accepted into the MDS data repository, facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the electronic record submitted to and accepted into the MDS database is the legal assessment. Changes made to the electronic record after data transmission or to the paper copy maintained in the medical record are not recognized as proper corrections. The MDS correction process is described in Chapter 5.

However, several additional processes have been put into place to assure that the MDS data is accurate both at the facility and in the State MDS database:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.

- Software used in the facility to encode the MDS must run all standard edits as defined in the data specifications released by CMS.

- Enhanced record rejection standards have been implemented in the State MDS database. If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent, e.g., a skip pattern is not observed, the record is rejected. Inaccurate data is not added to the State MDS database.

- If an error is discovered in a record in the State MDS database, Modification or Inactivation procedures must be implemented by the facility to assure that the database information is corrected.

- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed. A Significant Change in Status assessment or a Significant Correction of a Prior assessment may be needed as well as corrections to the information in the State MDS database.

## 1.18 Reproduction and Maintenance of the Assessments

Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs.

While use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically, the guidance language for Clinical Records found in Appendix PP [42 CFR 483.75(1)(1)] notes that facilities have the option for an individual's record to be maintained by computer rather than hard copy. In addition, proper security measures must be implemented via facility policy to ensure the privacy and integrity of the record and to ensure that access to clinical records is made available to surveyors and others who are authorized by law.

Long-term care facilities that are not capable of maintaining MDSs electronically must adhere to the current requirements that either a hand written copy or a computer-generated form must be maintained in the clinical record. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard. In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

Unless the provider has exercised the option to maintain electronic MDSs, facilities are required to maintain hard copies of 15 months of assessment data in the resident's active clinical record according to CMS policy. There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB,AC, andAD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, assessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.

The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, including linking the prior electronic MDS to the new admission record, but the15-month requirement for maintenance of the RAI data does not restart with each new admission. In Cases where the resident returns to the facility after a long break in care (e.g., 14 ½ months), staff may want to review the older record to familiarize them with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirement.

For additional information, refer to Resident Assessment Requirements for Long-Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

# CHAPTER 2: THE ASSESSMENT SCHEDULE FOR THE RAI

**This chapter presents the instructions for the completion of the mandated clinical and Medicare assessments in nursing facilities.**

## 2.1 Introduction to the OBRA Assessment Schedule for the MDS

### INTRODUCTION TO THE OBRA ASSESSMENT SCHEDULE

The OBRA regulations have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment. These are known as "OBRA assessments." MDS assessments are also required for Medicare payment purposes and are discussed in detail in Section 2.6.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. It is important for facility staff to fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort.

### OBRA ASSESSMENTS

When the resident is first admitted to a facility, the RN Assessment Coordinator (RNAC) and the interdisciplinary team will agree on a period known as the observation period for the Admission assessment. The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified time periods such as 7, 14, or 30 days, the ARD is the common endpoint of these "look back" periods. This concept of setting the ARD is used for all assessment types. When completing the MDS, only those items that occurred during the look back period will be captured. In other words, if it did not occur during the look back period, it should not be coded on the MDS.

When all members of the team have completed their portions of the assessment and the assessment is complete, the RN Assessment Coordinator (RNAC) will sign Item R2a and will date Item R2b with the date that R2a was signed. The R2b date is the completion date for all assessment types that do not require RAPs, and is the date used to determine when the next OBRA assessment is to be completed. An OBRA assessment is due no less frequently than every 92 days.

Resident Assessment Protocols (RAPs) are reviewed following the completion of the MDS portion of the RAI for comprehensive assessments in order to identify the resident's strengths, problems, and needs. This decision-making process is documented on the Resident Assessment Protocol Summary, which is detailed in Chapter 4.

The timing requirements for a comprehensive assessment apply to both completion of the MDS (R2b) and the completion of the RAPs (VB2). For example, an Admission assessment must be completed within 14 days of admission. This means that both the MDS and the RAPs (R2b and VB2 dates) must be completed by day 14. The MDS Completion Date (R2b) may be earlier than or the same as the RAPs Completion Date (VB2), and neither can be later than day 14.

The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (VB2). The care plan must be completed by the end of the 7th day following completion of the RAI assessment. In other words, 7 days following the VB2 date.

Assuming the resident does not have any significant changes in status or is not discharged from the facility, the next assessment in the OBRA assessment schedule is the Quarterly assessment. The Quarterly assessment is to be completed within 92 days of the R2b date of the Admission assessment. The OBRA schedule would continue with another Quarterly assessment to be completed within 92 days of the R2b of the previous Quarterly. A third Quarterly is completed within 92 days of the completion (R2b) of the previous Quarterly.

Following the third Quarterly, and within a year of the Admission assessment, an Annual assessment is completed. This is a comprehensive assessment that requires a full MDS with RAPs and care plan review.

This cycle (comprehensive assessment – Quarterly – Quarterly - Quarterly assessment - comprehensive assessment) would repeat itself annually for a resident who never experienced a significant change or discharge.

However, residents do experience significant changes, are discharged and are readmitted to facilities. Therefore, OBRA regulations have defined a comprehensive assessment that a facility completes in the event of a significant change in status that includes RAP review and care plan revision. When a resident is discharged from a facility, a Discharge Tracking form may be required. When a resident who was discharged returns to a facility, a Reentry Tracking form may be required. When a resident is readmitted to the hospital and an OBRA-required assessment is due during the resident's absence, the facility has up to 14 days after the resident's readmission to complete the assessment. If the assessment that was due during the resident's absence was the initial Admission assessment, see page 2-4. If a significant change is identified on readmission, the significant change assessment would replace the assessment that was due while the resident was in the hospital. (Error messages will result from the late assessment but can be ignored.) The Significant Change in Status assessment, and the Discharge and Reentry Tracking forms, including their impact on the assessment schedule are discussed in more detail later in this chapter.

A comprehensive assessment is also required when the facility has identified a major error in a previously submitted comprehensive assessment. A Significant Correction of a Prior Full assessment (SCPA) must be completed within 14 days of the identification of the error. A major error is one where the resident's overall clinical status is not accurately represented on the MDS, has not been addressed in a subsequent assessment, nor addressed in the resident's care plan. Because this is a comprehensive assessment, completion of the full MDS, RAPs and the RAPs Summary is required.

Section 2.2 of this chapter examines each of the OBRA assessments and provides detailed information on the completion requirements. The following table summarizes the different types of federally mandated assessments.

| TYPE OF ASSESSMENT | TIMING OF ASSESSMENT | REGULATORY REQUIREMENT CMS "F" TAG |
|---|---|---|
| Admission (Initial) Assessment (Comprehensive) | Must be completed (VB2) by the 14th day of the resident's stay. | 42 CFR 483.20 (b)(2)/F 273 |
| Annual Reassessment (Comprehensive) | Must be completed (VB2) within 366 days of the most recent comprehensive assessment. | 42 CFR 483.20 (b)(2)(iii)/F 275 |
| Significant Change in Status Reassessment (Comprehensive) | Must be completed (VB2) by the end of the 14th calendar day following determination that a significant change has occurred. | 42 CFR 483.20 (b)(2)(ii)/F 274 |
| Quarterly Assessment (State mandated subset or MPAF) | Set of MDS items, mandated by State (contains at least CMS established subset of MDS items). Must be completed every 92 days. | 42 CFR 483.20 (c) /F 276 |
| Significant Correction of a Prior Full Assessment | Completed (VB2) no later than 14 days following determination that a significant error in a prior full assessment has occurred. | 42 CFR 483.20(f)(3)(iv)/F 287 |
| Significant Correction of a Prior Quarterly Assessment | Completed (R2b) no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred. | 42 CFR 483.20(f)(3)(v)/F 287 |

The MDS is also completed for the Medicare Prospective Payment System. The Medicare schedule is discussed in detail in Section 2.5

## 2.2 Required OBRA Assessments for the MDS

### ADMISSION ASSESSMENTS

The Admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility if:

- this is the resident's first stay,
- the resident has just returned to the facility after being discharged prior to the completion of the initial assessment, or
- the resident has just returned to the facility after being discharged as return not anticipated.

The 14-day calculation includes weekends. When calculating when the RAI is due, the day of admission is counted as Day "1". For example, if a resident is admitted at 8:30 a.m. on Wednesday

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(Day 1), a completed RAI is required by the end of the day Tuesday (Day 14), 13 days after admission. If a resident dies or is discharged within 14 days of admission, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[1] In closing the record, the facility may wish to note why the RAI was not completed.

**The interdisciplinary team may start and complete the initial assessment at any time prior to the end of the 14th day. If desired by the facility, the MDS could be completed in entirety on the day of admission. However, this requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident's status during the time periods used to code each MDS item, as opposed to allowing a period for facility observation. Facilities may find early completion of the MDS and RAPs particularly beneficial for individuals with short lengths of stay, when the assessment and care planning process is often accelerated.**

**EXAMPLES**

Miss A is admitted on Friday, September 1. Staff establish the Assessment Reference Date as September 8, which means that September 8 is the final day of the observation period for all MDS items (i.e., count back 6 days before the ARD to determine the period of observation for 7-day items, count back 13 days before the ARD for 14-day items, and so on). As this is an initial assessment, staff must rely on the resident and family's verbal history and transfer documentation accompanying Miss A to complete items requiring longer than a 7-day period of observation. Staff completes the MDS by September 12 (note that the Assessment Reference Date (A3a) does not need to be the same as the date RN Assessment Coordinator signed as complete (R2b). Staff takes an additional 2 days to assess the resident using triggered RAPs and to complete all related documentation, which is noted as a date field that accompanies the signature of the RN Coordinator for the RAP assessment process on the RAP Summary form (VB2).

If a resident goes to the hospital and returns during the 14-day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. In this case, the Assessment Reference Date remains the same and the Admission comprehensive assessment must be completed by day 14 counting from the original date of admission. Otherwise the assessment should be reinitiated with a new Assessment Reference Date and completed within 14 days after readmission from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.

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

***Assessment Management Tips*: ADMISSION COMPREHENSIVE ASSESSMENT**

| | Assessment Reference Date (ARD) | 7-day Observation Look Back | 14- day Observation Look Back | RAPs Completion Date (VB2) |
|---|---|---|---|---|
| **ADMISSION** | No later than admission date + 13 days | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | No later than admission date + 13 days |

- The above chart summarizes how to count the days for various points within the admission assessment. As stated previously, the date of admission is Day 1 for determining when the assessment must be completed and for setting the Assessment Reference Date. Once the ARD has been established, then the ARD is day 1 whenever counting back for those items observed over a specific time period.

- Both the MDS Completion Date (R2b) and RAPs Completion Date (VB2) must be dated within 14 days of admission. R2b must always be earlier than or the same as VB2. If R2b is dated prior to day 14, VB2 may or may not be the same day, but can be no later than day 14.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following VB2 (VB2 + 7 days) and can be no later than day 21.

- Electronic submission is due within 31 days following VB4 (VB4 + 31 days).

## ANNUAL REASSESSMENTS

The annual comprehensive assessment must be completed within 366 days of the completion date at VB2 of the most recent comprehensive assessment (could be the Admission assessment, an Annual assessment, a Significant Change in Status assessment or a Significant Correction of a Prior Full assessment). If a significant change reassessment is completed in the interim, the clock "restarts," and the Annual assessment would be due within 366 days of the significant change reassessment. Routinely scheduled RAI assessments may be scheduled early if a facility wants to stagger due dates for assessments.

In managing the dates for the Annual assessment, the anticipated completion date of the assessment to be scheduled as well as the completion dates of the previous comprehensive and Quarterly assessments must be considered when setting the ARD. The completion date of the Annual assessment must meet two requirements: 1) a comprehensive assessment must be completed within 366 days of the RAPs Completion Date (VB2 ) of the previous comprehensive, <u>and</u> 2) there can be no more than 92 days since the (MDS Completion Date (R2b) of the last Quarterly assessment.

If a significant change in status is identified in the process of completing an Annual assessment, code the assessment as a Significant Change in Status assessment. Do not code it as an Annual assessment.

***Assessment Management Tips*: ANNUAL COMPREHENSIVE REASSESSMENT**

| | Assessment Reference Date (ARD) | 7-day Observation Look Back | 14- day Observation Look Back | RAPs Completion Date (VB2) |
|---|---|---|---|---|
| **ANNUAL** | **No later than:**<br><br>RAPs Completion Date (VB2) of previous OBRA comprehensive assessment + 366 days<br><br>**AND**<br><br>MDS Completion Date (R2b) of previous OBRA assessment + 92 days | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | ARD + 14 days<br><br>**BUT**<br><br>**No later than:**<br><br>RAPs Completion Date (VB2) of previous OBRA assessment + 366 days<br><br>**AND**<br><br>MDS Completion Date (R2b) of previous OBRA assessment + 92 days |

- The Annual assessment must be completed no later than 14 days after the ARD. That is, R2b and VB2 can be no more than 14 days from the ARD (ARD + 14 days). Since the ARD is part of the observation period, it is considered day 0, and is not included in calculating the 14-day completion period. VB2 is not required to be the same day as R2b but can be no later than 14 days following the ARD.

- Once the ARD has been established, it is the last day of the observation period.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following VB2 (VB2 + 7 days) and can be no later than 21 days following the ARD.

- Electronic submission is due within 31 days following VB4 (VB4 + 31 days).

## SIGNIFICANT CHANGE IN STATUS ASSESSMENTS (SCSA)-Comprehensive Assessment

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident's condition they should share this information with the resident's physician, who they may consult about the permanency of the change. The facility's medical director may also be consulted when differences of opinion about a resident's status occur among team members.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. A Significant Change in Status (SCSA) assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred.

An SCSA can be performed at any time after the completion of the Admission assessment. If a significant change in status is identified in the process of completing a Quarterly assessment, code the assessment as a SCSA and complete a comprehensive assessment. Do not code it as a Quarterly assessment. The SCSA restarts the schedule and the next Quarterly assessment would be due no more than 92 days from R2b of the SCSA. Similarly, if an SCSA is identified in the process of completing an Annual assessment, it should be coded as an SCSA.

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

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

A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease related clinical interventions. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a "significant change" reassessment. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff should begin a comprehensive RAI assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a significant change reassessment, unless a second area of decline accompanies it. Note that this answer assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and if the problem persists or worsens, a comprehensive RAI reassessment may be clinically indicated.

If there is only one change, however, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique and the interdisciplinary treatment team must make the decision as to whether or not the resident will benefit from an RAI.

Other conditions may not be permanent but would have such an impact on the resident's overall status that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through the RAI reassessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent," but a change does not necessarily need to be both major and permanent.

An SCSA is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement). Any determination about whether or not a resident has experienced a significant change in status is a clinical decision. When a SCSA is completed, the facility must review all of the RAPs because they are interrelated. If there are no changes in a RAP, they can then document that there were no changes and bring that RAP forward and specify where the supporting documentation can be located in the medical record.

## GUIDELINES FOR DETERMINING SIGNIFICANT CHANGE IN RESIDENT STATUS (Please note this is not an exhaustive list.)

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the clinical staff and the guidelines shown below.

**Decline in two or more of the following:**

- Resident's decision-making changes from 0 or 1 to 2 or 3 for Item B4;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2);
- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1"s for Item E4B);

- Any decline in an ADL physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) for Item G1A;
- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4 (Item H1a or b), or there was placement of an indwelling catheter (Item H3d);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (Item K3a);
- Emergence of a pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher (Item M2a);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (Items P4c and e);
- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making) (Item Q2 = 2);
- Emergence of a condition or disease in which a resident is judged to be unstable (Item J5a).

**EXAMPLE**

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

**Improvement in two or more of the following:**

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (Item G1A);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (Items E2 and E4B);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (Item B4);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (Item H1a or b);
- Overall improvement of resident's condition; resident receives fewer supports (Item Q2 = 1).

**EXAMPLE**

Mrs. G has been in the facility for 5 weeks, following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or agitated. The resident, her family, and staff agree that she has made remarkable progress. A reassessment is required at this time. The resident is not the person she was at admission; her initial problems have resolved. Reassessment will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

While a facility may choose to perform more frequent comprehensive assessments than mandated by CMS, reassessments are not required for minor or temporary variations in resident status. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary clinical interventions, even though a reassessment is not required. In these cases the resident's condition is expected to return to baseline within a short period of time, such as 1-2 weeks.

**GUIDELINES FOR WHEN A CHANGE IN RESIDENT STATUS IS NOT SIGNIFICANT (Please note this is not an exhaustive list)**

- Discrete and easily reversible cause(s) documented in the resident's record and for which the interdisciplinary team can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a significant change reassessment).

- Short-term acute illness, such as a mild fever secondary to a cold from which the interdisciplinary team expects the resident to fully recover.

- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a significant change assessment).

- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.

- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

## GUIDELINES FOR DETERMINING THE NEED FOR AN SCSA FOR RESIDENTS WITH TERMINAL CONDITIONS

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual. If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment is required. Similarly, if the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at the facility, an SCSA should be performed if the terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration. The facility is responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.

If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing facility and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and whether or not the resident's condition requires a new assessment. Because a Medicare-certified hospice must also conduct an assessment at the initiation of its services, this is an appropriate time for the nursing facility to evaluate the MDS information to determine if it reflects the current condition of the resident. The nursing facility and the hospice's plans of care should be reflective of the current status of the resident.

- Complete an SCSA for a newly diagnosed resident with end-stage disease when:
  - a change is reflected in more than one area of decline; and
  - the resident's status will not normally resolve itself; and
  - the resident's status requires interdisciplinary review and/or revision of the care plan.
- Complete subsequent SCSA's based upon the degree of decline and the impact upon the comprehensive care plan. Consider the following criteria:
  - completion date of the last MDS;
  - clinical relevancy and accuracy of the MDS to the resident's current status; and
  - the need to change the resident's care plan to reflect the current status.

**EXAMPLES**

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

Mrs. K came into the facility with identifiable problems and has steadily responded to treatment. Her condition has improved over time and plateaued. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified, as necessary, to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A reassessment need not be completed in view of the imminent discharge. **Remember, facilities have 14 days to complete a reassessment once the resident's condition has stabilized, and if Mrs. K is discharged within this period, a new assessment is not required. If the resident's discharge plans change or if she is not discharged, a reassessment is required by the end of the allotted 14-day period.**

Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an MDS reassessment at this time. However, if her condition was to stabilize and her discharge was not imminent, a reassessment would be in order.

***Assessment Management Tips*: *SIGNIFICANT CHANGE IN STATUS ASSESSMENT***

| | **Assessment Reference Date (ARD)** | **7-day Observation Look Back** | **14- day Observation Look Back** | **Assessment Completion Date (VB2)** |
|---|---|---|---|---|
| **SIGNIFICANT CHANGE IN STATUS** | **No later than:**<br>14 days following determination that a significant change has occurred | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | ARD + 14 days<br>**BUT**<br>**No later than:**<br>the end of the 14th calendar day following determination that a significant change has occurred. |

- The Significant Change in Status assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) and the RAPs Completion Date (VB2) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a significant change has occurred overrides this.
- Once the ARD has been established, it is the last day of the observation period.
- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following RAPs Completion Date (VB2) (VB2 + 7 days) and can be no later than 21 days following the ARD.
- Electronic submission is due within 31 days following Care Plan Completion Date (VB4) (VB4 + 31 days).
- If the significant change has been identified in the course of completing either a Quarterly assessment or an Annual reassessment, then the SCSA must be completed no later than 92 days from the previous OBRA assessment and 366 days from the previous comprehensive assessment.

## SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT

A Significant Correction of Prior Full assessment (SCPA), including the full MDS form, RAPs and care plan review, is completed when an uncorrected major error is discovered in a prior comprehensive assessment. An error is major when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of a Prior Full assessment is appropriate after a comprehensive assessment has been accepted into the State MDS database, or when a major error has been identified in a comprehensive assessment that has been completed but is no longer in the editing and revision time period (later than 7 days following VB4). This could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected. It is not necessary to complete a new Significant Correction of Prior Full assessment if another, more current assessment has just been completed or is in progress and includes a correction to the item(s) in error.

A Significant Correction of a Prior Full assessment uses a new observation period (as defined by a new Assessment Reference Date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the state, the facility should also correct the assessment that was in error by completing and submitting a correction request for the erroneous assessment, in addition to completing a new assessment, the Significant Correction of a Prior Full assessment. See Chapter 5 for detailed information on processing corrections. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

The Significant Correction of a Prior Full assessment differs from a Significant Change in Status assessment, in which there has been an actual significant change in the resident's health status. In any instance in which a resident experiences a significant change in status, regardless of whether or not there was also an error on the previous assessment, the primary reason for assessment should be coded as a significant change in status. In the event of a significant change in status where there are also errors in a prior assessment already accepted into the State MDS database, the facility should also correct the assessment that was in error by completing and submitting a correction request for that erroneous assessment, in addition to completing a Significant Change in Status assessment.

***Assessment Management Tips:*** ***SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT***

| | **Assessment Reference Date (ARD)** | **7-day Observation Look Back** | **14- day Observation Look Back** | **RAPs Completion Date (VB2)** |
|---|---|---|---|---|
| **SIGNIFICANT CORRECTION OF A PRIOR FULL ASSESSMENT** | **No later than:**<br><br>14 days following determination that a major error in the prior full assessment has occurred | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | ARD + 14 days<br><br>**BUT**<br><br>**No later than:**<br><br>the end of the 14th calendar day following determination that a major error in the prior full assessment has occurred. |

- The Significant Correction of a Prior Full assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) and the RAPs Completion Date (VB2) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a major error in a prior full assessment has occurred overrides this.

- Once the ARD has been established, it is the last day of the observation period.

- Care Plan Completion Date (VB4) must be dated by the end of the 7th calendar day following RAPs Completion Date (VB2) (VB2 + 7 days) and can be no later than 21 days following the ARD.

- Electronic submission is due within 31 days following the Care Plan Completion Date (VB4) (VB4 + 31 days).

## ASSESSMENTS UPON READMISSION/RETURN

If a facility has formally discharged a resident without the expectation that the resident would return, but later the resident does return (AA8a = 6, Discharged-Return Not Anticipated), this situation is considered a **new admission**. When this occurs, a new Admission assessment, including Sections AB (Demographic Information) and AC (Customary Routine), must be completed within **14 days of admission**.

If a resident returns to a facility following a temporary absence for hospitalization or therapeutic leave, it is considered a **readmission**. Facilities should evaluate a resident upon readmission to determine if a significant change in the resident's condition has occurred. In these situations, follow the procedures for Significant Change in Status assessments. It is not necessary to complete Sections AB (Demographic Information) or AC (Customary Routine) of the MDS if this information has previously been collected and entered into the resident's record. If it is determined that a resident has not experienced a Significant Change in Status, the next OBRA assessment is completed within 92 days of the completion (R2b) of the last OBRA assessment prior to the resident leaving the facility.

## QUARTERLY ASSESSMENTS

Each State's RAI includes, at a minimum, CMS's required Quarterly assessment items. Not all MDS items appear on the Quarterly assessment form. However, states may add items from the core MDS on their Section S, and require completion of Sections T and/or U. If you are unsure of your State's Quarterly assessment requirements, check with your State RAI Coordinator (listed in Appendix B of the User's Manual) to determine what is required in your state.

The Quarterly assessment is used to track the resident's status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, three Quarterly assessments and one comprehensive assessment are required in each 12-month period. Federal requirement CFR 483.20(c) specifies that a Quarterly assessment must be conducted "not less frequently than once every three months." Timing edits in the MDS standard system count 92-day intervals because there are never more than 92 days in any consecutive three-month intervals. These 92 days are measured from the date at MDS Item R2b of one assessment to Item R2b of the next assessment.

The resident's status must be assessed for each of the key mandated items of the Quarterly assessment using the State-specified form. For information on State requirements, contact your State RAI Coordinator. In conducting Quarterly assessments, facilities must also assess any additional items required for use by the State. Based on the Quarterly assessment, the resident's care plan is revised if necessary. If a Significant Change in Status assessment was completed replacing the Quarterly, the next assessment that is required is a Quarterly assessment. The Quarterly must be completed within 92 days of Item R2b on the Significant Change in Status assessment. In other words, there can be no more than 92 days between the dates recorded at MDS Item R2b of the last to the next clinical assessment.

***Assessment Management Tips*: QUARTERLY ASSESSMENT**

| | Assessment Reference Date (ARD) | 7-day Observation Look Back | 14- day Observation Look Back | MDS Completion Date (R2b) |
|---|---|---|---|---|
| **QUARTERLY** | **No later than:**<br><br>R2b of previous OBRA assessment + 92 days | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | ARD + 14 days<br><br>**BUT**<br><br>**No later than:**<br><br>92 days from the R2b of previous OBRA assessment |

- When setting the ARD for the Quarterly assessment, the anticipated completion date of the assessment to be scheduled as well as the MDS Completion Date (R2b) of the previous OBRA assessment must be considered. The completion date of the Quarterly assessment must be within 92 days of the MDS Completion Date (R2b) of the last OBRA assessment.

- If, in the course of completing the Quarterly assessment, it is determined that a significant change in status has occurred, the comprehensive Significant Change assessment must be completed instead of the Quarterly. The next Quarterly assessment would be due no more than 92 days of the R2b date of the SCSA.

- The Quarterly assessment must be completed no later than 14 days after the ARD. That is, R2b can be no more than 14 days from the ARD (ARD + 14 days).

- Once the ARD has been established, it is the last day of the observation period.

- Electronic submission is due within 31 days following the MDS Completion Date (R2b) (R2b + 31 days).

## SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT

Significant Correction of a Prior Quarterly assessment is completed when an uncorrected major error is discovered in a Quarterly assessment. An error is major when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of a Prior Quarterly assessment is appropriate when an uncorrected major error is identified in a Quarterly assessment that has been accepted into the State MDS database, or in a Quarterly assessment that has been completed and is no longer in the editing and revision time

period (later than 7 days from R2b). This could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected. It is not necessary to complete a new Significant Correction of Prior Quarterly assessment if another, more current assessment is already due or in progress that contains and will correct the item(s) in error.

A Significant Correction of a Prior Quarterly assessment uses a new observation period (as defined by a new Assessment Reference Date). A Significant Correction of a Prior Quarterly assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, the facility should also correct the assessment that was in error by completing and submitting a correction request for the erroneous assessment, in addition to completing a new assessment, the Significant Correction of a Prior Quarterly assessment. Refer to Chapter 5 for details regarding the CMS correction process. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

***Assessment Management Tips*: *SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT***

| | **Assessment Reference Date (ARD)** | **7-day Observation Look Back** | **14- day Observation Look Back** | **MDS Completion Date (R2b)** |
|---|---|---|---|---|
| **SIGNIFICANT CORRECTION OF A PRIOR QUARTERLY ASSESSMENT** | **No later than:**<br><br>14 days following determination that a major error in the prior Quarterly assessment has occurred | Consists of ARD + 6 previous calendar days | Consists of ARD + 13 previous calendar days | ARD + 14 days<br><br>**BUT**<br><br>**No later than:**<br><br>the end of the 14th calendar day following determination that a major error in the prior Quarterly assessment has occurred. |

- The Significant Correction of a Prior Quarterly assessment must be completed no later than the ARD + 14 days. That is, the MDS Completion Date (R2b) can be no more than 14 days following the ARD. However, the requirement that the assessment be completed by the end of the 14th day following the determination that a significant error in a prior Quarterly assessment has occurred overrides this.

- Once the ARD has been established, it is the last day of the observation period.

## 2.3 RAPs and Care Plan Completion

After completing the MDS portion of the comprehensive assessment, the assessor(s) then proceed(s) to further identify and evaluate the resident's strengths, problems, and needs through use of the **Resident Assessment Protocol Guidelines (RAPs)** described in detail in Chapter 4 of this manual and through further investigation of any resident-specific issues not addressed in the RAI. For example, those items that are not automatically triggered, such as Item P4 (side rails), may require further investigation.

Completed along with the MDS, the RAPs provide the foundation upon which the care plan is formulated. There are 18 problem-oriented RAPs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review. Triggers and their definitions for each RAP appear in Appendix C. Also in Appendix C are the RAP Guidelines for additional assessment and review to determine if a care plan is appropriate to address the triggered condition.

***Assessment Management Tips*: *COMPREHENSIVE ASSESSMENTS REQUIRING RAPs***

| | **MDS Completion Date (R2b)** | **RAPs Completion Date (VB2)** |
|---|---|---|
| **COMPREHENSIVE ASSESSMENTS REQUIRING RAPs** | **Admission assessment:**<br>No later than Admission date + 13 days<br><br>**Annual assessment:**<br>ARD + 14 days, but no later than R2b of previous OBRA assessment + 92 days.<br><br>**Significant Change assessment:**<br>Date of determination + 14 days<br><br>**Significant Correction of a Prior Full Assessment:**<br>Date of determination of error + 14 days | **Admission assessment:**<br>No later than Admission date + 13 days<br><br>**Annual assessment:**<br>ARD + 14 days, but no later than VB2 of previous OBRA comprehensive assessment + 366 days.<br><br>**Significant Change assessment:**<br>Date of determination + 14 days<br><br>**Significant Correction of a Prior Full Assessment:**<br>Date of determination of error + 14 days |

- MDS Completion Date (R2b) must be earlier than or the same date as the RAPs Completion Date (VB2). In no event can either date be later than the established timeframes as described above.

## FORMULATION OF THE CARE PLAN

**For an Admission assessment,** the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically reviews these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, which form the basis for care plan development.

On day 1, facility staff also begins to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determines whether or not there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The MDS and RAPs provide the clinician with additional information to assist in this preliminary care planning process. The MDS ensures that staff has timely access to a wide range of assessment data. The RAPs provide criteria that trigger review of possible problem conditions to ensure that staff identifies problems in a consistent and systematic manner. Use of the RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission MDS is not completed until the last date possible (i.e., at the end of calendar day 14 of the residency period), interventions will already have been implemented to address priority problems. Many of the appropriate RAP problems will have been identified, causes will have been considered, and a preliminary care plan initiated. The final care plan is then required no later than 7 days after the RAI assessment is completed.

For triggered problems that have already resulted in a care plan intervention, the final RAP review will ensure that all causal factors have been considered. For RAP conditions for which facility staff has not yet initiated a care program, the RAP review will focus on whether or not these conditions are, in fact, problems that require facility intervention. For any triggered problem, staff will apply the RAP Guidelines to evaluate the resident's status and determine whether or not a situation exists that warrants care planning. If it does, the RAP Guidelines will next be used to help identify the factors that should be considered for developing the care plan.

For an Annual reassessment or a Significant Change in Status assessment, the process is basically the same as that described for newly admitted residents. In these cases, however, the care plan will already be in place, and staff is unlikely to be actively instituting a new approach to care as they simultaneously complete the MDS and RAPs. Here, review of the RAPs when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the RAP may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

***Clarification:*** ◆ The RAI was not designed to identify every conceivable problem that a resident might experience. An example of this is "chewing problem" at MDS Item K1a. Although the resident might have a chewing problem, checking this problem does not trigger a RAP. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. In ensuring that a resident's care plan is unique and specific to the resident, it is not sufficient to rely solely on the triggered RAPs. Another example of this is "side rails" at MDS Item P4. Although the resident may use side rails, this item does not automatically trigger a RAP.

## CARE PLAN COMPLETION

Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident's care plan. The RN coordinator should sign and date the RAP Summary form after all triggered RAPs have been reviewed to certify completion of the comprehensive assessment (RAPs Completion Date, VB1 and VB2). Facilities should use this date to determine the date by which the care plan must be completed.

The 7-day requirement for completion or modification of the care plan applies to the Admission, Significant Change in Status, Significant Correction of a Prior Full assessment, or Annual RAI assessment. A new care plan does not need to be developed after each SCSA, Significant Correction of a Prior Full assessment, or Annual reassessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each Quarterly assessment and modify the care plan if necessary. (See Chapter 4 for more information on care planning.)

***Clarification:*** ◆ The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving. The care plan is an interdisciplinary communication tool. Review 42 CFR 483.20(d), Comprehensive Care Plans. The comprehensive care plan 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 periodically reviewed and revised, and the services provided or arranged must be in accordance with each resident's written plan of care. Refer to the SOM Transmittal #274, (F Tag 279), "The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care."

***Assessment Management Tips*: CARE PLAN COMPLETION (VB4)**

| | MDS Completion Date (R2b) | RAPs Completion Date (VB2) | Care Plan Completion Date (VB4) |
|---|---|---|---|
| **COMPREHENSIVE ASSESSMENTS** | **Admission assessment:** No later than Admission date + 13 days<br><br>**Annual assessment:** ARD + 14 days, but no later than R2b of previous OBRA assessment + 92 days.<br><br>**Significant Change assessment:** Date of determination + 14 days<br><br>**Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days | **Admission assessment:** No later than Admission date + 13 days<br><br>**Annual assessment:** ARD + 14 days, but no later than VB2 of previous OBRA comprehensive assessment + 366 days.<br><br>**Significant Change assessment:** Date of determination + 14 days<br><br>**Significant Correction of a Prior Full Assessment:** Date of determination of error + 14 days | **Admission assessment:** VB2 + 7 days, no later than Admission date + 21 days<br><br>**Annual assessment:** VB2 + 7 days, no later than ARD + 21 days<br><br>**Significant Change assessment:** VB2 + 7 days, no later than ARD + 21 days<br><br>**Significant Correction of a Prior Full Assessment:** VB2 + 7 days, no later than ARD + 21 days |

- Care plan development or revision is to be completed with every comprehensive assessment.
- Care Plan Completion Date (VB4) is no later than 7 days following the completion of the RAPs (RAPs Completion Date, VB2).

The following chart provides a summary of the RAI Assessment Schedule.

# RAI ASSESSMENT SCHEDULE SUMMARY

| Record Type | Completion | Care Plan Completion (VB4) | Submit to State by No Later Than: |
|---|---|---|---|
| Admission | By VB2, no later than Day 14. | VB2 + 7 Days | VB4 + 31 Days |
| Annual Assessment | Completed within 366 days of most recent comprehensive assessment (VB2 to VB2). | VB2 + 7 Days | VB4 + 31 Days |
| Significant Change in Status | Must be completed by the end of the 14th calendar day following determination that a significant change has occurred. | VB2 + 7 Days | VB4 + 31 Days |
| Significant Correction of Prior Full Assessment | Must be completed within 14 days of identification of a major, uncorrected error in a prior comprehensive assessment. | VB2 + 7 Days | VB4 + 31 Days |
| Quarterly | R2b, no later than 14 days after the ARD, 92 days from R2b to R2b. | N/A | R2b + 31 Days |
| Significant Correction of Prior Quarterly Assessment | Must be completed within 14 days of the identification of a major, uncorrected error in a prior Quarterly assessment. | N/A | R2b + 31 Days |
| Discharge Tracking Form | Date of Event at R4 + 7 Days | N/A | R4 + 31Days |
| Reentry Tracking Form | Date of Event at A4a + 7 Days | N/A | A4a + 31 Days |
| Correction Request Form | Date at AT6, no later than 14 days after detecting an inaccuracy in an MDS record that has been accepted in State MDS database. | N/A | AT6 + 31 Days |

## 2.4 Tracking Documents: Discharge and Reentry for Nursing Facilities

With MDS Version 2.0, two new forms have been developed to track each resident's "whereabouts" in the health care system. The Discharge and Reentry Tracking forms provide key information to identify and track the movement of residents in and out of the facility.

**The Discharge Tracking form contains:**

- Section AA (Identification Information), Items 1 through 7,
- A subset of codes from Item AA8a, Primary Reason for Assessment, numbers 6, 7, or 8,
- AB1 (Date of Entry) and AB2 (Admitted From [at Entry]) completed if AA8a = 8,
- A6 (Medical Record Number),
- R3 (Discharge Status) and R4 (Discharge Date),
- Section W Supplemental Items.

**The Reentry Tracking form contains:**

- Section AA (Identification Information), Items 1 through 7,
- A single code from Item AA8a, Primary Reason for Assessment, number 9,
- A4a (Date of Reentry), A4b (Admitted From [at Reentry]) and A6 (Medical Record Number).

Some parts of the State specific Section S may be required with these tracking documents. The Discharge and Reentry documents can be found in Chapter 1. Contact your State RAI Coordinator for specific State requirements.

In some situations, Discharge and Reentry Tracking forms **<u>are not completed</u>**:

- When the resident leaves the facility on a temporary visit home, or on another type of therapeutic or social leave.

- When residents are in a hospital outpatient department for an observational stay of less than 24 hours and the resident is not admitted for acute care as an inpatient.

If the observational stay goes beyond 24 hours or if the resident is admitted for acute care, then a Discharge Tracking form must be completed within seven days. The discharge date entered at R4 would be the date that the resident actually left the facility, not the date he was admitted to the hospital.

The clinician must clearly understand the differences between the three types of discharge in order to correctly select the appropriate response at AA8a. They are:

- Discharged-return not anticipated (Reason for Assessment AA8a = 6)
- Discharged-return anticipated (Reason for Assessment AA8a = 7)
- Discharged prior to completing initial assessment (Reason for Assessment AA8a = 8)

A **Discharge-return not anticipated** (AA8a = 6) is completed when it is determined that the resident is being discharged with no expectation of return after a comprehensive Admission assessment has been completed. A discharge with return not anticipated can be a formal discharge to home, to another facility, or when the resident dies. If the resident is formally discharged from the facility and returns at a later date, this will be a new admission and requires a new Date of Entry (AB1). The MDS assessment schedule will start over with a new comprehensive Admission assessment. If the resident will receive Medicare Part A services, then the Medicare 5-Day assessment would be completed and the Medicare assessment schedule would continue.

A **Discharge-return anticipated** (AA8a = 7) reports a more temporary absence from the facility after the Admission assessment is completed, when it is anticipated that the resident will return for continued nursing facility services. If a resident is temporarily admitted for acute care in the hospital, or a hospital observation stay lasts more than 24 hours, but the resident is expected to return to the nursing facility, the Discharge Tracking form would be coded as a discharge with return anticipated. When the resident returns to the facility, a Reentry Tracking form must be completed to report the return of the resident.

In some situations, a resident may be discharged with a return anticipated and later the facility learns that he/she will not be returning or has died. In this situation, another Discharge Tracking form (return not anticipated) is not necessary unless the State requires this second discharge document. Please contact your State RAI Coordinator for clarification if your state requires this additional Discharge Tracking form.

The **Discharged-prior to completion of the initial assessment** (AA8a = 8) is indicated when a resident is admitted to the facility and the Admission assessment is not completed before the resident is discharged. This reason for assessment should be selected whether or not the resident is expected to return, e.g., from an admission to the hospital, or is not expected to return, e.g., the resident dies in the nursing facility. If the Admission assessment had not been completed, the only discharge that may be selected is AA8a = 8.

If the resident is unstable and has several return visits to the hospital before the Admission assessment is completed, the facility should continue to submit discharges prior to completion of the initial assessment (AA8a = 8) until the resident is in the facility long enough to complete the comprehensive Admission assessment. The same date of entry (AB1) should be used for all these discharges.

In some situations, the resident may be admitted to the skilled nursing unit and a 5-Day Medicare assessment was completed before the resident was admitted to the hospital. If an MDS full assessment or a Medicare Prospective Payment Assessment Form (MPAF) was used, it is not a comprehensive assessment (AA8a = 0 (None of the Above)).

If the resident is admitted to the hospital or the observational stay is longer than 24 hours, a Discharge Tracking form should be completed with the reason for assessment being discharged prior to completing the Admission assessment (AA8a = 8). If the resident returns to the facility, a Reentry Tracking form (see below) is not required, but an Admission assessment (AA8a = 1) must be completed.

A **Reentry** Tracking form (AA8a = 9) is only required if the resident returns to the facility after being discharged – return anticipated (AA8a = 7). If the resident returns after being discharged prior to completing the initial assessment (AA8a = 8), the date of reentry is recorded on the comprehensive Admission assessment at A4a, Date of reentry.

If a resident is in the hospital for a short stay and returns to the facility, the facility can either complete the initial comprehensive admission assessment that was started or start another admission assessment. Any incomplete MDS documents should be saved in the resident's clinical record.

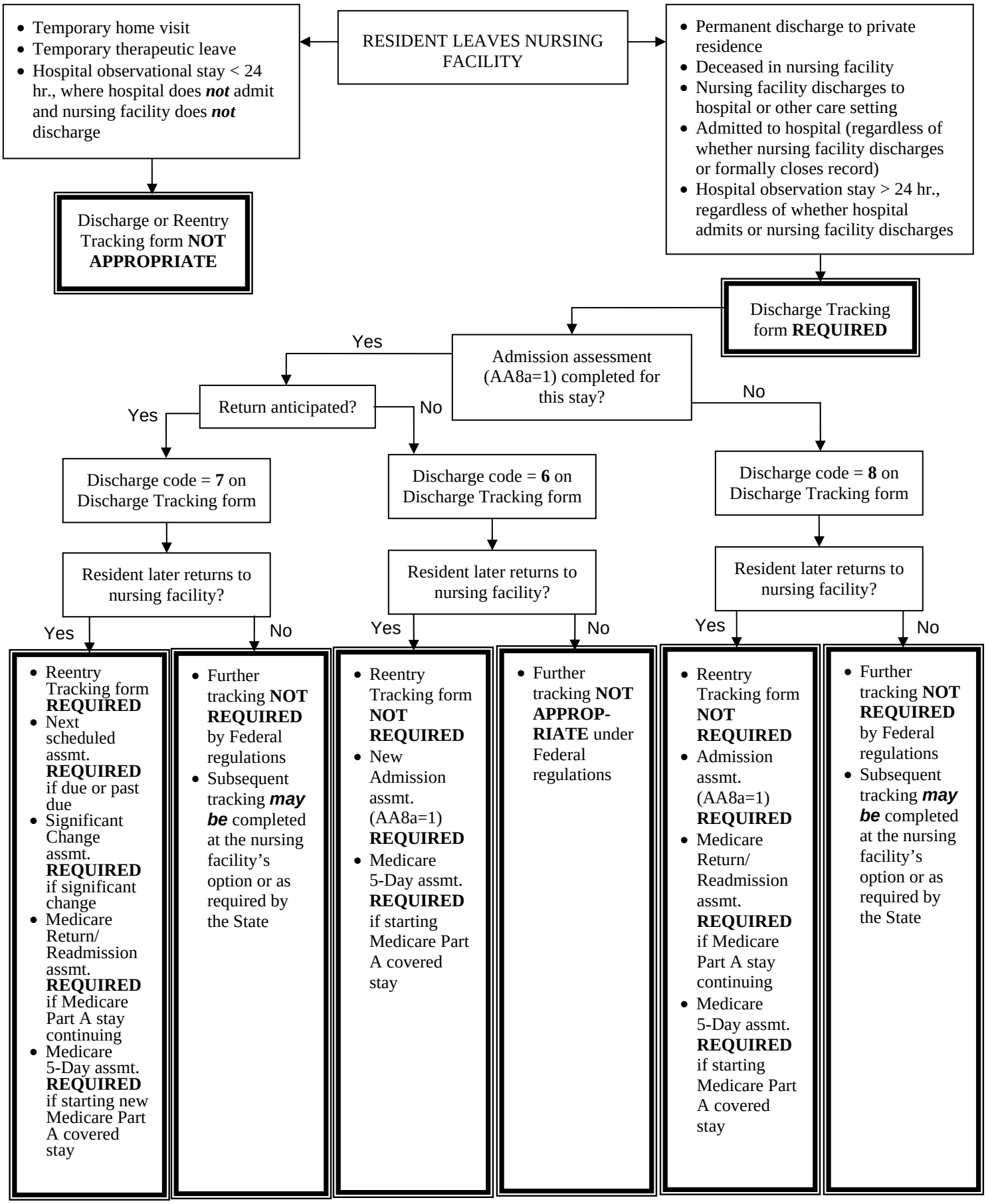
***Clarification:***

- The requirements for completion of a Discharge Tracking form are not associated with bedhold status. A Discharge Tracking form is required whenever a resident is discharged, regardless of bedhold status. If the bed is being held, it logically follows that return is anticipated, and Item AA8a on the Discharge Tracking form is coded "7" (return anticipated).

  **NOTE:** The above response assumes that a comprehensive Admission assessment had been completed.

The following chart details the facility's requirement for completion of Discharge and Reentry Tracking forms.

# MDS 2.0 DISCHARGE AND REENTRY FLOWCHART



## 2.5 The SNF Medicare Prospective Payment System Assessment Schedule

Nursing facilities will assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care. The MDS must be completed in compliance with the Medicare schedule as shown in the chart below.

| Medicare MDS Assessment Type | Reason for Assessment (AA8b code) | Assessment Reference Date | Assessment Reference Date Grace Days+ | Number of Days Authorized for Coverage and Payment | Applicable Medicare Payment Days |
|---|---|---|---|---|---|
| 5 Day | 1 | Days 1-5* | 6 - 8 | 14 | 1 through 14 |
| 14 Day | 7 | Days 11-14 | 15 - 19 | 16 | 15 through 30 |
| 30 Day | 2 | Days 21-29 | 30 - 34 | 30 | 31 through 60 |
| 60 Day | 3 | Days 50-59 | 60 - 64 | 30 | 61 through 90 |
| 90 Day | 4 | Days 80-89 | 90 - 94 | 10 | 91 through 100 |

*If a resident expires or transfers to another facility before the 5-Day assessment has been completed, the facility will still need to prepare an MDS as completely as possible for the RUG-III Classification and Medicare payment purposes. Otherwise, the days will be paid at the default rate. The Assessment Reference Date must also be adjusted to no later than the date of discharge.

+Grace Days: A specific number of grace days (i.e., days that can be added to the Medicare assessment schedule without penalty) are allowed for setting the Assessment Reference Date (ARD) for each scheduled Medicare assessment.

The Medicare assessment schedule includes a 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessment. The first day of Medicare Part A coverage is considered Day 1. In most cases, the first day of Medicare Part A eligibility is also the date of admission. However, there are situations where the Medicare beneficiary may only become eligible for Part A services at a later date. See Section 2.9 for more detailed information.

Assessments must also be completed whenever there is a significant change in clinical status or when all therapies are discontinued for a beneficiary who is classified in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group, and that beneficiary continues to require skilled services.

A Readmission/Return assessment must be completed when a beneficiary who was receiving Part A SNF-level services is hospitalized and returns to the SNF and continues to receive Part A SNF-level services.

Assessments performed solely for Medicare payment purposes must be completed within 14 days of the Assessment Reference Date (ARD). The Assessment Reference Date establishes a common reference end-point for all items. The Assessment Reference Date is described in detail in Chapter 3. Nursing facility staff should make every effort to complete assessments in a timely

manner. Each of the Medicare scheduled assessments has defined days when the Assessment Reference Date may be set. For example, for the Medicare 5-Day assessment, days one through five have been defined as the optimal days for setting the Assessment Reference Date. However, there may be situations when an assessment might be delayed and CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. The Medicare 5-Day Assessment Reference Date can be extended one to three grace days.

Grace days can be added to the Assessment Reference Date in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting ARDs, and should be used sparingly. If a facility chooses to routinely use grace days, it may be subject to review through the survey process, by the fiscal intermediary, or by the Data Assessment and Verification (DAVE) contractor.

A Medicare assessment is considered complete on the day that the registered nurse (RN) coordinating the assessment signs and dates the assessment (MDS Completion Date, R2b). Each MDS record must be encoded and edited at the nursing facility. The MDS records must then be submitted electronically to the State MDS database and will be considered timely if transmitted and accepted into the database within 31 days of completion.

The following chart summarizes the Medicare MDS Assessment Schedule for skilled nursing facilities.

# MEDICARE MDS ASSESSMENT SCHEDULE FOR SNFs

| Codes for Assessments Required for Medicare | Assessment Reference Date (ARD) Can be set on any of following days | GRACE PERIOD DAYS ARD can also be set on these days | BILLING CYCLE Used by the business office | SPECIAL COMMENT |
|---|---|---|---|---|
| 5 DAY<br>AA8b = 1<br>AND<br>Readmission/ Return<br>AA8b = 5 | Days 1-5 | 6-8 | Set payment rate for Days 1-14 | • If a resident transfers or expires before the Medicare 5-Day assessment is finished, prepare an MDS as completely as possible for the RUG Classification and proper Medicare payment, or bill at the default rate.<br>• RAPS must be completed only if the Medicare 5-Day assessment is dually-coded as an Admission assessment or SCSA. |
| 14 Day<br>AA8b = 7 | Days 11-14 | 15-19 | Set payment rate for Days 15-30 | • RAPs must be completed only if the 14-Day assessment was dually coded as an Admission or Significant Change in Status assessment.<br>• Grace period days do not apply when RAPs are required on a dually coded assessment, e.g., Admission assessment. |
| 30 Day<br>AA8b = 2 | Days 21-29 | 30-34 | Set payment rate for Days 31-60 | |
| 60 Day<br>AA8b = 3 | Days 50-59 | 60-64 | Set payment rate for Days 61-90 | |
| 90 Day<br>AA8b = 4 | Days 80-89 | 90-94 | Set payment rate for Days 91-100 | • Be careful when using grace days for a Medicare 90-Day assessment. The completion date of the Quarterly (R2b) must be no more than 92 days after the R2b of the prior OBRA assessment. |
| Other Medicare Required Assessment (OMRA) | • 8 - 10 days after all therapy (PT, OT, ST) services are discontinued and resident continues to require skilled care.<br>• The first non-therapy day counts as day 1. | N/A | Set payment rate effective with the ARD | • Not required if the resident has been determined to no longer meet Medicare skilled level of care.<br>• Establishes a new non-therapy RUG Classification.<br>• Not required if the resident is dis-charged from Medicare prior to day 8.<br>• Not required if not previously in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation group |
| Significant Change in Status Assessment (SCSA) | Completed by the end of the 14th calendar day following determination that a significant change has occurred. | N/A | Set payment rate effective with the ARD | • Could establish a new RUG Classification and remains effective until the next assessment is completed. |

***NOTE:** Significant Correction assessments are not required for Medicare assessments that have not been combined with an OBRA assessment. See Chapter 5 for detailed instructions on the correction process.

## 2.6 Types of MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment in Items AA8a and A8a. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item AA8b and A8b. The Medicare and State reasons for assessment are described in this section. In many cases, assessments are combined to meet both OBRA and Medicare requirements. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Section 2.8.

**Codes for Assessments Required for Medicare or in States When Required** - It is possible to select a code for the MDS from both AA8a and AA8b (e.g., Item AA8a coded "3" (Significant Change in Status assessment), and Item AA8b coded "3" (60-Day assessment).

1. **Medicare 5-Day Assessment** - The first Medicare assessment completed upon admission to the nursing facility for Part A SNF-level services. The 5-Day Medicare assessment must have an ARD (Item A3a) established between days 1-5 of the SNF stay. The ARD (Item A3a) can be extended to day 8 if using the designated "Grace Days." The 5-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 14-day calculation is based on calendar days and includes weekends. The 5-Day assessment authorizes payment from days 1 through 14 of the stay, as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission.

2. **Medicare 30-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 21-29 of the SNF stay. The ARD (Item A3a) can be extended to day 34 if using the designated "Grace Days." The 30-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 30-Day assessment authorizes payment from days 31 through 60 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

3. **Medicare 60-Day assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 50-59 of the SNF stay or as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 64 if using the designated "Grace Days." The 60-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 60-Day assessment authorizes payment from days 61 through 90 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

4. **Medicare 90-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 80-89 of the SNF stay. The ARD (Item A3a) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (Item R2b) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). (NOTE: When combined with an OBRA Quarterly assessment, see Section 2.2).

5. **Medicare Readmission/Return Assessment** - Medicare assessment that is completed when a resident whose stay was being reimbursed by Medicare Part A was hospitalized, discharged, and later readmitted to the SNF from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (Item A3a) established between days 1-8 of the return. The Readmission/Return assessment must be completed (Item R2b) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b).

6. **Other State-Required Assessment – This assessment is not used for Medicare purposes.** In some cases, States have established assessment requirements in addition to the OBRA and Medicare assessments. Contact your RAI Coordinator for State specific requirements.

7. **Medicare 14-Day Assessment** - Medicare assessment that must have an ARD (Item A3a) established between days 11-14 of the SNF stay or as long as the resident remains eligible for Part A SNF-level services. The ARD (Item A3a) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (Item R2b) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, or as long as the resident remains eligible for Part A SNF-level services. The MDS records must be submitted electronically to the State MDS database and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If combined with the Admission assessment, then the assessment must be completed at VB2 by day 14 of admission. (NOTE: When combined with an OBRA Admission assessment, see instructions in Sections 2.2 and 2.8.)

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8. **Other Medicare-Required Assessment** - The OMRA is completed only if the resident was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG-III group and Medicare payment rate. The MDS records must be submitted electronically, and will be considered timely if submitted and accepted into the database within 31 days of completion (Item R2b). If the OMRA falls in the assessment window of a regularly schedule Medicare assessment, code the assessment as an OMRA to affect the change in payment status.

## 2.7 The Medicare Prospective Payment System Assessment Form (MPAF)

Effective July 1, 2002, skilled nursing facilities may choose to complete and submit a shorter version of the MDS called the Medicare Prospective Payment System Assessment Form (MPAF), rather than a full Minimum Data Set (MDS) assessment for Medicare assessments. The MPAF provides facilities with options concerning the forms used for Medicare assessments. The MPAF consists of a subset of the MDS items that includes:

- Items for resident identification,
- Items necessary to complete the Resource Utilization Group-III calculation, and
- Items needed to calculate the Quality Indicators (QIs).

Although the MPAF has fewer items than the full MDS, the included item-by-item definitions and coding instructions are identical. The item-by-item information is not repeated in this section. Refer to the item-by-item definitions in Chapter 3. A copy of the MPAF form is in Chapter 1.

The MPAF was implemented effective July 1, 2002. Skilled nursing facilities have the option of using the MPAF rather than the full MDS assessment when performing many of the required Medicare assessments. Use of the MPAF is completely optional. If a facility continues to submit a full MDS assessment for Medicare, the extra MDS items (those not on the MPAF) will be ignored and will not be edited or stored in the State MDS database. No errors or warnings will occur because a full assessment is submitted for Medicare. NOTE: Facilities should work with their software vendors to update their systems to include the MPAF option.

When assessments are completed for both OBRA reasons and Medicare, all OBRA-required items, all Medicare-required items, and any State-specific items (Section S) must be submitted, with all required items being stored in the State MDS database. When assessments are Medicare (no OBRA reason present), only the MPAF items and any State-specific items (Section S) will be active and stored in the State MDS database.

The MPAF optional form cannot be used for a Significant Change in Status Assessment or Significant Correction of a Prior Full assessment. These are comprehensive assessments and require the full MDS, RAPs, and care planning. However, the MPAF can be used for an OMRA when it is not combined with any other comprehensive assessment.

The State may not require additional MDS items on Medicare assessments. However, the State may require State-specific items in Section S on all MDS records, including Medicare assessments. If Section S is required on Medicare assessments, then the Section S items must be submitted. CMS has approved the MPAF for use as a Quarterly assessment. A state may adopt the MPAF form as the State-specified Quarterly assessment by sending written notification to CMS.

The following are the form requirements and assessment options for different types of MDS records including the MPAF.

***Scenarios 1-3 are situations when the MPAF may be used.**

## *Scenario 1*

### The Clinician is Completing a Medicare Assessment

Reason for Assessment:
AA8a = 00 None of the Above
AA8b =1 Medicare 5 day assessment
2 Medicare 30 day assessments
3 Medicare 60 day assessments
4 Medicare 90 day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 day assessments
8 Other Medicare required assessment

**Full Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

**MPAF Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

## *Scenario 2*

### The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Uses a RUG-III Quarterly as the State-Specified Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b = 1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

**Full Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

**MPAF Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

*Scenario 3*

The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Uses a Minimum Quarterly as the State-Specified Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

**Full Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

**MPAF Assessment Option**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. The exception is that AB5a through AB5f (items included on the MPAF form) can be submitted alone (without other face sheet items).
- MPAF form is required.
- Section S can be required by State.

***Scenarios 4-6 are situations when the MPAF may not be used.**

*Scenario 4*

The Clinician is Completing a Medicare Assessment Combined with an OBRA Admission Assessment

Reason for Assessment:
AA8a = 01 Admission assessment (required by day 14)
AA8b =1 Medicare 5 Day assessment
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

**Full Assessment Required for All OBRA Admission Assessments**

- Assessment tracking form (Section AA) is required.
- Background (face sheet) form is required.
- Full MDS assessment form is required.
- RAP Summary form (Section V) is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by the State.

*Scenario 5*

The Clinician is Completing a Medicare Assessment Combined with an OBRA Comprehensive Assessment Other Than an Admission

Reason for Assessment:
AA8a = 02 Annual assessment
03 Significant Change in Status assessment
04 Significant Correction of Prior Full assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

**Full Assessment Required for All OBRA Comprehensive Assessments**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

*Scenario 6*

The Clinician is Completing a Medicare Assessment Combined with an OBRA Quarterly Assessment **In a State That Requires a Full MDS Assessment**

Reason for Assessment:
AA8a = 05 Quarterly review assessment
10 Significant Correction of Prior Quarterly assessment
AA8b =1 Medicare 5 Day assessment
2 Medicare 30 Day assessments
3 Medicare 60 Day assessments
4 Medicare 90 Day assessments
5 Medicare Readmission/Return assessments
7 Medicare 14 Day assessments
8 Other Medicare-required assessment

**Full Quarterly Assessment Required by the State**

- Assessment tracking form (Section AA) is required.
- All background (face sheet) items in Sections AB and AC are optional in all-or-none-fashion, with one exception. That exception is that AB5a through AB5f (items included on the MPAF form) can be optionally submitted alone (without other face sheet items).
- Full MDS assessment form is required.
- Medicare therapy supplement form (Section T) is required.
- Section S can be required by State.

## 2.8 Combining the RAI OBRA Schedule with the Medicare Schedule for SNFs

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

- The OBRA standards, requiring comprehensive assessments on admission, annually, when a significant change in status occurs or when a Significant Correction of a Prior Full assessment is required. Quarterly assessments are also required on the form designated by the State. These assessments are designated by the reason selected in AA8a, Primary Reason for Assessment.

- The Medicare standards, requiring assessments for payment for a resident in a Medicare Part A stay at 5-day, 14-day, 30-day, 60-day and 90-day time frames. An OMRA assessment must also be completed when a resident who was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification, had all therapies discontinued, and continues a Part A stay due to other skilled needs. These assessments are designated by the reason selected in AA8b, codes for assessments required for Medicare or the State. If the assessment is completed only for Medicare (AA8a = 00), then either the full MDS or MPAF form can be used.

When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. When combining the OBRA and Medicare assessments, the most stringent requirement for MDS completion must be met. For example, an Admission assessment, including RAPs, must be completed within the first 14 days of the resident's stay. The requirements for Medicare specify that facilities must complete two assessments for each resident in a Medicare covered Part A stay – a 5-Day and a 14-Day.

There is no need to complete three separate assessments: the Admission assessment may be combined with either the 5-Day (AA8a = 01, AA8b = 1) or the 14-Day (AA8a = 01, AA8b = 7). However, the Admission assessment would have to be a comprehensive assessment with RAPs, not the shorter form that may be completed for Medicare assessments. The other assessment completed in the 14-day period solely for Medicare would be done using either the full MDS or the optional MPAF form (AA8a = 00, AA8b = 1 or 7 as applicable).

The nursing facility must be very careful in selecting the ARD for an Admission assessment combined with a 14-Day Medicare assessment. For the admission standard, the ARD must be set between Days 1 to 14. For Medicare, the ARD must be set between Days 11 and 14, but the regulation allows grace days up to Day 19. However, when combining a 14-Day Medicare assessment with the Admission assessment, grace days are not allowed. To assure, in this situation, that the assessment meets both standards, an ARD between Days 11 and 14 would have to be chosen.

Any OBRA assessment and any Medicare assessment may be combined in this way as long as the ARD and completion date (R2b or VB2) meet both requirements, and the most stringent completion timeframe requirement is met. For example, often the Quarterly assessment and the 90-Day Medicare assessment are due in the same time period. The facility must assure that the completion date (R2b) will occur within 92 days of the R2b of the previous comprehensive or Quarterly

assessment. The ARD must also be set within the proper window for the Medicare requirement. Then the facility must decide which form to complete.

- If the State requires only a two page or RUG-III Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, either a full MDS or MPAF would be completed. The full MDS or MPAF is the more extensive MDS form; the most stringent requirement must be met.

- If the State requires a full assessment for a Quarterly, for an assessment designated as AA8a = 05 and AA8b = 4, a full MDS form must be completed. It is the more extensive MDS form; the most stringent requirement must be met.

NOTE: It is extremely important to understand the MDS requirements established in your state. Your decision to use the MPAF may be dependent upon your State Medicaid agency's MDS assessment requirements and the State-designated Quarterly assessment.

For a resident who was already in the nursing facility but is now beginning a new Medicare Part A stay, it might be appropriate to combine a Quarterly with a Medicare 5-Day, depending on the resident's status.

A Significant Change in Status assessment might be combined with any Medicare assessment including an OMRA, presuming that the ARD is within the assigned Medicare assessment window and the assessment is completed within 14 days of the identification of the change. At all times, when the nursing facility chooses to complete one assessment to meet both an OBRA and a Medicare requirement, staff must carefully review the standards for each assessment to assure that the most stringent requirement is met.

## 2.9 Factors Impacting the SNF Medicare Assessment Schedule

**Resident Expires or Transfers**

If a beneficiary expires or transfers to another facility before the 5-Day assessment is completed, the nursing facility prepares a Medicare assessment as completely as possible to obtain the RUG-III Classification so the provider can bill for the appropriate days. If the Medicare assessment is not completed then the nursing facility provider will have to bill at the default rate.

**Resident Discharges to Hospital Prior to the Admission Assessment Completion**

Since the Admission assessment was not completed, the facility must complete a Discharge Tracking form with a reason for assessment A8a = 8, discharged prior to completion of admission assessment. In most cases, the facility will have completed a 5-Day Medicare assessment covering the period from the date of admission to the earlier of the Assessment Reference Date (which can be assigned up through day 8 of the Part A stay) or the actual date of discharge. This Medicare assessment will be needed to bill for Part A days.

When the beneficiary returns, the facility completes the Admission (OBRA) assessment by continuing the assessment started prior to the hospital stay (and completing it within 14 days of the initial date of admission) or completes a new assessment within 14 days of the reentry date. In addition, the facility must complete a Medicare Readmission/Return assessment coded AA8b = 5. Generally the Admission assessment can be combined with either the Medicare Readmission/Return assessment or the Medicare 14-Day assessment.

**Resident is Admitted to an Acute Care Facility and Returns**

If a Medicare resident is admitted to an acute care facility and later returns to the SNF, the Medicare assessment schedule is restarted with the Medicare Readmission/Return assessment followed by the 14-Day, 30-Day, etc. A Discharge Tracking form, return anticipated and a Reentry Tracking form, would precede this.

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted, the Medicare assessment schedule is not restarted. However, there are payment implications, since the day preceding the midnight on which the resident was absent from the facility is not a covered Part A day. This is known as the "midnight rule." The Medicare schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment "clock" is adjusted by skipping that day in calculating when the next Medicare assessment is due.

**Resident Leaves the Facility and Returns During the Middle of an ARD Period**

The ARD is not altered if the beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines - see Chapter 3) but may not extend the observation period.

**Resident Discharged from Skilled Services and Returns to SNF-Level Services**

The beneficiary is discharged from Medicare Part A services but remains in the facility in a certified bed with another pay source. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. When the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day assessment, MDS Item AA8b = 1.

The original date of entry (AB1) is retained. The beneficiary should be assessed to determine if there was a significant change in status. An SCSA could be completed with either the Medicare 5-Day or 14-Day assessment.

**Resident in a Part A Stay Begins Therapy**

Adding therapy services to the treatments furnished to a beneficiary in a Part A stay does not automatically require a new assessment. However, if the therapy was added because the beneficiary experienced a significant change, an SCSA must be completed. In this case, the primary reason for assessment would be a SCSA (A8a = 3). If the SCSA is done during a Medicare assessment

window, the SCSA can be combined with a regularly scheduled Medicare assessment. If the SCSA is not within a Medicare assessment window, the Medicare reason for assessment should be coded as AA8a = 3 and AA8b = 8, Other Medicare Required assessment.

## Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the nursing facility provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of a physician hold could occur when a resident is admitted to the nursing facility for rehabilitation services but is not ready for weight-bearing exercises. The physician will write an order to start therapy when the resident is able to do weight bearing. Once the resident is able to start the therapy, the Medicare Part A stay begins, and the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the resident is able to start therapy services.

## Combining Assessments

Significant Change in Status Assessment (SCSA) or the Other Medicare Required Assessment (OMRA) may be combined with the regularly scheduled Medicare assessments. If the Medicare assessment window coincides with the SCSA assessment, a single assessment may be coded as both a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and an SCSA. If the Assessment Reference Date of an OMRA coincides with a regularly scheduled Medicare assessment, it is coded only as the OMRA. For billing purposes, it is identified as an OMRA replacing a 14-Day, 30-Day, 60-Day or 90-Day.

Currently there is no way to code that a SCSA performed outside the assessment window is a Medicare assessment. Until this problem can be corrected, code AA8a = 3 to show the SCSA and AA8b = 8 to indicate that the record is a Medicare assessment. This procedure is an exception to the rule that OMRAs are performed only to show discontinuation of therapy for residents in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification. In some circumstances, an SCSA can be used as an OMRA and a scheduled Medicare assessment.

## Non-Compliance with the Assessment Schedule

According to the Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate. Frequent early or late assessment scheduling practices may result in onsite review.

## Early Assessment

An assessment should be completed according to the designated Medicare assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

## Default Rate

MDS assessments are completed according to an assessment schedule specifically designed for Medicare payment, and each assessment applies to specific days within a resident's SNF stay to determine the appropriate reimbursement for the resident. Compliance with this assessment schedule is critical to ensure that the appropriate level of payment is established. Accordingly, SNFs that fail to perform assessments timely are to be paid a RUG-III default rate for the days of a resident's care for which they are not in compliance with this schedule. The RUG-III default rate takes the place of the otherwise applicable Federal rate. The RUG-III default rate is equal to the rate paid for the RUG-III group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

## Late or Missed Assessment Criteria

A late or missed assessment may be completed as long as the window for the allowable ARD (including grace days) has not passed. If a late/missed assessment has an ARD within the allowable grace period, no financial penalty is assessed. If the assessment has an ARD after the mandated grace period, payment will be made at the default rate for covered services from the first day of the coverage period to the ARD of the late assessment. A late assessment cannot replace the next regularly scheduled assessment. Therefore, if the ARD of the 14-Day assessment was day 22, it cannot be used as both the Medicare 14-Day and Medicare 30-Day assessments.

In this situation, the late 14-Day assessment would be used to support payment for days 22-30 of the Part A stay. A new 30-Day assessment would need to be completed within the assessment window for the Medicare 30-Day assessment.

## Errors on a Medicare Assessment

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

- **Modification:** This procedure should be used if any of the item responses were incorrect, e.g., Medicare number, number of therapy minutes, etc.
- **Inactivation:** This procedure should be used if the assessment itself was invalid, e.g., the Reason for Assessment for Medicare (AA8b) was incorrect. This might be an assessment completed to meet the 30-Day assessment requirement, but incorrectly submitted as a 60-Day assessment. The assessment should be resubmitted with the corrected reason for assessment.

A Significant Correction assessment is not done when the assessment in error has been completed to meet the Medicare schedule only. However, if the assessment had been completed to meet an OBRA requirement, as well as the Medicare schedule, normal MDS correction procedures might require the completion of a Significant Change in Status assessment or a Significant Correction assessment, depending on the type of errors identified. Payment will be based on the new Assessment Reference Date if appropriate. Correction procedures are explained in detail in Chapter 5.

# CHAPTER 3: ITEM-BY-ITEM GUIDE TO THE MDS

## 3.1 Overview to the Item-by-Item Guide to MDS

This Chapter is to be used in conjunction with Version 2.0 of the MDS assessment. Also included in this chapter are the instructions for the supplemental items in MDS Sections S, T, and U. Contact your State RAI Coordinator regarding your State's requirements for Sections S, T, and U, as well as for any additional State-mandated MDS assessment requirements.

**This chapter provides information to facilitate an accurate and uniform resident assessment. Item-by-item instructions focus on:**

- The intent of items included on the MDS.
- Supplemental definitions, instructions and clarifications for completing MDS items.
- Reminders of which MDS items require observation of the resident for other than the standard 7-day observation period.
- Sources of information to be consulted in completing specific MDS items.

### Using This Chapter

**Use this chapter alongside the MDS Version 2.0 data collection form keeping the form in front of you at all times.** The amplifying information in this chapter should facilitate successful use of the MDS. The items from the MDS are presented in a sequential basis in this chapter. Where items are presented on a form other than the full MDS assessment form, this fact is noted in the text.

***The chart that follows summarizes the recommended approach to assist you in becoming familiar with MDS Version 2.0. The initial time investment in this multi-step review process will have a major payback.***

## Recommended Approach for Becoming Familiar with the MDS

**(A) First, review the MDS form itself.**

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Complete the MDS assessment for a resident at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS. Where your review could benefit from additional information, make note of that fact. ***Where might you acquire additional information?***

**(B) Complete an initial review of this chapter.**

- Review procedural instructions, time frames, and general coding conventions.
- Review clarifications, since they provide important information and context in response to questions from other MDS RAI Manual users.
- ***Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?***
- As you read this chapter, clarify questions that arose as you used the MDS for the first time to assess a resident. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- ***Once again, read the instructions that apply to a single section of the MDS. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same? It will take time to go through all this material. Do it slowly, carefully, without rushing. Work through the Manual MDS form one section at a time.***
- *Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?*
- *Would you now complete your initial case differently?*
- *Are there definitions or instructions that differ from current practice patterns in your facility? If so, discuss with your MDS coordinator or Director of Nursing to make sure that facility practices comply with the MDS requirements.*

**(continued on next page)**

## Recommended Approach for Becoming Familiar with the MDS
**(continued)**

- Make notations next to any section(s) of this Manual you have questions about. Be prepared to discuss these issues during any formal training program you attend, or contact your State RAI Coordinator (see Appendix B).

**(C)** **In a second review of this chapter, focus on issues that seemed to you to be more difficult, problematic, or unfamiliar during the first pass.** Make notes on the MDS of issues that warrant attention.

**(D)** **The third chapter review may occur during the formal MDS training program at your facility.** It will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

**(E)** **Future use of information in this chapter:**

- Keep this chapter at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- This Manual is the primary source of information for completing an assessment. Use it to increase the accuracy of your assessments.
- Check the MDS 2.0 web site regularly for updates at:
  **http://cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp**

## Standard Format Used in This Chapter

To facilitate completion of Version 2.0 of the MDS assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many **(but not all)** items:

***Intent:*** Reason(s) for including the item (or set of items) in the MDS, including discussions of how the information will be used by clinical staff to identify resident problems and develop the plan of care.

***Definition:*** Explanation of key terms.

***Process:*** Sources of information and methods for determining the correct response for an item. Sources include:

- Discussion with facility staff - licensed and non-licensed staff members
- Resident interview and observation
- Clinical records, facility records, transmittal records (at admission) - physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g., vital signs, weights, intake and output), care plans, and any similar documents in the facility record system
- Discussion with the resident's family
- Attending physician.

***Coding:*** Proper method of recording each response, with explanations of individual response categories.

***Clarifications:*** ◆ Clarifications for MDS items provided by CMS. These clarifications apply to the MDS.

## 3.2 Coding Conventions

The coding conventions to be used when preparing the MDS are as follows:

- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences - boxes a. - m.).

- Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)

- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

**The convention of entering "0":** In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded "0" is a self-sufficient resident; the resident whose ADLs have no "0" codes indicates a resident that receives help from others.

- **When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.**

- **Dates** - Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2002 is recorded as:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 1 | 0 | 3 | 2 | 0 | 0 | 2 |
| Month | | Day | | Year | | | |

- **The standard no-information code is a "dash" (-).** This code indicates that all available sources of information have been exhausted; that is the information is not available, and despite exhaustive probing, it remains unavailable. The no-information code entered on the form manually or electronically may be any of the alternatives: circled dash, "NA", or plain dash.

- **NONE OF ABOVE** is a response item to several items (e.g., MDS Item I2, Infections, box "m"). **Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If "None of Above" is not present and none of the items apply, e.g., H2 Bowel Elimination on MPAF), simply leave all boxes blank.**

- **"Skip" Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to "skip" over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to "skip" to Section G. if B1 is answered "1" - "yes". **The intervening items from B2 - F3 would not be coded.** If B1 were recorded as "0" - "no", then the assessor would continue with Item B2.).

  A useful technique for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" instructions before going to the next appropriate item.

**This page revised—August 2003**

**The "8" code is for use in MDS Section G., Physical Functioning and Structural Problems only.** The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period of observation. When the "8" code is entered for self-performance, it should also be entered for support

## 3.3 Section AA. Identification Information for MDS

### AA1. Resident Name

***Definition:*** Legal name in record.

***Coding:*** Use printed letters. Enter in the following order:

**a.** First Name
**b.** Middle Initial; if the resident has no middle initial, leave Item 1b blank,
**c.** Last Name, and
**d.** Jr./Sr.

### AA2. Gender

***Coding:*** Enter "**1**" for Male or "**2**" for Female.

### AA3. Birthdate

***Coding:*** Fill in the boxes with the appropriate birthdate. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:

| 0 | 1 | | 0 | 2 | | 1 | 9 | 1 | 8 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

### AA4. Race/Ethnicity

***Process:*** Enter the race or ethnic category the resident uses to identify him or herself. Consult the resident, as necessary. For example, if parents are of two different races, consult with resident to determine how he or she wishes to be classified.

***Coding:*** Choose only one answer.

***Clarification:***

- Item AA4 uses the race/ethnicity categories mandated by the Executive Office of Management and Budget (OMB) in 1996 when MDS Version 2.0 was implemented nationally. OMB guidelines require self-identification of race/ethnicity. This means that the resident should be asked to select the category that most closely corresponds to her race/ethnicity from the list in AA4. If the resident is unable to respond, a family member should be asked to make the selection. If the resident is unable to respond and no family member is available, or if the resident does not appear to fit into any of the categories, the assessor should assign whichever category they feel is most appropriate. For example, an individual of Indian origin (i.e., Far East descent) is generally considered to be Asian (AA4 = 2).

## AA5. Social Security and Medicare Numbers

***Intent:*** To record resident identifier numbers.

***Process:*** Review the resident's record. If these numbers are missing, consult with your admissions office.

***Coding:*** Enter one number per box starting with the left most box. Recheck the number to be sure you have entered the digits correctly.

**Social Security Number** - If no Social Security number is available for the resident (e.g., if the resident is a recent immigrant or a child), leave it blank or enter the standard "no information" code (**-**).

**Medicare Number (or comparable railroad insurance number)** - Enter a Medicare number or railroad number exactly as it appears on the beneficiary documents. A Medicare number always starts with a number and the first 9 characters must be digits (0-9). It is important to remember that the Medicare Health Insurance number may be different from the resident's social security number (SSN). For example, many residents may be receiving Medicare benefits based on a spouse's Medicare eligibility.

In rare instances, the resident will have neither a Medicare number nor a social security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. Railroad retirement numbers contain 12 characters. Enter the number itself, one digit per box beginning with the left most box. CMS had required the letter "C" to be placed in the first box in front of the railroad retirement number. Effective October 1, 2002 CMS instructed facilities that the letter "C" is not to be placed

before the railroad retirement number. Enter the complete 12 characters starting with the left-most box.

## AA6. Facility Provider Numbers

***Intent:*** To record the facility identifier numbers.

***Definition:*** The identification numbers assigned to the nursing facility by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; i.e., Medicare-only facilities. Dually eligible facilities (i.e., facilities participating in both the Medicare and Medicaid programs) will have Federal (Medicare) and State (Medicaid) identification numbers. While some facilities participate only in the Medicaid program, these Medicaid-only facilities are issued Federal as well as a State Medicaid numbers. The Medicaid Federal number has a letter in the third box.

***Process:*** You can obtain the nursing facility's Medicare and Medicaid numbers from the admission office. Once you have these numbers, they apply to all residents of that nursing facility.

***Coding:*** The Medicare provider number is a 6-digit number. For Medicare and Medicaid dually-certified facilities, the first two digits are the State identifier followed by a numeric character that is either a "5" or "6" followed by three numeric characters. For Medicaid-only facilities, the Federal ID number consists of a two-digit State identifier followed by one alpha character and three numeric characters. Enter one number per box. Start with the left most box. Recheck the number to be sure you have entered the digits correctly. Do not enter imbedded dashes. There must always be a Federal provider number. Each State establishes the structure of its Medicaid provider numbers. The State Medicaid number is optional.

## AA7. Medicaid Number (if applicable)

***Coding:*** Record this number if the resident is a Medicaid recipient. Enter one number per box beginning in the left most box. Recheck the number to make sure you have entered the digits correctly. Enter a "+" in the left most box if the number is pending. If you get notified later that the resident does have a Medicaid number, just include it on the next assessment. It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. If not applicable because the resident is not a Medicaid recipient, enter "N" in the left most box.

***Clarification:***

- The Medicaid number is a unique identifier assigned by the State Medicaid office. Questions regarding the Medicaid number should be referred to the State Medicaid office.

## AA8. Reasons for Assessment [This item also appears and must be completed on the MDS Full Assessment Form, Section A, Item 8.]

***Intent:*** To document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. **For detailed information on the scheduling and timing of the assessments, see Chapter 2, Section 2.2.**

**a. Primary Reason for Assessment**

***Definition:***

1. **Admission Assessment (required by day 14)**
2. **Annual Assessment**
3. **Significant Change in Status Assessment**
4. **Significant Correction of Prior Full (Comprehensive) Assessment**
5. **Quarterly Review Assessment**
6. **Discharged-Return Not Anticipated**
7. **Discharged-Return Anticipated**
8. **Discharged Prior to Completing Initial Assessment**
9. **Reentry**
10. **Significant Correction of Prior Quarterly Assessment**

**0.** ***NONE OF ABOVE*** - Use this code when preparing Medicare assessments or when your state requires you to complete one of the additional assessment types referenced in Item AA8b (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., case mix payment). Select the code under Item AA8b (below) that indicates the Medicare or State Reason for Assessment. Also, use this code when completing a PPS-only assessment or an assessment for another payer, such as an HMO.

***Coding:*** Enter the number corresponding to the primary reason for assessment. This item contains 2 digits. For codes 1-9, leave the first box blank, and place the correct response in the second box. If you were coding this item for an OBRA-only assessment, you would not complete the Medicare Reasons for Assessment (AA8b). However, if you were combining an OBRA assessment with a Medicare assessment, you would have a code in both Items AA8a and AA8b.

**b. Assessment Codes Used for the Medicare Prospective Payment System**

***Definition:***

1. **Medicare 5-Day Assessment**
2. **Medicare 30-Day Assessment**
3. **Medicare 60-Day Assessment**
4. **Medicare 90-Day Assessment**
5. **Medicare Readmission/Return Assessment**
6. **Other State-Required Assessment**
7. **Medicare 14-Day Assessment**
8. **Other Medicare Required Assessment**

***Coding:*** Enter the number corresponding to the assessment code used for the Medicare Prospective Payment System. It is possible to select a code from both AA8a and AA8b (e.g., Item AA8a = coded "3" [Significant Change in Status assessment], and Item AA8b = coded "3" [60-Day assessment]). See Chapter 2, Section 2.6 for details on combining assessments.

If there are two Medicare Reasons for Assessment, i.e., an OMRA combined with a regularly scheduled Medicare assessment, code Item AA8b = 8.

When the Primary Reason for Assessment is "00", and the Medicare Reason for Assessment is "6" or blank, the record is not edited or stored in the State MDS database. Facilities completing Medicare assessments on a standby basis should code AA8b as 1, 2, 3, 4, 5, or 7 to make sure that the assessments are properly edited and retained in the database.

**Example**

Mr. X was admitted to the nursing facility from an acute care hospital on 1/20/02. At the time of the admission assessment, he exhibited some signs of delirium that had begun post-operatively in the hospital. Functionally he required extensive assistance with all ADLs. It is now time for his Quarterly assessment. Cognitively, Mr. X's confusion has cleared to the point that the decisions he makes are now consistent and reasonable. His ADL performance has improved in all areas; he is either independent or receives some supervision. The Quarterly assessment should be coded as a Significant Change in Status assessment.

**Example**
**(continued)**

***Coding:*** Enter the number corresponding to the primary reason for assessment. For Item AA8a, Primary Reason for Assessment, would be coded AA8a = 3, Significant Change in Status assessment. The assessment codes AA8b, used for the Medicare Prospective Payment System, would be left blank as this assessment is not being completed for Medicare purposes.

## AA9. Signatures of Persons Completing These Items

***Coding:*** All staff responsible for completing any part of the MDS, MPAF, and/or tracking forms must enter their signatures, titles, sections they completed, and the date they completed those sections. Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, MPAF, and/or tracking form is correct. Penalties may be applied for submitting false information.

# MDS BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION SECTIONS AB., AC., AD.

This section is completed once, when the resident first enters the nursing facility. The face sheet is also required if the resident is admitted to the facility following a discharge return not anticipated. With any assessment, all background (face sheet) items in Sections AB and AC are optional in an all-or-none fashion. If using the MPAF, Items AB5a-f must be submitted alone or with the entire face sheet.

# SECTION AB. DEMOGRAPHIC INFORMATION

## AB1. Date of Entry

***Intent:*** Normally, the MDS face sheet (Sections AB and AC) is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering your facility after a discharge-return not anticipated (AA8a=6).

Do not complete the face sheet following temporary discharges to hospitals or after therapeutic leaves/home visits. If the face sheet was transmitted prior to the hospital stay, and none of the information has changed, a new face sheet is not required. If you identify changes to the face sheet data, you should update it and transmit the revised face sheet with your next assessment.

Admission and "bed-hold" policies vary among nursing facilities across the country. Likewise, the way in which facilities "open" and "close" resident's medical records also varies. Some facilities choose to "close" a record when a resident is transferred for an overnight stay at an acute care hospital, and "open" a new record when the resident returns to the nursing facility. Other nursing facilities maintain the resident's clinical record as open (current) even when the resident is transferred for a temporary hospital stay. **For MDS purposes, the date of entry is the date the resident first entered the facility for care,**

**regardless of how the facility chooses to "open" or "close" its medical records during the course of the stay.**

***Definition:*** **Date the Stay Began -** The initial date of admission to the nursing facility. This date will not change on subsequent assessments until the resident is discharged with a return not anticipated. If the resident is discharged as a return not anticipated and returns at a later date, the resident will be considered a new admission and a new date of entry will be entered on the assessment.

***Process:*** Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at your facility.

***Coding:*** *Use all boxes*. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

| 0 | 2 | | 0 | 3 | | 2 | 0 | 0 | 2 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

**Example**

Mrs. F, a diabetic, had been living with her daughter when she fractured her left hip during a fall off a footstool. She spent a few days in the local hospital after surgery, followed by an admission to a nursing facility on 5/26/2001 for rehabilitation. Three weeks later, Mrs. F was transferred to the hospital for an infected incision. She was discharged with return anticipated on the Discharge Tracking form. Mrs. F returned to the nursing facility eight days later. No changes are necessary in the face sheet. The rationale being that she was discharged with a return anticipated.

| 0 | 5 | | 2 | 6 | | 2 | 0 | 0 | 1 |
|---|---|---|---|---|---|---|---|---|---|

**Rationale:** The face sheet sections of the MDS - AB and AC are completed only when the resident first becomes a resident of the facility. In this case there is no need to complete a new face sheet upon return readmission from a temporary hospital stay where the resident is expected to return to the nursing facility. Had she been discharged with return not anticipated, the record would be closed. When she returned to the facility, it would be considered a new admission with a new date of entry.

## AB2. Admitted From (At Entry)

***Intent:*** To facilitate care planning by documenting the place from which the resident was admitted to the nursing facility on the date given in Item AB1. For example, if

the admission was from an acute care hospital, an immediate review of current medications might be warranted since the resident could be at a higher risk for delirium or may be recovering from delirium associated with acute illness, medications or anesthesia. Or, if admission was from home, the resident could be grieving due to losses associated with giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

***Definition:***

1. **Private Home or Apartment** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled or sick persons. Include admissions from hospital swing beds here.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Other** - Includes hospices and chronic disease hospitals.

***Process:*** Review admission records. Consult the resident and the resident's family.

***Coding:*** Choose only one answer.

**Example**

Mr. F, who had been living in his own home with his wife, was admitted to an acute care hospital with a CVA. From the hospital, Mr. F was transferred to this nursing facility for rehabilitation. Since Mr. F was admitted to your facility from the acute care hospital, "5" is the appropriate code.

## AB3. Lived Alone (Prior to Entry)

***Intent:*** To document the resident's living arrangements prior to admission.

***Definition:*** **In Other Facility** - Any institutional/supportive setting, such as a nursing facility, group home, sheltered care, board and care home.

***Process:*** Review admission records. Consult the resident and the resident's family.

***Coding:*** If living in another facility (i.e., nursing facility, group home, board and care, assisted living) prior to admission to the nursing facility, code Item AB2 = 2.

If the resident was not living in another facility prior to admission to the nursing facility, enter "**0**" or "**1**", as appropriate.

**Examples**

- Mrs. H lived on her own and her daughters took turns sleeping in her home so she would never be alone at night. **Code "0" for No (did not live alone)**. If, however, her daughters stayed with her only 3-4 nights per week, **Code "1" for Yes (lived alone).**
- Mr. J lived in his own second-floor apartment of a two-family home and received constant attention from his family, who lived on the first floor. **Code "0" for No (did not live alone).**
- Mr. D lived with his wife in housing for the elderly prior to admission. **Code "0" for No (did not live alone).**
- Mrs. X was the primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. **Code "0" for No (did not live alone)**.
- Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. **Code "1" for Yes (lived alone)**.
- Mr. M, who has been blind since birth, was admitted to the nursing facility with his Seeing Eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. **Code "1" for Yes (lived alone).**
- Mr. G lived in a board and care home. **Code "2" (In other facility).**

## AB4. Zip Code of Prior Primary Residence

***Definition:*** **Prior Primary Residence** - The community address where the resident last resided prior to nursing facility admission. A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing facility or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing facility, etc.

***Process:*** Review resident's admission records and transmittal records as necessary. Ask resident and family members as appropriate. Check with your facility's admissions office.

***Coding:*** Enter first five digits of the zip code. Enter one digit per box beginning with the left most box. For example, Beverly Hills, CA 90210 should be entered as:

| | | | | |
|---|---|---|---|---|
| 9 | 0 | 2 | 1 | 0 |

**Examples**

- Mr. T was admitted to the nursing facility from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida 34957. **Enter the 34957 for Jensen Beach.**

- Mrs. F was admitted to the nursing facility's Alzheimer's Special Care Unit after spending 3 years living with her daughter's family in Newton, MA 02458. Prior to moving in with her daughter, Mrs. F lived in Boston, MA for 50 years with her husband until he died. **Enter the 02458. Rationale:** Her daughter's home was Mrs. F's primary residence prior to nursing facility admission.

- Ms. Q was admitted from a State psychiatric hospital in Illinois where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Kansas City, Kansas 66110. **Enter the Kansas City zip code 66110.**

## AB5. Residential History 5 Years Prior to Entry

***Intent:*** To document the resident's previous experience living in institutional or group settings.

***Definition:***

**a. Prior Stay at This Nursing Home** - Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

**b. Stay in Other Nursing Home** - Prior stay in one or more nursing facilities other than current facility.

**c. Other Residential Facility** - Examples include board and care home, group home, and assisted living.

**d. MH/Psychiatric Setting** - Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

**e. MR/DD Setting** - Examples include mental retardation or developmental disabilities facility (including MR/DD institutions), intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

**f. *NONE OF ABOVE***

***Process:*** Review the admission record. Consult the resident or family. Consult the resident's physician.

***Coding:*** Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e., the place the resident called "home" at that time). If the resident has not lived in any of these settings in the past five years, check *NONE OF ABOVE*.

## AB6. Lifetime Occupation

***Intent:*** To identify the resident's role or past role in life and to establish familiarity in how staff should address the resident. For example, a physician might appreciate being referred to as "Doctor". Knowing a person's lifetime occupation is also helpful for care planning purposes. For example, a carpenter might enjoy pursuing hobby shop activities.

***Coding:*** Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box.

The lifetime occupation of a person whose primary work was in the home should be recorded as "Homemaker." *When two occupations are identified, place a slash (/) between each occupation.* A person who had two careers (e.g., carpenter and night watchman) should be recorded as "Carpenter/Night Watchman." *For a resident who is a child or an MR/DD adult resident who has never been employed, record as "NONE."*

## AB7. Education (Highest Level Completed)

***Intent:*** To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g., interpreting cognitive patterns or language skills), care planning (e.g., deciding how to focus a planned activity program), and planning for resident education in self-care skills.

***Definition:*** The highest level of education attained.

1. **No Schooling**

2. **Grades 1-8 or Less**

3. **9-11 Grades**

4. **High School Graduate**

5. **Technical or Trade School:** Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g.,

carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

6. **Some College:** Includes completion of some college courses, junior (community) college, or associate's degree.

7. **Bachelor's degree:** Includes any undergraduate bachelor's level college degree.

8. **Graduate Degree:** Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

***Process:*** Ask the resident and significant other(s). Review the resident's record.

***Coding:*** Code for the best response. For MR/DD residents who have received special education services, code "**2**" (1-8th grade or less).

## AB8. Language

***Definition:*** **a. Primary Language** - The language the resident primarily speaks or understands.

***Process:*** Interview the resident and family. Observe and listen. Review the clinical record.

***Coding:*** Enter "**0**" for English, "**1**" for Spanish, "**2**" for French, "**3**" for Other. If the resident's primary language is not listed, code "**3**" for Other; and print the resident's primary language in Item 8b beginning with the left most box.

**Example**

Mrs. F emigrated with her family from East Africa several years ago. She is able to speak and understand very little English. She depends on her family to translate information in Swahili.

a. Primary Language – Code "3" for Other

b. If Other, specify

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| S | W | A | H | I | L | I | | | |

## AB9. Mental Health History

***Intent:*** To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

***Definition:*** Resident has one of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but

- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

***Process:*** Review the resident's record only. For a "yes" response to be entered, there must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient).

***Coding:*** Enter "**1**" for Yes or "**0**" for No.

## AB10. Conditions Related to MR/DD Status (Mental Retardation/ Developmental Disabilities)

***Intent:*** To document conditions associated with mental retardation or developmental disabilities.

***Definition:*** **For Item AB10e, "Other Organic Condition Related to MR/DD"** - Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

***Process:*** Review the resident's record only. For any item (AB10b through AB10f) to be checked, the condition must be documented in the clinical record.

***Coding:*** Check all conditions related to MR/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.

- If an MR/DD condition is not present, check Item AB10a, Not Applicable - No MR/DD, and skip to Item AB11.
- If an MR/DD condition is present, check each condition that applies; AB10b, Down's syndrome; AB10c, Autism; AB10d, Epilepsy; AB10e, Other organic condition related to MR/DD.
- If an MR/DD condition is present but the resident does not have any of the specific conditions listed, check Item AB10f, MR/DD with No Organic Condition.

## AB11. Date Background Information Complete

***Intent:*** For tracking purposes, this item should reflect the date that the *Background (Face Sheet) Information At Admission* form is completed or amended.

***Coding***: Enter the date the *Background (Face Sheet) Information At Admission* form is originally completed. In some circumstances (e.g., if a knowledgeable family member is not available during the 14-Day assessment period), it is difficult to fill in all the background information requested on this form. However, the information is often obtained at a later date. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item (AB 11) should then reflect the date that new information is recorded or existing information is revised.

If any face sheet (AB) information is updated and submitted to the database, then all the face sheet items must be submitted. Do not submit just the updated items.

**NOTE:** The only exception to this "all-or-nothing" rule is the requirement to submit Items AB5a-f with the MPAF form. With the introduction of the MPAF form, CMS requires that Items AB5a-f be submitted with each MPAF assessment.

**Examples**

Mr. B was admitted to your facility on 12/03/2001 in a comatose state and therefore, unable to communicate on his own behalf. By reviewing transmittal records that accompanied him from the acute care hospital, you find that you are only able to partially complete Section AB (Demographic Information), and you are unable to complete Section AC (Customary Routine) because the records are scanty in these areas. You decide to complete what you can by day 14 of Mr. B's residency (the date the MDS assessment is to be completed) and enter the date 12/16/2001 for Item AB 11. On 12/24/2001 Mr. B's only relative, a daughter, visits and you are able to obtain more information from her. Enter the new information (e.g., demographic or customary routines) on the form and then enter the date 12/24/2001 for Item AB11.

# SECTION AC. CUSTOMARY ROUTINE

## AC1. Customary Routine (In the year prior to DATE OF ENTRY to this nursing facility, or year last in community if now being admitted from another nursing facility)

***Intent:*** These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (AB1) to your nursing facility. If the resident is being admitted from another nursing facility, review the resident's routine during the last year the resident lived in the community. The items should initiate a flow of information about cognitive patterns, activity preferences, nutritional preferences and problems, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the MDS that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care.

Facilities have flexibility in determining who should participate in the assessment process as long as the MDS 2.0 is accurately conducted. A facility may assign the Customary Routine section to one person or to several members of the interdisciplinary team. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. All staff that completed any part of Sections AB - AC must sign their names and identify the sections they have completed in Section AD.

Engaging the resident and or the family member in a discussion about the resident's routines in the year prior to the date of entry is an excellent means of obtaining important information and starting the therapeutic relationship between facility clinicians and the resident and family. Information about the resident's prior routines in areas such as bathing, dietary preferences, and usual social activities or hobbies can be used by the facility staff to develop a care plan that is specific to that resident's needs and preferences. Through the completion of Section AC, the nursing facility staff begins the assessment of areas such as speech patterns, hearing, vision, cognition, decision-making, and others.

***Process:*** Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process, such as described in Guidelines for Interviewing Resident that follows. Also see Appendix D.

If the resident cannot respond (e.g., is severely demented or aphasic), ask a family member or other representative of the resident (e.g., legal guardian). For some residents you may be unable to obtain this information (e.g., a demented resident who first entered the facility many years ago and has no family to provide accurate information, etc.).

**Guidelines for Interviewing Resident**

Staff should regard this step in the assessment process as a good time to get to know the resident as an individual and an opportunity to set a positive tone for the future relationship. It is also a useful starting point for building trust prior to asking difficult questions about urinary incontinence, advance directives, etc.

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the resident at ease. Explain at the outset why you are asking these questions ("Staff want to know more about you so you can have a comfortable stay with us." "These are things that many older people find important." "I'm going to ask a little bit about how you usually spend your day.")

Begin with a general question - e.g., "Tell me, how did you spend a typical day before coming here (or before going to the first nursing facility)?" or "What were some of the things you liked to do?" Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and leisure activities involvements. As the resident becomes engaged in the discussion, probe for information on each item of the Customary Routine section (i.e., cycle of daily events, eating patterns, ADL patterns, involvement patterns). Realize, however, that a resident who has been in an institutional setting for many years prior to coming to your facility may no longer be able to give an accurate description of pre-institutional routines. Some residents will persist in describing their experience in the long-term care setting, and will need to be reminded by the interviewer to focus on their usual routines prior to admission. Ask the resident, "Is this what you did before you came to live here?"

If the resident has difficulty responding to prompts regarding particular items, backtrack by re-explaining that you are asking these questions to help you understand how the resident's usual day was spent and how certain things were done. It may be necessary to ask a number of open-ended questions in order to obtain the necessary information. Prompts should be highly individualized.

Walk the resident through a typical day. Focus on usual habits, involvement with others, and activities. Phrase questions in the past tense. Periodically reiterate to the resident that you are interested in the resident's routine before nursing facility admission, and that you want to know what he or she actually did, not what he or she might like to do.

**(continued on next page)**

**Guidelines for Interviewing Resident**
**(continued)**

For example:

After you retired from your job, did you get up at a regular time in the morning?
When did you usually get up in the morning?
What was the first thing you did after you arose?
What time did you usually have breakfast?
What kind of food did you like for breakfast?
What happened after breakfast? (Probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
When did you have lunch? Was it usually a big meal or just a snack?
What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
Did you ever have a drink before dinner? Every day? Weekly?
What time did you usually bathe? Did you usually take a shower or a tub bath?
How often did you bathe? Did you prefer AM or PM?
Did you snack in the evening?
What time did you usually go to bed? Did you usually wake up during the night?

***Definition:*** **CYCLE OF DAILY EVENTS**

a. **Stays Up Late at Night (e.g., after 9 pm)**

b. **Naps Regularly During Day** - At least 1 hour

c. **Goes Out 1+ Days a Week -** Went outside for any reason (e.g., socialization, fresh air, clinic visit).

d. **Stays Busy with Hobbies, Reading, or Fixed Daily Routine**

e. **Spends Most of Time Alone or Watching TV**

f. **Moves Independently Indoors (with Appliances, if used)**

g. **Use of Tobacco Products at Least Daily** - Used any type of tobacco (e.g., cigarettes, cigars, pipe) at least once daily. This item also includes sniffing or chewing tobacco.

h. ***NONE OF ABOVE***

## EATING PATTERNS

i. **Distinct Food Preferences** - This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; allergic to wheat and avoids bread, etc.). *Do not check this item for simple likes and dislikes.*

j. **Eats Between Meals All or Most Days**

k. **Use of Alcoholic Beverage(s) at Least Weekly** - Drank at least one alcoholic drink per week.

l. ***NONE OF ABOVE***

## ADL PATTERNS

m. **In Bedclothes Much of Day**

n. **Wakens to Toilet All or Most Nights** - Awoke to use the toilet at least once during the night all or most of the time.

o. **Has Irregular Bowel Movement Pattern -** Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether or not the resident prefers a different pattern.

p. **Showers for Bathing**

q. **Bathing in PM -** Took shower or bath in the evening.

r. ***NONE OF ABOVE***

## INVOLVEMENT PATTERNS

s. **Daily Contact with Relatives/Close Friends** - Includes visits, telephone calls, regular e-mail. Does not include exchange of letters only.

t. **Usually Attends Church, Temple, Synagogue (etc.)** - Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

u. **Finds Strength in Faith**

v. **Daily Animal Companion/Presence -** Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

w. **Involved in Group Activities**

**x.** ***NONE OF ABOVE***

**y.** ***UNKNOWN*** **-** If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check the last box in the category ("UNKNOWN"). Leave all other boxes in Section AC blank.

***Coding:*** Coding is limited to selected routines in the year prior to the resident's first admission to a nursing facility. *Code the resident's actual routine rather than his or her goals or preferences* (e.g., if the resident would have liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/close friends").

Under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a *NONE OF ABOVE* choice is available. For example, if the resident did not engage in any of the items listed under Cycle of Daily Events, indicate this by checking *NONE OF ABOVE* for Cycle of Daily Events.

If an individual item in a particular category is not known (e.g. "Finds strength in faith," under Involvement Patterns), enter "**-**".

If information is unavailable for all the items in the entire Customary Routine section, check the final box "UNKNOWN" - Resident/family unable to provide information. If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

# SECTION AD. FACE SHEET SIGNATURES

## ADa. Signature of RN Assessment Coordinator

***Coding:*** When the RN Assessment Coordinator worked on the *Background (Face Sheet) Information at Admission* he or she must enter his or her signature on the date it is completed. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the *Background (Face Sheet) Information at Admission* cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.

### ADb-g. Signature of Others Who Completed Part of Background Assessment Sections AB and AC

***Coding:*** All staff responsible for completing any part of the *Background (Face Sheet) Information at Admission* must enter their signatures, titles, sections they completed, and the date they completed those sections. Read the Attestation Statement carefully. You are certifying that the information you entered on the Background Face Sheet is correct. Penalties may be applied for submitting false information.

# SECTION A. MDS IDENTIFICATION AND BACKGROUND INFORMATION

## A1. Resident Name

***Definition:*** Legal name in record.

***Coding:*** Use printed letters. Enter in the following order:

**a.** First Name
**b.** Middle Initial; if the resident has no middle initial, leave Item b. blank.
**c.** Last Name
**d.** Jr./Sr.

## A2. Room Number

***Intent***: Another identifying number for tracking purposes.

***Definition:*** The number of resident's room in the facility.

***Coding:*** Start in the left most box; use as many boxes as needed.

**Example**

| | | | | |
|---|---|---|---|---|
| N | 3 | 0 | 5 | |

Mr. F lives in Room N305 at your facility. The N stands for New Building in your two building complex. The three hundred series of rooms are on the third floor.

# A3. Assessment Reference Date

## a. Last Day of MDS Observation Period

***Intent:*** To establish a common reference point for all staff participating in the resident's assessment. As staff members may work on a resident's MDS assessment on different days, establishing the Assessment Reference Date ensures a common assessment period. In other words, the ARD designates the end of the observation period so that all assessment items refer to the resident's objective performance and health status during the same period of time. See Chapter 2 for completion timing requirements for each assessment type.

***Definition:*** This date refers to a specific end-point for a common observation period in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, the observation period is a 7-day period ending on this date. Some observation periods cover the 14 days ending on this date, and some cover 30 days ending on this date.

***Clarifications:***

- The ARD is the common date on which all MDS observation periods end. The observation period is also referred to as the look-back period. It is the time period during which data is captured for inclusion on the MDS assessment. The ARD is the last day of the observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7$^{th}$ day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (Item A3a).

  **NOTE:** Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment. For Part A billing, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; e.g., Significant Change in Status or OMRA. In these situations, the ARD of the non-scheduled assessment has sometimes been referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.

- When the resident dies or is discharged prior to the end of the observation period for a required assessment, the ARD must be adjusted to equal the discharge date. Generally, facilities are required to complete these assessments after the resident's discharge in order to bill for Medicare or Medicaid payment. Facilities have 2 options to choose from when adjusting the ARD to the date of discharge. In the first situation, changing the ARD shortens the observation period. Since some facilities prefer to use data for a full observation period, even if it means collecting more information on the resident's condition prior to admission to the nursing facility, CMS has established a second option that would allow the nursing facility to establish a full observation period.

  ***Option 1*** - Change the ARD to the date of discharge, but complete the MDS using less than a full observation period. In this case, the Assessment Reference Date had been set at Day 5, and the resident was discharged after 4 days of the observation period. For items with a 7-day observation period, the MDS would be completed using the data collected for the 4-day period in the nursing facility and the 2-day period prior to admission.

  ***Option 2*** - Change the ARD to the date of discharge, but extend the observation period prior to the date of admission, and collect additional data to complete the assessment. Generally, this expanded observation period would require additional data from the prior hospital stay. In this example, if the resident was discharged after 4 days, the MDS would be completed using the data collected for the 4-day period in the nursing facility. For a 7-day assessment item, hospital data could be used for the 3-day period prior to the nursing facility admission.

  Nursing facility providers must select one of these options and apply it consistently in all cases where the resident is discharged prior to the end of the observation period. It is not appropriate to change options on a case-by-case basis in order to increase reimbursement.

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- The observation period may not be extended simply because a resident was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. For example, if the ARD is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. When collecting assessment information, you may use data from the time period of the LOA as long as the particular MDS item allows you. For example, section P7, if the family takes the resident to the physician, the visit may be counted. For information on coding minutes of therapy while the resident is out of the SNF, see pages 3-185 and 3-186. This procedure applies to all assessments, regardless of whether or not they are being completed for clinical or payment purposes.

- If the resident is admitted to the hospital prior to completing the Admission assessment, and returns to the facility, the facility staff may choose to complete the original Admission assessment or start a new assessment. If the staff chooses to complete the original assessment, then the original Assessment Reference Date must be retained and staff must properly identify those MDS items that can be coded only when furnished during the nursing facility stay. For example, services such as therapy or doctor visits occurring during the resident's hospital stay would not be coded on the MDS. The facility can also choose to start a new assessment upon the resident's return. The facility would then have 14 days from the return date (A4a) to perform the Admission assessment.

  If the resident was in a Medicare Part A stay prior to the hospitalization, the facility will generally complete all or part of a 5-Day Medicare assessment in order to establish a RUG-III group for payment purposes. Then, when the beneficiary returns, the facility will complete a Medicare 5-Day Readmission/Return assessment (Item A8b=5). The Medicare Readmission/ Return assessment may be combined with the Admission assessment.

***Coding:*** Complete the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, August 2, 2002 should be entered as:

| 0 | 8 | | 0 | 2 | | 2 | 0 | 0 | 2 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

**b. Original (00) or Corrected Copy of Form:** Always enter a (00) in this item. It is not used in the correction process. See Chapter 5 for information on the correction process.

## A4a. Date of Reentry

This item appears on the MDS Reentry Tracking form. See Chapter 1 for copies of this form.

***Intent:*** To track the date of the resident's return to the facility following a discharge-return anticipated.

***Definition:*** The date the resident most recently returned to your facility after being discharged with return anticipated for hospital stay in last 90 days (or since last assessment or admission if less than 90 days).

***Process:*** Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

***Coding:*** If the resident has not been hospitalized in last 90 days, leave blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

| 0 | 2 | - | 0 | 3 | - | 2 | 0 | 0 | 2 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

## A4b. Admitted From at Reentry

This item appears on the MDS Reentry Tracking form-see forms in Chapter 1.

***Definition:***

1. **Private Home or Apartment** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Other** - Includes hospices and chronic disease hospitals.

***Process:*** Review admission records. Consult the resident and the resident's family.

***Coding:*** Choose only one answer.

## A5. Marital Status

***Coding:*** Choose the answer that best describes the current marital status of the resident: **1.** Never Married, **2.** Married, **3.** Widowed, **4.** Separated, or 5**.** Divorced.

## A6. Medical Record Number

***Definition:*** This number is the unique identifier assigned by the facility for the resident. If not on the medical record, it is available from the facility's admissions office, business office, or Health Information Management Department.

## A7. Current Payment Source(s) for Nursing Home Stay

***Intent:*** To determine payment source(s) that covers the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days.

***Definition:***

a. **Medicaid Per Diem** - Room, board, nursing care, activities, and services included in the routine daily charge. Check this item if Medicaid is pending.

b. **Medicare Per Diem** – Room, board, nursing care, activities, and services included in the routine daily charge.

c. **Medicare Ancillary Part A** - Services such as medications, equipment for treatments, or supplies billed outside of the daily routine per diem charge.

d. **Medicare Ancillary Part B**

e. **CHAMPUS Per Diem** – The resident's military insurance is covering daily charges.

f. **VA Per Diem** – The Veterans Administration has contracted with the facility to pay for the resident's daily charges.

g. **Self or Family Pays for Full Per Diem** - Includes full private pay by resident or family.

h. **Medicaid Resident Liability or Medicare Co-Payment** - The resident is responsible for a co-payment.

i. **Private Insurance Per Diem (Including Co-Payment)** - The resident's private insurance company is covering daily charges.

j. **Other** - Examples include Commission for the Blind, Alzheimer's Association.

***Process:*** Check with the billing office to review current payment sources. Do not rely exclusively on information recorded in the resident's clinical record, as the resident's clinical condition may trigger different sources of payment over time. Usually business offices track such information.

***Coding:*** Check all that apply. We recognize that many facility staff have had a lot of difficulty in reporting payment source. To a great extent, the problems are the result of lack of information; business office staff is more aware of secondary insurance coverage than clinical staff. For this reason, we are evaluating the usefulness of this item in our MDS 3.0 development. For now, please continue to use the definitions provided. When evaluating the accuracy of MDS coding at a facility, errors in just the Payment Source item should not be heavily weighted. If the clinical coding and key identifiers are coded accurately, Payment Source errors should not be cited as evidence of inaccurate MDS processing.

## A8. Reasons for Assessment

***Intent:*** To document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. **For detailed information on the scheduling and timing of the assessments, see Chapter 2, Section 2.2.**

**a. Primary Reason for Assessment**

***Definition:***

1. **Admission Assessment (required by day 14)**
2. **Annual Assessment**
3. **Significant Change in Status Assessment**
4. **Significant Correction of Prior Full (Comprehensive) Assessment**
5. **Quarterly Review Assessment**
6. **Discharged-Return Not Anticipated**
7. **Discharged-Return Anticipated**
8. **Discharged Prior to Completing Initial Assessment**
9. **Reentry**
10. **Significant Correction of Prior Quarterly Assessment**

**0.** ***NONE OF ABOVE*** **-** Use this code when preparing Medicare assessments or when your State requires you to complete one of the additional assessment types referenced in Item AA8b (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., case mix payment). Select the code under Item AA8b (below) that indicates the Medicare or State Reason for Assessment. Also, use this code when completing a PPS-only assessment or an assessment for another payer, such as an HMO.

***Coding:*** Enter the number corresponding to the primary reason for assessment. This item contains 2 digits. For codes 1-9, leave the first box blank, and place the correct response in the second box. If you were coding this item for an OBRA-only assessment, you would not complete the Medicare Reasons for Assessment (AA8b). However, if you were combining an OBRA assessment with a Medicare assessment, you would have a code in both Items AA8a and AA8b.

**b. Assessment Codes Used for the Medicare Prospective Payment System**

***Definition:***

1. **Medicare 5-Day Assessment**
2. **Medicare 30-Day Assessment**
3. **Medicare 60-Day Assessment**
4. **Medicare 90-Day Assessment**

5. **Medicare Readmission/Return Assessment**

6. **Other State-Required Assessment**

7. **Medicare 14-Day Assessment**

8. **Other Medicare Required Assessment**

***Coding:*** Enter the number corresponding to the assessment code used for the Medicare Prospective Payment System. It is possible to select a code from both AA8a and AA8b (e.g., Item AA8a = coded "3" [Significant Change in Status assessment], and Item AA8b = coded "3" [60-Day assessment]). See Chapter 2, Section 2.6 for details on combining assessments.

If there are two Medicare Reasons for Assessment, i.e., an OMRA combined with a regularly scheduled Medicare assessment, code Item AA8b = 8.

When the Primary Reason for Assessment is "00", and the Medicare Reason for Assessment is "6" or blank, the record is not edited or stored in the State MDS database. Facilities completing Medicare assessments on a standby basis should code AA8b as 1, 2, 3, 4, 5, or 7 to make sure that the assessments are properly edited and retained in the database.

## A9. Responsibility/Legal Guardian

***Intent:*** To record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending on the resident's condition, multiple options may apply. For example, a resident with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a resident may have executed a limited power of attorney to someone responsible only for legal affairs. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

***Definition:***

a. **Legal Guardian** - Someone **who has been appointed after a court hearing** and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian.

b. **Other Legal Oversight** - Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

c. **Durable Power of Attorney/Health Care** - Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

d. **Durable Power of Attorney/Financial** - Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

e. **Family Member Responsible** - Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.

f. **Resident Responsible for Self** - Resident retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

g. ***NONE OF ABOVE***

***Process:*** Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

***Coding:*** Check all that apply.

## A10. Advanced Directives

***Intent:*** To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any

discrepancies between the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

***Definition:***

**a. Living Will** - A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

**b. Do Not Resuscitate** - In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

**c. Do Not Hospitalize** - A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

**d. Organ Donation** - Instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

**e. Autopsy Request** - Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family or responsible party must still be contacted upon the resident's death and re-asked if they want an autopsy to be performed.

**f. Feeding Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

**g. Medication Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

**h. Other Treatment Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

**i.** ***NONE OF ABOVE***

***Process:*** You will need to familiarize yourself with the legal status of each type of directive in your state. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether or not the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

***Coding:*** The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.

- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded, but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.

- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Check all that apply. If none of the directives are verified by documentation in the medical records, check *NONE OF ABOVE*.

42 CFR 483.10 requires facilities to protect and promote the rights of each resident, including the right to "formulate an advanced directive." There is no regulatory text specifying a location for advanced directive information. Unless there are State codes or regulations regarding this matter, the method of communicating the information is up to the facility. If documentation is not available in the resident's clinical record, facility staff should be the source of this information, and surveyors will assess whether or not the staff knowledge and actions are in agreement with resident/family wishes. Some facilities elect to maintain the information in the resident's clinical record and may even verify the advanced directive was properly prepared, i.e., not witnessed by someone who will benefit from the resident's death. Make sure you are well aware of your facility's policies.

## 3.4 Clinical Items for the MDS

# SECTION B.
# COGNITIVE PATTERNS

***Intent:*** To determine the resident's ability to remember, think coherently, and organize daily self-care activities. These items are crucial factors in many care planning decisions. Your focus is on resident performance, including a demonstrated ability to remember recent and long-past events and to perform key decision-making skills.

Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the questions cogently.

Be sure to interview the resident in a private, quiet area without distractions - i.e., not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust between staff and resident. Be cognizant of possible cultural differences that may affect your perception of the resident's response. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to clarify or validate information regarding the resident's cognitive function over the last seven days. For residents with limited communication skills or who are best understood by family or specific caregivers, you will need to carefully consider their insights in this area.

- Engage the resident in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember - repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the resident (e.g., "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, "Let's talk about something else now," or "We don't need to talk about

that now. We can do it later". Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

It is often difficult to accurately assess cognitive function, or how someone is able to think, remember, and make decisions about their daily lives, when they are unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a resident and hear responses from them that give you clues to how the resident is able to think (judgment), if he understands his strengths and weaknesses (insight), whether he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia).

To assess an aphasic resident it is very important that you hone your listening and observation skills to look for non-verbal cues to the person's abilities. For example, for someone who is unable to speak with you but seems to understand what you are saying (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident.

In all cases code the cognitive items with answers that reflect your best clinical judgment, realizing the difficulty in assessing residents who are unable to communicate. MDS Items B1, B4, B5 and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment.

## B1. Comatose (7-day look back)

***Intent:*** To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

***Coding:*** Enter the appropriate number in the box.

If the resident has been diagnosed as comatose or in a persistent vegetative state, code "**1**". ***Skip to Section G***. If the resident is not comatose or not in a persistent vegetative state, code "**0**" and proceed to the next Item (B2).

***Clarification:***

- Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

  Sometimes residents who were comatose for a period of time after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they have extensive damage to both cerebral hemispheres. This state is different from coma, and if it continues, is called a persistent vegetative state. Both coma and vegetative state have serious consequences in terms of long-term clinical outcomes and care needs.

  Many other residents have severe impairments in cognition that are associated with late stages of progressive neurological disorders such as Alzheimer's disease. Although such residents may be non-communicative, totally dependent on others for care and nourishment, and sleep a great deal of time, they are usually not comatose or in a persistent vegetative state as described above.

  To prevent any resident from being mislabeled as such, it is imperative that coding of comatose reflect physician documentation of a diagnosis of either coma or persistent vegetative state.

## B2. Memory (7-day look back)

***Intent:*** To determine the resident's functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory).

***Process:***

**a. Short-Term Memory** - Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over time or following through on a direction given five minutes earlier) the correct response is "**1**", Memory Problem.

If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and the staff was unable to make a determination based on observation of the resident, use the "**-**" response to indicate that the information is not available because it could not be assessed.

**Examples**

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else - do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1". For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number).

**b. Long-Term Memory** - Engage in conversation that is meaningful to the resident. Ask questions for which you can validate the answers (from your review of record, general knowledge, the resident's family). For residents with limited communication skills, ask staff and family about the resident's memory status. If there is no positive indication of memory ability, the correct response is "**1**", Memory Problem.

If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and the staff was unable to make a determination based on observation of the resident, use the "**-**" response to indicate that the information is not available because it could not be assessed.

**Example**

Ask the resident, "Where did you live just before you came here?" If "at home" is the reply, ask, "What was your address?" If "another nursing facility" is the reply, ask, "What was the name of the place?" Then ask: "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

***Coding:*** Enter the numbers that correspond to the observed responses.

***Clarifications:***

- Many persons with memory problems can learn to function successfully in a structured, routine environment. Observing resident function in multiple daily activities is only one aspect of evaluating short-term memory function. For example, a resident may remember to come to lunch, but may not remember what he/she ate. The short-term memory test described above is still an important component of the overall evaluation.

- When coding short-term memory, identify the most representative level of function, not the highest. Therefore, a resident with short-term memory problems 6 of the 7 days should be coded as "1". For many residents, performance varies. Staff must use clinical judgment to decide whether or not a single observation provides sufficient information on the resident's typical level of function.

## B3. Memory/Recall Ability (7-day look back)

***Intent:*** To determine the resident's memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition, yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

***Definition:***

a. **Current Season** - Able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).

b. **Location of Own Room** - Able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

c. **Staff Names/Faces** - Able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.

d. **That He/She Is In a Nursing Home** - Able to determine that he/she is currently living in a nursing facility. To check this item, it is not necessary that the resident be able to state the name of the facility, but he/she should be able to refer to the facility by a term such as a "home for older people," a "hospital for the elderly," "a place where older people live," etc.

e. ***NONE OF ABOVE* are recalled.**

***Process:*** Test memory/recall. Use information obtained from clinical records or staff. Ask the resident about each item. For example, "What is the current season?" "What is the name of this place?" "What is this kind of place?" If the resident is not in his or her room, ask, "Will you show me to your room?" Observe the resident's ability to find the way.

***Coding:*** For each item that the resident can recall, check the corresponding answer box. If the resident can recall none, check *NONE OF ABOVE*.

## B4. Cognitive Skills for Daily Decision-Making (7-day look back)

***Intent:*** To record the resident's actual performance in making everyday decisions about tasks or activities of daily living.

**Examples**

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging need to use a walker, and using it faithfully.

***Process:*** Review the clinical record. Consult family and nurse assistants. Observe the resident. The inquiry should focus on whether or not the resident is actively making these decisions, and not whether staff believes the resident might be capable of doing so or not. Remember the intent of this item is to record what the resident is doing (performance). Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making, whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

***Coding:*** Enter one number that corresponds to the most correct response.

**0. Independent -** The resident's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

**1. Modified Independence -** The resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

**2. Moderately Impaired** - The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

3. **Severely Impaired** - The resident's decision-making was severely impaired; the resident never (or rarely) made decisions.

***Clarifications:***

- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item B4 would be coded as "3" for Severely Impaired. If the resident attempts to make decisions, although poorly, code "2" for Moderately Impaired.

- Coding the following examples for MDS Item B4 "Cognitive Skills for Daily Decision-Making:"

  (1) If a resident seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the resident be considered moderately or severely impaired?

  (2) If a resident does not generally make conversation or make his needs known, but replies "yes" when asked if he would like to take a nap, would the resident be considered moderately or severely impaired?

  These examples are similar in that the residents are primarily non-verbal and do not make their needs known, but they do make basic verbal or non-verbal responses to simple gestures or questions regarding care routines (e.g., comfort). More information about how the resident functions in his environment is needed to definitively answer the questions. From the limited information provided about these residents, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week, and MDS Item B4 would be coded as "3", Severe Impairment. The assessor should determine if the resident would respond in a similar fashion to other requests made during the 7-day observation period. If such "decisions" are more frequent, the resident may be only moderately impaired or better.

## B5. Indicators of Delirium - Periodic Disordered Thinking/Awareness
**(7-day look back)**

***Intent:*** To record behavioral signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get "lost."

***Definitions:*** Examples of behaviors to be assessed and coded include the following:

**a. Easily Distracted** - Difficulty paying attention; gets sidetracked.

**b. Periods of Altered Perception or Awareness of Surroundings** - Moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day.

**c. Episodes of Disorganized Speech** - Speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought.

**d. Periods of Restlessness** - Fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out.

**e. Periods of Lethargy** - Sluggishness, staring into space; difficult to arouse; little body movement.

**f. Mental Function Varies Over the Course of the Day** - Sometimes better, sometimes worse; behaviors sometimes present, sometimes not.

***Coding:*** Code for resident's behavior in the last seven days regardless of what you believe the cause to be - focusing on when the manifested behavior first occurred.

**0.** Behavior not present
**1.** Behavior present, not of recent onset
**2.** Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

**Case Example 1**

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days Mrs. K has "not been herself." She has been napping more frequently and for longer periods during the day. She is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with a fork. Then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff demanding to be taken to see her husband (although he is deceased). On 3 occasions Mrs. K was observed attempting to climb out of bed over the foot of the bed.

| Indicators | Coding |
|---|---|
| a. Easily distracted | 2 (present, new) |
| b. Periods of altered perception or awareness of surroundings | 2 (present, new) |
| c. Episodes of disorganized speech | 2 (present, new) |
| d. Periods of restlessness | 2 (present, new) |
| e. Periods of lethargy | 2 (present, new) |
| f. Mental function varies over the course of the day | 2 (present, new) |

**Case Example 2**

Mr. D has a history of Alzheimer's disease. His skills for decision-making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does it is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he's talking to someone. Although Mr. D is often restless and fidgety this behavior is not new for him and it rarely interferes with a good night's sleep.

| Indicators | Coding |
|---|---|
| a. Easily distracted | 1 (present, not new) |
| b. Periods of altered perception or awareness of surroundings | 1 (present, not new) |
| c. Episodes of disorganized speech | 1 (present, not new) |
| d. Periods of restlessness | 1 (present, not new) |
| e. Periods of lethargy | 0 (behavior not present) |
| f. Mental function varies over the course of the day | 1 (present, not new) |

## B6. Change in Cognitive Status (90 days ago)

***Intent:*** To document changes in the resident's cognitive status, skills, or abilities as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). These can include, but are not limited to, changes in level of consciousness, cognitive skills for daily decision-making, short-term or long-term memory, thinking or awareness, or recall. Such changes may be permanent or temporary; their causes may be known (e.g., a new pain or psychotropic medication) or unknown. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Coding:*** Enter "**0**" for No change, "**1**" for Improved, or "**2**" for Deteriorated.

**Examples of Change in Cognitive Status**

Mrs. G experienced delirium (acute confusion) secondary to pneumonia approximately 30 days ago. With appropriate antibiotic therapy, hydration, and a quiet supportive milieu, she recovered. Although Mrs. G's cognitive skills did not increase beyond the level that existed prior to her pneumonia, and she remains unable to make daily decisions, she has steadily improved to her pre-pneumonia status. **Code "0" for No Change.**

Ms. P is intellectually intact. About two and one-half months ago she was informed by her daughter that her neighbor and lifelong friend had died while on a trip to Europe. Ms. P took the news very hard; she was stunned and seemed to be confused and bewildered for days. With support of family and staff, confusion passed. Although she continued to grieve, her cognitive status returned to what it was prior to her receiving the bad news. **Code "0" for No change.**

Mr. D was admitted to the nursing facility three months ago upon discharge from the hospital with signs of post-operative delirium. Since that time he no longer requires frequent reminders and re-orientation throughout each day. His decision-making skills have improved. **Code "1" for Improved**.

Mr. F has Alzheimer's disease. He did well until two months ago, when his primary nurse assistant reported that he could no longer find his way back to his room, which he was able to do three months ago. He often gets lost now while trying to find his way to the unit activity/dining room. **Code "2" for Deteriorated**.

Mrs. F was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long-term memory, and good recall abilities. Since that time, Mrs. F has had a stroke, which has left her with deficits in these areas. Within this Significant Change assessment period, her decisions have become poor. She is not aware of her new physical limitations and has taken unreasonable safety risks in transferring and locomotion. She receives supervision at all times. **Code "2" for Deteriorated**.

**MDS Cognitive Performance Scale©**

Many facilities have asked for a system to combine MDS cognitive items into an overall Cognitive Performance Scale. Such a scale has been produced: The MDS Cognitive Performance Scale (CPS)© **[see Appendix F]**. Five MDS items are used in assigning residents to one of seven CPS categories. The CPS categories are highly related to residents' average scores on the Folstein Mini-Mental Status Examination (MMSE), which has a score range of zero (worst) to thirty (best). According to Folstein, an MMSE score of 23 or lower usually suggests cognitive impairment but it may be lower for persons with an eighth grade education or less.

# SECTION C. COMMUNICATION/HEARING PATTERNS

***Intent:*** To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many possible causes for the communication problems experienced by elderly nursing facility residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

## C1. Hearing (7-day look back)

***Intent:*** To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the past 7-day period. Environmental adjustments include reducing noise volume by lowering the sound volume on televisions or radios, and installing amplification devices on televisions.

***Process:*** Evaluate hearing ability after the resident has a hearing appliance in place, if the resident uses an appliance. Review the clinical record. Interview and observe the resident, and ask about the hearing function. Consult the resident's family, direct care staff, and speech or hearing specialists. Test the accuracy of your findings by observing the resident during your verbal interactions.

Be alert to what you have to do to communicate with the resident. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the resident needs to see your face to know what you are saying, or if you have to take the resident to a more quiet area to conduct the interview - all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, observe the resident interacting with others and while engaged in group activities. Ask the activities personnel how the resident hears during group leisure activities.

***Coding:*** Enter one number that corresponds to the most correct response.

**0. Hears Adequately** - The resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.

**1. Minimal Difficulty** - The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.

**2. Hears in Special Situations Only -** Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible or requires the use of a hearing-enhanced telephone.

**3. Highly Impaired/Absence of Useful Hearing** - The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

## C2. Communication Devices/Techniques (7-day look back)

***Definition:*** **a. Hearing Aid, Present and Used** - A hearing aid or other assistive listening device is available to the resident and is used regularly.

**b. Hearing Aid, Present and Not Used Regularly** - A hearing aid or other assistive listening device is available to the resident and is not regularly used (e.g., resident has a hearing aid that is broken or is used only occasionally).

c. **Other Receptive Communication Technique Used (e.g., lip reading) -** A mechanism or process is used by the resident to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, writing by staff member, use of communication board).

d. ***NONE OF ABOVE***

***Process:*** Consult with the resident and direct care staff. Observe the resident closely during your interaction.

***Coding:*** Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check *NONE OF ABOVE*.

## C3. Modes of Expression (7-day look back)

***Intent:*** To record the types of communication techniques (verbal and non-verbal) used by the resident to make his or her needs and wishes known.

***Definition:***

a. **Speech**

b. **Writing Messages to Express or Clarify Needs -** Resident writes notes to communicate with others.

c. **American Sign Language or Braille**

d. **Signs/Gestures/Sounds -** This category includes nonverbal expressions used by the resident to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for "yes" and once for "no" or squeezing another's hand in the same manner.

- Sounds may include grunting, banging, ringing a bell, etc.

e. **Communication Board -** An electronic, computerized or other homemade device used by the resident to convey verbal information, wishes, or commands to others.

f. **Other -** Examples include flash cards or various electronic assistive devices.

g. ***NONE OF ABOVE***

***Process:*** Consult with the primary nurse assistant and other direct-care staff from all shifts, if possible. Consult with the resident's family. Interact with the resident and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations.

***Coding:*** Check the boxes for each method used by the resident to communicate his or her needs. If the resident does not use any of the listed items, check *NONE OF ABOVE*.

## C4. Making Self Understood (7-day look back)

***Intent:*** To document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.

***Process:*** Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary nurse assistant (over all shifts) if available, the resident's family, and speech-language pathologist.

***Coding:*** Enter the number corresponding to the most correct response.

**0. Understood** - The resident expresses ideas clearly.

**1. Usually Understood** - The resident has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self understood.

**2. Sometimes Understood** - The resident has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

**3. Rarely or Never Understood** - At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

***Clarification:***

- A resident assessed in Item C4 (Making Self Understood) as "3" (Rarely/Never Understood), should not necessarily be coded as severely impaired in daily decision-making (Item B4, Cognitive Skills). The two areas of function are not always associated. The ability to understand may not be a functional problem, but a different language spoken by the resident. For example, a person who rarely/never understands may speak a language other than that spoken by caregivers, or he/she may be profoundly hearing or vision impaired. A more thorough assessment must be done to determine the actual level of cognitive function.

## C5. Speech Clarity (7-day look back)

***Intent:*** To document the quality of the resident's speech, not the content or appropriateness - just words spoken.

***Definition:*** **Speech** - the expression of articulate words.

***Process:*** Listen to the resident. Confer with primary assigned caregivers.

***Coding:*** Enter the number corresponding to the most correct response.

**0. Clear Speech** - utters distinct, intelligible words.

**1. Unclear Speech** - utters slurred or mumbled words.

**2. No Speech** - absence of spoken words.

## C6. Ability to Understand Others (7-day look back)

***Intent:*** To describe the resident's ability to comprehend verbal information whether communicated to the resident orally, by writing, or in sign language or Braille. This item measures not only the resident's ability to hear messages but also to process and understand language. This may be due to functional problems or that the resident uses a different language.

***Process:*** Interact with the resident. Consult with primary direct care staff (e.g., nurse assistants) over all shifts if possible, the resident's family, and speech-language pathologist. The resident may definitely be able to understand others when the information is presented to the resident in a way that he or she is most able to receive it. However, not all persons who interact with the resident will share information in the same way. If the resident needs to receive information in writing because he is highly hearing impaired but others (e.g., a roommate, visitors, other residents, etc.) do not present the information in writing, you must take this into consideration in coding the response that best reflects the resident's objective ability to understand information as it is presented to him.

***Coding:*** Enter the number corresponding to the most appropriate response.

**0. Understands** - The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

**1. Usually Understands** - The resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.

2. **Sometimes Understands** - The resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When staff rephrases or simplifies the message(s) and/or use gestures, the resident's comprehension is enhanced.

3. **Rarely/Never Understands** - The resident demonstrates very limited ability to understand communication. Or, staff has difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

## C7. Change in Communication/Hearing (90-days ago)

***Intent:*** To document any change in the resident's ability to express, understand, or hear information compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Process:*** In addition to consulting primary care staff (over all shifts if possible), consulting the family of new admissions, and reviewing prior Quarterly assessment when available, ask the resident if he or she has noticed any changes in the ability to hear, talk, or understand others. Sometimes, residents do not complain of changes being experienced because they attribute them to "old age." Therefore, it is important that they be asked directly. Some types of deterioration are easily corrected (e.g., by new hearing aid batteries or removal of ear wax).

***Coding:*** Enter the number corresponding to the most correct response. Enter "**0**" for No change, "**1**" for Improved, or "**2**" for Deteriorated.

**Examples of Change in Communication/Hearing**

Mrs. L has had expressive aphasia for two years. Although she periodically says a word or phrase that is understood by others, this is not new for her. During the last 90 days her communication status has essentially remained unchanged. **Code "0" for No change.**

Mrs. R's hearing is severely impaired. Five months ago the occupational therapist developed flash cards for staff to use when communicating with her. This was a tremendous boost for both Mrs. R and staff. Her ability to understand others continues to improve. **Code "1" for Improved.**

Upon admission two months ago Mrs. T had difficulty hearing unless the speaker adjusted his or her tone of voice and spoke more distinctly. She has worn hearing aids in the past but lost them during a hospital admission. Since admission to the nursing facility, Mrs. T was tested and fitted with new hearing aids. She hears much better with the aids though she is still trying to adjust to wearing them. **Code "1" for Improved.**

# SECTION D.
# VISION PATTERNS

***Intent:*** To record the resident's visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used.

## D1. Vision (7-day look back)

***Intent:*** To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses, magnifying glass). It is not intended that the staff do an eye chart exam.

***Definition:*** **"Adequate" Lighting** - What is sufficient or comfortable for a person with normal vision.

***Process:***

- Ask direct care staff over all shifts if possible, if the resident has manifested any change in usual vision patterns over the past seven days - e.g., is the resident still able to read newsprint, menus, greeting cards, etc.?

- Then ask the resident about his or her visual abilities.

- Test the accuracy of your findings by asking the resident to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.

- Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures. Be sure to display this information in two sizes (equivalent to regular and large print).

- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the resident has any visual ability.

- For residents who do not have the ability to see small objects and who are unable to participate in the eye testing described above, the assessor needs to conduct his or her own observation during the assessment process. Information may also be obtained by consulting with other staff that may be familiar with the resident's visual acuity.

***Coding:*** Enter the number corresponding to the most correct response.

**0. Adequate** - The resident sees fine detail, including regular print in newspapers/books.

**1. Impaired** - The resident sees large print, but not regular print in newspapers/books.

**2. Moderately Impaired** - The resident has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

**3. Highly Impaired** - The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).

**Note:** Many residents with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

**4. Severely Impaired** - The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

## D2. Visual Limitations/Difficulties (7-day look back)

***Intent:*** To document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurological diseases). It is important to identify whether or not these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

***Process:*** **a. Side Vision Problems** - Observe the resident during his or her daily routine (e.g., eating meals, traveling down a hallway). Also, ask the resident about any vision problems (e.g., spilling food, bumping into objects and people). Ask the primary nurse assistant and other direct-care staff on each shift if possible, whether or not the resident appears to have difficulties related to decreased peripheral vision (e.g., leaves food on one side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).

b. **Experiences Any of the Following** - Ask the resident directly if he or she is seeing halos or rings around lights, flashes of light, floaters, or "curtains" over the eyes. Ask staff members if the resident complains about any of these problems.

c. ***NONE OF ABOVE***

***Coding:*** Check all that apply. If none apply, check *NONE OF ABOVE*.

## D3. Visual Appliances (7-day look back)

***Intent:*** To determine if the resident uses visual appliances regularly.

***Definition:*** Glasses; contact lenses; magnifying glass - Includes any type of corrective device used at any time during the last seven days.

***Coding:*** Enter "**1**" if the resident used glasses, contact lenses, or a magnifying glass during the past seven days. Enter "**0**" if none apply.

# SECTION E.
# MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to the nursing facility, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly nursing facility residents because they are very treatable.

In many facilities, staff has not received specific training in how to evaluate residents who have distressed mood or behavioral symptoms. Therefore, many problems are under diagnosed and under treated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities has found the various mental health RAPs (e.g., Mood, Behavior) to be helpful and these should be carefully reviewed.

The process for gathering information should include direct observation of the resident, communication with the resident's direct caregivers across all shifts, review of relevant information in the resident's clinical record and if possible, consultation with family members or friends who have a direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not observe the behavior but others report that it occurred, the behavior must be considered as having occurred and should be so documented. It is important to document chronic symptoms as well as new onset. As always, the medical record should support the resident's status as reported on the MDS.

It is important to note that coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E.; they simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators and consider them when developing the resident's care plan.

## E1. Indicators of Depression, Anxiety, Sad Mood (30-day look back)

***Intent:*** To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

***Definition:*** Feelings of distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older nursing facility population. Rather, distress is more commonly expressed in the following ways:

### VERBAL EXPRESSIONS OF DISTRESS

**a. Resident Made Negative Statements** - e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

**b. Repetitive Questions** - e.g., "Where do I go; What do I do?"

**c. Repetitive Verbalizations** - e.g., Calling out for help, ("God help me").

**d. Persistent Anger with Self or Others** - e.g., easily annoyed, anger at placement in nursing facility; anger at care received.

**e. Self Deprecation** - e.g., "I am nothing; I am of no use to anyone".

**f. Expressions of What Appear to Be Unrealistic Fears** - e.g., fear of being abandoned, left alone, being with others.

**g. Recurrent Statements that Something Terrible is About to Happen** - e.g., believes he or she is about to die, have a heart attack.

**h. Repetitive Health Complaints** - e.g., persistently seeks medical attention, obsessive concern with body functions.

**i. Repetitive Anxious Complaints/Concerns (non-health related)** - e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationship issues.

**DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES:**

**SLEEP CYCLE ISSUES** - Distress can also be manifested through disturbed sleep patterns.

j. **Unpleasant Mood in Morning** - e.g., angry, irritable.

k. **Insomnia/Change in Usual Sleep Pattern** - e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

**SAD, APATHETIC, ANXIOUS APPEARANCE**

l. **Sad, Pained, Worried Facial Expressions** - e.g., furrowed brows

m. **Crying, Tearfulness**

n. **Repetitive Physical Movements** - e.g., pacing, hand wringing, restlessness, fidgeting, picking

**LOSS OF INTEREST** - These items refer to a change in resident's usual pattern of behavior.

o. **Withdrawal from Activities of Interest** - e.g., no interest in long standing activities or being with family/friends. If the resident's withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the resident has withdrawn from activities of interest or has shown no interest in being with family/friends.

p. **Reduced Social Interaction** - e.g., less talkative, more isolated

***Process:*** Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts, if possible, and family who have direct knowledge of the resident's behavior. Relevant information may also be found in the clinical record.

***Coding:*** For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code regardless of what you believe the cause to be.

**0.** Indicator not exhibited in last 30 days
**1.** Indicator of this type exhibited up to five days a week (*i.e., exhibited at least once during the last 30 days but less than 6 days a week*)
**2.** Indicator of this type exhibited daily or almost daily (6, 7 days a week)

***Clarifications:***

◆ The keys to obtaining, tracking and recording accurate information in Item E1, Indicators of Depression are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

- Daily communication between nurses, nurse assistants and other direct care providers is crucial for resident monitoring and care giving.

- Educate all caregivers (including direct care staff and staff who routinely come into contact with residents, such as housekeepers, maintenance, and dietary personnel about the residents' status in this area, and how to observe mood and behavior patterns that are captured in MDS Item E1. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated. Part of the reason may be that over time, these symptoms tend to be perceived as the residents' "normal" or "usual" behaviors.

- Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

◆ The mood items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether or not it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6 or 7 days a week), or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior occurred at least once, use code "1".

◆ If an indicator of depression occurs twice in the last 30 days (not 2 times each week), it should be coded as "1" to indicate that the indicator of depression was exhibited up to 5 days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the 30-day period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days.

**Example**

Mr. F is a new admission that becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He chastises her 'for not taking him into her home,' and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, tearful, and says "What's the use. I'm no good. I wish I died when my wife did." **Coding "1" for a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self deprecation), m. (Crying, tearfulness); remaining Mood items would be coded "0".**

## E2. Mood Persistence (7-day look back)

***Intent:*** To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console, or reassure the resident over the last seven days.

***Process:*** Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

***Coding:*** Enter "**0**" if the resident did not exhibit any mood indicators over last seven days, "**1**" if indicators were present and easily altered by staff interactions with the resident or "**2**" if any indicator was present but not easily altered (e.g., behavior persisted despite staff efforts to console resident).

## E3. Change in Mood (90 days ago)

***Intent:*** To document change in the resident's mood as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Definition:*** **Change in Mood -** Refers to status of any of the symptoms (new onset, improvement, worsening) described in Item E1 (verbal expressions of distress, sleep cycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and Item E2 (mood persistence). Such changes include:

- increased or decreased numbers of expressions or signs of distress
- increased or decreased frequency of distress occurrence

- increased or decreased intensity of expressions or signs of distress

***Process:*** Review the clinical records including the last Quarterly assessment findings and transmittal records of newly admitted residents. Interview and observe the resident. Consult with staff from all shifts, if possible, to clarify your observations.

***Coding:*** Code "**0**" if No Change, "**1**" if Improved, or "**2**" if Deteriorated as compared to status of 90 days ago.

**Examples of Changes in Mood**

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital for evaluation and treatment. Since her return to the nursing facility three weeks ago, her mood and appetite have improved while on a new lithium dose and an additional antidepressant drug. She is back to her "old self" of 90 days ago. **Code "0" for No change.**

During the admission assessment period of 90 days ago, Mr. M was tearful and expressed great sadness and anger over entering the nursing facility. He had difficulties falling asleep at night, was restless off and on during the night, and awakened too early in the morning, upset that he couldn't fall back to sleep. Since that time, Mr. M has been involved in a twice-weekly support group, and has been enjoying socializing in activities with new friends. He is currently sleeping through the night and feels well in the morning. Although he still expresses sadness and anger over his need for nursing facility care, it is less frequent and intense. **Code "1" for Improved**.

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was too restless. After the medication was discontinued, intensity of feelings and behaviors diminished and she has less frequent episodes of agitation. Mrs. D is better than she was, but she still has feelings of sadness. Mrs. D is now better than her worst status two months ago, but she has not fully recovered to her status of 90 days ago. **Code "2" for Deteriorated**.

During the admission assessment 6 weeks ago, Mrs. Z was very agitated. She had multiple daily complaints of vague aches and pains. She repetitively asked the nurses to "Call the doctor, I'm sick." After no physical problems could be identified, Mrs. Z was evaluated by a psychiatrist who diagnosed a clinical depression and prescribed an antidepressant drug. Its effect on Mrs. Z has been dramatic. During this Significant Change assessment, Mrs. Z had many fewer complaints about her health and was more involved in unit activities. **Code "1" for Improved.**

## E4. Behavioral Symptoms (7-day look back)

***Intent:*** To identify **(A)** the **frequency**, and **(B)** the **alterability** of behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others on the unit. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused.").

Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provide a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the resident's current status may not initially be detailed (and in some cases will not pinpoint the resident's actual problems) and it is not intended to be the one and only source of information. (See Process below) However, once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

***Definition:***

a. **Wandering** - Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

   Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item E1n, "Repetitive physical movements."

b. **Verbally Abusive Behavioral Symptoms** - Other residents or staff were threatened, screamed at, or cursed at.

c. **Physically Abusive Behavioral Symptoms** - Other residents or staff were hit, shoved, scratched, or sexually abused.

d. **Socially Inappropriate/Disruptive Behavioral Symptoms** - Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. **Resists Care** - Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has

exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

***Process:*** Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff has become used to the behavior and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptom or not? Is the resident combative during personal care and strike out at staff or not?

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff that provides direct care on all three shifts. A symptomatic behavior can be present and the RN Assessment Coordinator might not see it because it occurs during intimate care on another shift. Therefore, it is especially important that input from all nurse assistants having contact with the resident be solicited.

Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behavior over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

***Coding:***

## (A) Behavioral Symptom Frequency in Last 7 Days.

Record the frequency of behavioral symptoms manifested by the resident across all three shifts.

**Code "0"** if the behavioral symptom described was not exhibited in the last seven days.

Code "0" for each type of behavior described in Item E4, if the resident did not exhibit that type of symptom in the last seven days. This code applies to residents who have never exhibited the behavioral symptom or those who have

previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program. For example: A "wandering" resident who did not wander in the last seven days because he was restricted to a geri-chair would be coded "0" - Behavioral symptom not exhibited in last seven days. The questionable clinical practice of restricting wandering by placing a person in a geri-chair to restrict movement would then be evaluated using the Physical Restraints RAP.

**Code "1**" if the described behavioral symptom occurred 1 to 3 days, in last 7 days.

**Code "2"** if the described behavioral symptom occurred 4 to 6 days, but less than daily.

**Code "3"** if the described behavioral symptom occurred daily or more frequently (i.e., multiple times each day).

## (B) Behavioral Symptom Alterability in Last 7 Days.

**Code "0"** if either the behavioral symptom was not present or the behavioral symptom was easily altered with current interventions.

**Code "1"** if the described behavioral symptom occurred with a degree of intensity that is not responsive to staff attempts to reduce the behavioral symptom through limit setting, diversion, adapting unit routines to the resident's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc. For example: A cognitively impaired resident who hits staff during morning care and swears at staff with each physical contact on multiple occasions per day, and the behavior is not easily altered, would be coded "1".

| Examples for Wandering | (A) Frequency | (B) Alterability |
|---|---|---|
| Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behavior is easily channeled into other activities when staff redirects Ms. T by inviting her to activities. Ms. T is easily engaged and is content to stay and participate in whatever is going on. | 3 | 0 |

| Examples for Wandering (continued) | (A) Frequency | (B) Alterability |
|---|---|---|
| Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been met with Mr. W hitting and pushing staff. Over time, staff has found him to be most content while he is wandering within a structured setting. | 3 | 1 |

## E5. Change in Behavioral Symptoms (90 days ago)

***Intent:*** To document if the behavioral symptoms or resistance to care exhibited by the resident remains stable, increased or decreased in frequency of occurrence or alterability as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). Consider changes in any area, including (but not limited to) wandering, symptoms of verbal or physical abuse or aggressiveness, socially inappropriate behavior, or resistance to care. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Definition:*** **Change in Behavioral Symptoms** - refers to the status (new onset, improvement, worsening) of any of the symptoms described in Item E4 (Behavioral Symptoms). Such changes include:

- increased or decreased **numbers** of behavioral symptoms,
- increased or decreased **frequency** of behavioral symptoms occurrence,
- increased or decreased **intensity** of behavioral symptoms,
- increased or decreased **alterability** of behavioral symptoms.

***Process:*** Review nursing notes and resident's records, including the last Quarterly assessment findings and transmittal records of newly admitted residents. Observe the resident. Consult with direct care staff across all shifts, if possible, and family to clarify your observations.

***Coding:*** **Code "0"** if no change has occurred in behavioral symptoms. This code should also be used for the resident who has no behavioral symptoms currently or 90 days ago.

**Code "1"** (Improved) if the behavioral symptoms became fewer, less frequent, less intense, and were not complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

**Code "2"** (Deteriorated) if the behavioral symptoms became more frequent, more intense or were complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

**Examples of Change in Behavioral Symptoms**

Despite staff efforts to provide support and structure over the last 90 days, Mrs. H continues to hoard food in her room every day. Staff understands the needs of this formerly homeless woman, but because they have found ants and cockroaches in her room, they feel a need to reevaluate their approach to care. **Code "0" for No change since last assessment.**

During the seven-day assessment period, Mrs. D had a difficult time with bowel regularity. She had a history of constipation that became worse during an episode of pneumonia and poor fluid intake that resulted in dehydration. During this time Mrs. D was more confused and subdued. On several occasions during the assessment period She was found disimpacting herself and smearing feces (Socially Inappropriate/Disruptive Behavior). Upon examination, Mrs. D was found to have a fecal impaction. She received treatment and was placed on a bowel regimen. The program was successful in eliminating the socially inappropriate behavioral symptoms that were induced by discomfort. However, once Mrs. D started to feel better and was more alert, she resumed her former daily wandering (of 4 months ago), pushing others and rummaging through their dresser drawers. **Code "0" for No change since last assessment.**

Mrs. F has always been a quiet passive woman who has never exhibited any behavioral symptoms since her admission to the nursing facility. During this Significant Change assessment following Mrs. F's stroke, no problematic behavioral symptoms were noted. **Code "0" for No change since last assessment.**

Mr. C wanders in and out of other residents' rooms and rummages through their belongings at least once a day and sometimes more often. Despite this behavior, during the last few weeks, he has been easier to work with now that he is more familiar with staff. Although wandering and rummaging continue, he no longer screams, curses, and shoves residents and staff who try to stop this behavior as he did 90 days ago. **Code "1" for Improved.**

Ninety days ago Mrs. R banged her cane loudly and repetitively on the dining/activity room table about once a week. In the past week, staff has noticed that this socially inappropriate behavioral symptom (disruptive sounds) now occurs multiple times daily. **Code "2" for Deteriorated.**

# SECTION F.
# PSYCHOLOGICAL WELL-BEING

***Intent:*** To determine the resident's emotional adjustment to the nursing facility, including his or her general attitude, adaptation to surroundings, and change in relationship patterns.

## F1. Sense of Initiative/Involvement (7-day look back)

***Intent:*** To assess the degree to which the resident is involved in the life of the nursing facility and takes initiative in participating in various social and recreational programs, including solitary pursuits.

***Definitions:***

a. **At Ease Interacting with Others** - Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents, staff, and visitors. A resident who tries to shield himself or herself from being with others, spends most time alone, or becomes agitated when visited, is not "at ease interacting with others."

b. **At Ease Doing Planned or Structured Activities** - Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is at ease doing planned or structured activities, or a resident who pursues activity programs, seems content to be involved, and takes initiative in participating. A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses to attend any such activities, is not "at ease doing planned or structured activities."

c. **At Ease Doing Self-Initiated Activities** - These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., folding personal laundry, organizing belongings). Such residents find things to do to occupy themselves, like reading, writing letters or making phone calls. A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to find something for him or her to do, is not "at ease doing self-initiated activities." For these residents, there is no element of self-direction or self-initiation in activity involvement.

d. **Establishes Own Goals** - Consider statements the resident makes, such as "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. However, some goals may not actually be verbalized by the resident, but inferred in that the resident is observed to have an individual

way of living at the facility (e.g., organizing own activities or setting own pace).

e. **Pursues Involvement in Life of Facility** - In general, consider whether or not the resident partakes of facility events, socializes with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the nursing facility or the particular nursing unit is "involved in the life of the facility."

f. **Accepts Invitations into Most Group Activities** - A resident who is willing to try group activities even if later deciding the activity is not suitable and leaving, or who does not regularly refuse to attend group programs, "accepts invitations into most group activities."

g. ***NONE OF ABOVE***

***Process:*** Selected responses should be confirmed by objective observation of the resident's behavior (either verbal or nonverbal) in a variety of settings (e.g., in own room, in unit dining room, in activities room) and situations (e.g., alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident. Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations. Then talk with staff members who have regular contact with the resident (e.g., nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember, it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Cognitively impaired residents may show signs of being at ease by smiling, making eye contact with the activity leader, actively participating in the activity (clapping, tapping, dancing) and if not actively participating, the resident may be sitting or standing quietly during the activity. A cognitively impaired resident who is not at ease during an activity may cry or call out during the activity, repeatedly try to get up to leave the activity and not respond to gentle cueing to return to the activity, shout or strike out at staff or other residents. Use your best clinical judgment as a basis for planning care. If the resident is not at ease interacting with others and/or doing planned or structured activities, it should be coded regardless of the suspected reason and regardless of whether or not this is the resident's normal status. Continue to code this item if the problem persists over time.

***Coding:*** Check all that apply. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply. If you do not check any items in Section F1, check *NONE OF ABOVE*. For individualized care planning purposes, remember that information conveyed by unchecked items is no less important than information conveyed by checked items.

***Clarification:*** ◆ Item F1d, "Establishes own goals" and F3a, "Strong identification with past roles and life status" trigger the Psychosocial RAP. Both trigger elements were added in response to providers and consumer advocacy groups' desires to use the triggers to help staff focus on areas of resident strengths. This helps in staffs' efforts to assist the resident to reach his or her highest practicable level of well-being. Data indicated that triggers needed to be more inclusive for this RAP.

## F2. Unsettled Relationships (7-day look back)

***Intent:*** To indicate the quality and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff members, family, and other residents).

***Definition:***

a. **Covert/Open Conflict with or Repeated Criticism of Staff** - The resident chronically complains about some staff members to other staff members, verbally criticizes staff members in therapeutic group situations causing disruption within the group, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any assumption about why the problem exists or how it might be remedied.

b. **Unhappy with Roommate** - This category also includes "bathroom mate" for residents who share a private bathroom. Unhappiness may be manifested by frequent requests for roommate changes, or grumbling about "bathroom mate" spending too long in the bathroom, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioral status of roommate. Other examples of roommate compatibility issues include early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spending too much time on the telephone, or snoring, or odors from incontinence or poor hygiene.

c. **Unhappy with Residents Other Than Roommate** - May be manifested by chronic complaints about the behaviors of others, poor quality of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., repetitive, ongoing complaints beyond a reasonable level).

d. **Openly Expresses Conflict/Anger with Family/Friends** - Includes expressions of feelings of abandonment, ungratefulness on part of family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

e. **Absence of Personal Contact with Family/Friends** - Absence of visitors or telephone calls from others in the last seven days.

f. **Recent Loss of Close Family Member/Friend** - Includes relocation of family member/friend to a more distant location, even temporarily (e.g., for the winter months), incapacitation or death of a significant other, or a significant relationship that recently ceased (e.g., a favorite nurse assistant transferred to work on another unit).

g. **Does Not Adjust Easily to Change in Routines** - Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g., staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

**Example**

For the past 6 months, Mrs. A has been receiving 2 white pills, 1 blue pill, 1 yellow pill and 2 puffs of medication from an orange hand-held aerosol inhaler. The drug company that makes the inhaler recently changed its packaging. When Mrs. G is given the new blue inhaler to use and is told that it is the same drug with a different color holder, she becomes very agitated and upset. It takes a lot of patience and reassurance by the nurse before Mrs. G uses the new inhaler. This happened for several days during the past week. Based on this example, the clinician would check Item F2g, "does not adjust easily to change in routines."

***Process:*** Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about?

It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last seven days?

During routine nursing care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with direct-care staff (e.g., nurse assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the evaluator, you are seeking to gain an overall picture, a consensus view.

***Coding:*** Check all that apply over the last seven days. If none apply, check *NONE OF ABOVE*.

## F3. Past Roles (7-day look back)

***Intent:*** To document the resident's recognition or acceptance of feelings regarding previous roles or status now that he or she is living in a nursing facility.

***Definition:***

a. **Strong Identification with Past Roles and Life Status** - This may be indicated, for example, when the resident enjoys telling stories about his or her past, or takes pride in past accomplishments or family life, or continues to be connected with prior lifestyle (e.g., celebrating family events, carrying on life-long traditions).

b. **Expresses Sadness/Anger/Empty Feeling Over Lost Roles/Status** - Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use, I'm not capable of doing things I like to do anymore." Resident cries when reminiscing about past failures, accomplishments, memories.

c. **Resident Perceives that Daily Routine (Customary Routine, Activities) is Very Different from Prior Pattern in the Community** - In general, the resident's pattern of routines is perceived by the resident not to be comparable with his or her previous lifestyle.

**Examples**

In the nursing facility, a resident takes a shower 2 mornings a week vs. taking a daily tub bath before going to bed as she did at home.

A resident now retires at 7 pm whereas at home he stayed up to watch the 11 pm news.

In the community Mrs. L enjoyed multiple daily telephone conversations with her 5 daughters. In the nursing facility there is only one public telephone that seems to be in constant use by residents and staff. Mrs. L now speaks with each daughter only once a week.

The above examples could be coded in Item F3c.

***Process:*** Initiate a conversation with the resident about life prior to nursing facility admission. It is often helpful to use environmental cues to prompt discussions (e.g., family photos, grandchildren's letters or art work). This information may emerge from discussions around other MDS topics (e.g., Customary Routine, Activity Pursuits, ADLs). Direct care staff and family visitors may also have useful insights.

***Coding:*** Check item if it applies over the last seven days. If none apply, check *NONE OF ABOVE*.

# SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

**(7-day look back)**

Most nursing facility residents are at risk of physical decline. Most long-term and many short-term residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated. See Section 1.13 on the use of an interdisciplinary team to provide the most accurate assessment of each resident.

## G1. (A) Activities of Daily Living (ADL) Self-Performance (7-day look back)

***Intent:*** To record the resident's self-care performance in activities of daily living (i.e., what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the **last seven days**.

***Definition:*** **ADL SELF-PERFORMANCE** - Measures what the resident **actually did** (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

**a. Bed Mobility** - How the resident moves to and from a lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

**b. Transfer** - How the resident moves between surfaces - i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

**c. Walk in Room** - How resident walks between locations in his/her room.

**d. Walk in Corridor** - How resident walks in corridor on unit.

e. **Locomotion On Unit -** How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a wheelchair, locomotion is defined as self-sufficiency once in the chair.

f. **Locomotion Off Unit** - How the resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in a wheelchair, locomotion is defined as self-sufficiency once in chair.

g. **Dressing** - How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas, and housedresses.

h. **Eating -** How the resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

   Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and is not to be coded as an "8". The resident must be evaluated under the Eating ADL category for his/her level of assistance in the process. A resident who is highly involved in giving himself/herself a tube feeding is not totally dependent and should not be coded as a "4".

i. **Toilet Use** - How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.

j. **Personal Hygiene** - How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

***Process:*** In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the

resident's ADL self-performance over the seven-day period, 24 hours a day - i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources - i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how the resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility, yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each ADL performance coding option is intended to reflect real-world situations where slight variations in performance are common. Where small variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or two exceptions or instances for the provision of heavier care within the assessment period. For example, in scoring a resident as independent in ADL Self-Performance, there can be one or two exceptions. As soon as there are three exceptions, another code must be considered. While it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.

Because this section involves a two-part evaluation (Item G1A, ADL Self-Performance and Item G1B, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation.

To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as a "2" (Limited Assistance) in Toilet Use.

The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments.

**Guidelines for Assessing ADL Self-Performance and ADL Support**

- The scales in Items G1A and G1B are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the resident's capacity for involvement in self-care - i.e., what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. For nursing facilities, an assessment of potential capability is covered in Item G8 (ADL Functional Rehabilitation Potential).
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff, from all shifts, which have cared for the resident over the last seven days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Here is a typical conversation between the RN Assessment Coordinator and a nurse assistant regarding a resident's Bed Mobility assessment:

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

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

R.N. "She lays down and sits up without any verbal instructions or physical help?"

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

R.N. "How do you help her turn side to side?"

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

R.N. "Do you lift her by yourself or does someone help you?"

N.A. "I do it by myself."

R.N. "How many days during the last week did you give this type of help?"

N.A. "Every day."

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance Code of "3" (Extensive Assistance) and an ADL Support Provided Code of "2" (one person physical assist).

Now review the first two exchanges in the conversation between the RN Assessment Coordinator and nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the resident's skills or the nurse assistant's actual workload, or whether or not the current plan of care was being implemented.

***Coding:*** For each ADL category, code the appropriate response for the resident's actual performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF." Consider the resident's performance during all shifts, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

**0. Independent** - No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

**1. Supervision** - Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided, but only one or two times during last seven days.

**2. Limited Assistance** - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times), plus more weight-bearing support provided, but for only one or two times during the last 7 days.

3. **Extensive Assistance** - While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

   -- Weight-bearing support provided three or more times;
   -- Full staff performance of activity (3 or more times) during part (but not all) of last seven days.

4. **Total Dependence** - Full staff performance of the activity during entire seven-day period. There is complete non-participation by the resident in all aspects of the ADL definition task. If staff performed an activity for the resident during the entire observation period, but the resident performed part of the activity himself/herself, it would not be coded as a "4" (Total Dependence).

   Example: Eating is coded based on the resident's ability to eat and drink, regardless of skill, and includes intake of nourishment by other means (e.g., tube feeding, or total parenteral nutrition). For a resident to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity Did Not Occur During the Entire 7-Day Period** - Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

   - If the resident is bed bound and does not walk, there was no locomotion via bed, wheelchair, or other means, then you would code both Self Performance and Staff Support as "8". However, if the bed is moved in order to provide locomotion on or off the unit, then you would code the items according to the definitions provided in Section G1.

   - A resident who was restricted to bed for the entire 7-day period and was never transferred from bed would be coded for both Self Performance and Staff Support as "8", since the activity (transfer) did not occur.

   - To code Item G1hA = 8, consider if in the past 7 days the resident truly did not receive any nourishment. It should go without saying that this is a serious issue. Be careful not to confuse total dependence in eating (coded "4") with the activity itself (receiving nourishment and fluids). Keep in mind that as a resident who receives nourishment via tube feeding and manages the tube feeding independently is coded as G1hA = 0 (Independent). In addition, the definition for G1h includes IV fluids. Therefore, code G1hA = 4 (Total Dependence) rather than "8" for a resident who is receiving IV fluids or TPN.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 - Total Dependence) with the activity itself not occurring. For example: Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

***Clarification:***

- Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

  There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

**Examples**

The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Walking in Corridor. Rationale:** Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (i.e., putting a hat on resident's head) on two occasions, and weight-bearing assistance (i.e., lifting resident's arm into a sleeve) on one occasion during the last 7 days. **Code "2" for Limited Assistance in Dressing. Rationale:** There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

Additional clarification and coding examples have been developed for this Manual update and are presented below. Further clarification of ADL coding policy is presented later in this chapter starting on Page 3-92. You may wish to review these clarifications before proceeding to Section G1(B), ADL Support Provided.

# Self-Performance - INDEPENDENT

| ADLs - SELF-PERFORMANCE | INDEPENDENT |
|---|---|
| **Bed Mobility** | Mrs. D can easily turn and position her in bed and is able to sit up and lie down without any staff assistance. She requires use of a single side rail that staff place in the up position when she is in bed.<br>*Self Performance = 0 Support Provided = 1*<br>*Coding rationale: Resident is independent in set-up help only.* |
| **Transfer** | When transferring to her chair, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk over to her reclining chair.<br>*Self Performance = 0 Support Provided = 0*<br>*Coding rationale: Resident is independent.* |
| **Eating** | After staff delivered a lunch tray to Mr. K, he is able to consume all food and fluids without any cueing or physical help from staff.<br>*Self Performance = 0 Support Provided = 0*<br>*Coding rationale: Resident is independent.* |
| **Toilet Use** | Mrs. L was able to transfer herself to the toilet, adjust her clothing, and perform the necessary personal hygiene after using the toilet without any staff assistance.<br>*Self Performance = 0 Support Provided = 0*<br>*Coding rationale: Resident is independent.* |
| **Walk in Room** | Mr. R is able to walk freely in his room (obtaining clothes from closet, turning on T.V.) without any cueing or physical assistance from staff.<br>*Self Performance = 0 Support Provided = 0*<br>*Coding rationale: Resident is independent.* |
| **Walk in Corridor** | After receiving a new cane, Mr. X needed to be observed the first time he used it as he walked up and down the hall on his unit to insure that he appropriately used the cane. He does not require any additional staff assistance.<br>*Self Performance = 0 Support Provided = 0*<br>*Coding rationale: Resident requires no set up to complete task independently.* |

# Self-Performance – SUPERVISION

| ADLs - SELF-PERFORMANCE | SUPERVISION |
|---|---|
| **Bed Mobility** | Resident favors lying on right side. Since she has had a history of skin breakdown, staff must verbally remind her to reposition.<br>*Self Performance = 1 Support Provided = 0*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders for repositioning.* |
| **Transfer** | Staff must supervise the resident as she transfers from her bed to wheelchair. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.<br>*Self Performance = 1 Support Provided = 1*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders for safe transfer.* |
| **Eating** | One staff member had to verbally cue resident to eat slowly, and drink throughout the meal.<br>*Self Performance = 1 Support Provided = 0*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders for safe meal completion.* |
| **Toilet Use** | Staff member must remind resident to unzip pants and to wash his hands after using the toilet.<br>*Self Performance = 1 Support Provided = 0*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders.* |
| **Walk in Room** | Resident is able to walk in room, but staff member is available to cue and stand by during ambulation since the resident has had a history of unsteady gait.<br>*Self Performance = 1 Support Provided = 0*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders.* |
| **Walk in Corridor** | Staff member must provide continual verbal cuing while resident is walking down hallway to insure that the resident walks slowly and safely.<br>*Self Performance = 1 Support Provided = 0*<br>*Coding rationale: Resident requires staff supervision, cuing and reminders.* |

# Self Performance - Limited Assistance

| ADLs - SELF-PERFORMANCE | LIMITED ASSISTANCE |
|---|---|
| **Bed Mobility** | Resident favors laying on right side. Since she has had a history of skin breakdown, staff must sometimes help the resident place her hands on the side rail and encourage her to change her position when in bed.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: Resident requires cuing and encouragement with set up or minor physical help.* |
| **Transfer** | Mrs. H is able to transfer from the bed to chair when she uses her walker. Staff places the walker near her bed and then help to steady the resident as she transfers.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: Resident requires staff to set up her walker and provide help when she is ready to transfer.* |
| **Eating** | Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner, as he is tired and less interested in completing his meals. In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist in guiding his hand in order to get the utensil to his mouth.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: is unable to complete the meal without staff providing him non-weight-bearing assistance (3 or more times in the observation period).* |
| **Toilet Use** | Staff must assist Mr. P to zip pants, hand him a washcloth and remind him to wash his hands after using the toilet.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: Resident requires staff to perform non-weight bearing activities to complete the task.* |
| **Walk in Room** | Mr. K is able to walk in his room, but requires that a staff member place her arm around his waist when taking him to the bathroom due to his unsteady gait.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: Resident requires non-weight bearing assistance for safe ambulation.* |
| **Walk in Corridor** | Mrs. Q requires continual verbal cueing and help with hand placement when walking down the unit hallway. Mrs. Q needs frequent reminders how to use her walker, where to place her hands and to pick up feet. She frequently needs to be physically guided to the day room.<br>*Self Performance = 2 Support Provided = 2*<br>*Coding rationale: Resident requires non-weight bearing assistance for safe ambulation.* |

# Self-Performance – EXTENSIVE ASSISTANCE

| ADLs - SELF-PERFORMANCE | EXTENSIVE ASSISTANCE |
|---|---|
| **Bed Mobility** | Mr. Q has slid to the foot of the bed. Two staff members must physically lift and reposition him toward the head of the bed. Mr. Q was able to assist by bending his knees and push with legs when reminded by staff.<br>*Self Performance = 3 Support Provided = 3*<br>*Coding rationale: Resident partially participates in the task. 2 staff members are required.* |
| **Transfer** | Resident always had a difficult time standing from her chair. One staff member had to partially physically lift and support the resident as she stands up.<br>*Self Performance = 3 Support Provided = 2*<br>*Coding rationale: Resident partially participates in the task. 1 staff member is required.* |
| **Eating** | Mr. F begins eating a meal by himself. After he has only eaten the bread, he states he is tired and is unable to complete the meal. One staff member physically supports his hand and provides verbal cues to swallow the food in his mouth. The resident is able to complete the meal.<br>*Self Performance = 3 Support Provided = 2*<br>*Coding rationale: Resident partially participates in the task. 1 staff member is required.* |
| **Toilet Use** | Mrs. M has had recent bouts of vertigo. One staff member must assist and support her as she transfers to the bedside commode.<br>*Self Performance = 3 Support Provided = 2*<br>*Coding rationale: Resident partially participates in the task. 1 staff member is required.* |
| **Walk in Room** | Mr. A has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to support him help him select clothing from his closet.<br>*Self Performance = 3 Support Provided = 2*<br>*Coding rationale: Resident partially participates in the task. 1 staff member is required.* |
| **Walk in Corridor** | A resident had back surgery two months ago. Two staff members must physically support the resident as he is walking down the hallway due to his unsteady gait and balance problem.<br>*Self Performance = 3 Support Provided = 3*<br>*Coding rationale: Resident partially participates in the task. 2 staff members are required to help him walk.* |

# Self-Performance - Total Dependence

| ADLs - SELF-PERFORMANCE | TOTAL DEPENDENCE |
|---|---|
| **Bed Mobility** | Mrs. S is unable to physically turn, sit up or lay down in bed. Two staff members must physically turn her q 2 hours. She must be physically supported to a seated position in bed when reading.<br>*Self Performance = 4 Support Provided =3*<br>*Coding rationale: Resident did not participate and required 2 staff to position her in bed.* |
| **Transfer** | Mr. T is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer resident him to a reclining chair daily for. Mr. T. is unable to assist or participate in any way.<br>*Self Performance = 4 Support Provided =3*<br>*Coding rationale: Resident did not participate and required 2 staff to transfer him out of his bed.* |
| **Eating** | Mrs. U is severely cognitively impaired. She is unable to consume any of her meals or liquids served to her. One staff member is responsible to feed her all food and fluids.<br>*Self Performance = 4 Support Provided =2*<br>*Coding rationale: Resident did not participate and required 1 staff person to feed her all of her meal.*<br><br>Mr. B recently had a stroke. He is currently receiving 100% of his nutrition via a G-tube due to dysphagia. He does not assist in any part of the tube feed process.<br>*Self Performance = 4 Support Provided =2*<br>*Coding rationale: Resident did not participate and required 1 staff person to provide total nutritional support.* |
| **Toilet Use** | Miss W is cognitively and physically impaired resident, she is on strict bed rest. Staff is unable to physically transfer resident to toilet at this time. Miss W is incontinent of both bowel & bladder. One staff member must provide all care for her elimination and personal hygiene needs every 2 hours.<br>*Self Performance = 4 Support Provided =2*<br>*Coding rationale: Resident did not participate and required 1 staff person to provide total care for toileting and personal hygiene.* |

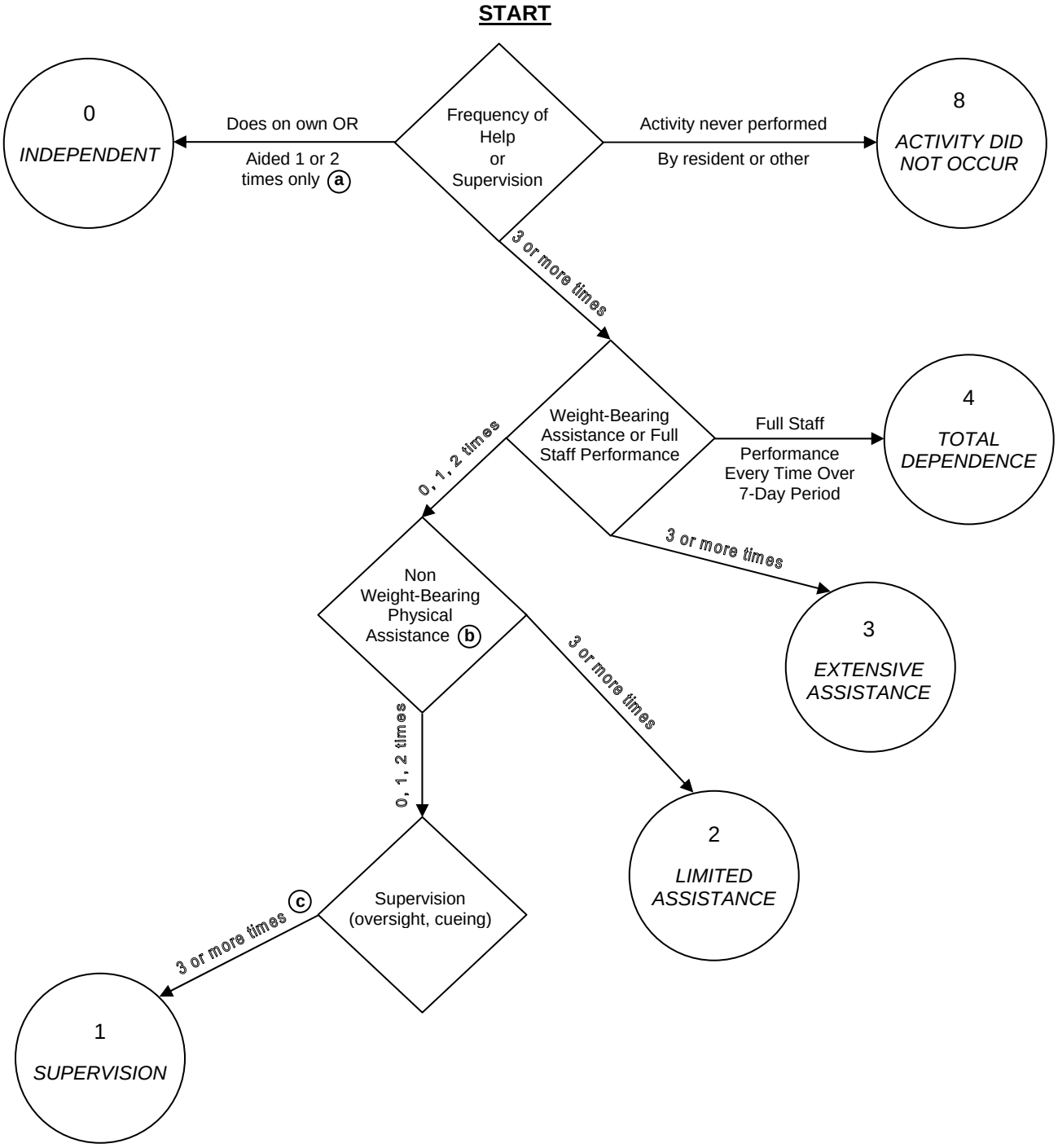
# Examples – ADL ACTIVITY DID NOT OCCUR

| ADLs - SELF-PERFORMANCE | 8/8 - ADL ACTIVITY DID NOT OCCUR |
|---|---|
| **Transfer** | Mrs. D is post-operative for extensive surgical procedures. Due to her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest and not moved from the bed.<br>*Self Performance = 8 Support Provided = 8*<br>*Coding rationale: Activity did not occur.* |
| **Walk in Room** | Mr. J is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance and utilizes a commode next to his bed.<br>*Self Performance = 8 Support Provided = 8*<br>*Coding rationale: Activity did not occur.* |
| **Walking in Corridor** | Mr. V is requires two therapy staff and parallel bars to ambulate learn how to ambulate. He currently attends physical therapy 6 days a week. He uses a wheelchair on the nursing unit.<br>*Self Performance = 8 Support Provided = 8*<br>*Coding rationale: Activity did not occur.* |
| **Locomotion on Unit** | Mrs. L is remaining on complete bed rest. She remains in her room or is transferred to a chair for 1 hour per day.<br>*Self Performance = 8 Support Provided = 8*<br>*Coding rationale: Activity did not occur.* |
| **Locomotion off Unit** | Mr. R does not like to go off his nursing unit. He prefers to stay in his room or the day room on his unit. He has visitors on a regular basis and they visit with him in the dayroom.<br>*Self Performance = 8 Support Provided = 8*<br>*Coding rationale: Activity did not occur.* |

# Examples - WHEN NOT TO CODE 8/8-ACTIVITY DID NOT OCCUR

| ADLs - SELF-PERFORMANCE | WHEN NOT TO CODE 8/8 – ADL ACTIVITY DID NOT OCCUR |
|---|---|
| **Bed Mobility** | Mrs. P is unable to physically turn, sit up or lay down in bed for the past week. Two staff members must physically turn her q 2hrs. She must be physically supported to a seated position in bed.<br>*Self Performance = 4 Support Provided =3*<br>*Coding rationale: Although the resident did not move herself, staff performed the activity for her. Self –performance code for the resident is total/did not participate; required 2 staff to position her in bed.* |
| **Eating** | Mrs. D is fed by feeding tube. No food or fluids are consumed thru her mouth.<br>*Self Performance = 4 Support Provided =2*<br>*Coding rationale: Resident does not participate in eating and receives nutrition and hydration thru a tube.* |
| **Toileting** | Mr. J has a catheter for urine. Adult briefs are utilized, checked, and changed every 3 hours.<br>*Self Performance = 4 Support Provided =2*<br>*Coding rationale: Resident requires total care and staff support in toileting.* |
| **Dressing** | Mrs. C does not feel well and chooses to stay in her room. She requests to stay in nightclothes and rest in bed for the entire day. After washing up, she changes nightclothes with limited assistance from the CNA.<br>*Self Performance = 2 Support Provided =2*<br>*Coding Rationale: Resident was highly involved in the activity and changed clothing.* |

# SCORING ADL SELF PERFORMANCE




a. Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.

b. Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".

c. Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".

# G1. (B) ADL Support Provided

***Intent:*** To record the type and highest level of support the resident received in each ADL activity over the last seven days.

***Definition:*** **ADL Support Provided:** Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. This is a different scale, and is entirely separate from the ADL Self-Performance assessment.

**Set-Up Help:** The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

**Examples of Setup Help**

- **For bed mobility** - handing the resident the bar on a trapeze, staff applies ½ rails and then provides no further help.
- **For transfer** - giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**

  **Walking** - handing the resident a walker or cane.

  **Wheeling** - unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** - retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** - cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** - handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** - providing a washbasin and grooming articles.
- **For bathing** - placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

***Process:*** For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

***Coding:*** Note: The highest code of physical assistance in this category (other than the "8" code) is a code of "**3**", not "4" as in Self-Performance.

**0. No Setup or Physical Help from Staff**

**1. Setup Help Only** - The resident is provided with materials or devices necessary to perform the activity of daily living independently.

**2. One Person Physical Assist**

**3. Two+ Persons Physical Assist**

**8. ADL Activity Itself Did Not Occur During the Entire 7 Days** - When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example, if a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

***Clarifications:***

- General supervision of a dining room is not the same as individual supervision of a resident. If the resident ate independently, then MDS Item G1h is coded as "0" (Independent). If the individual resident needed oversight, encouragement, or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a resident who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-Day assessment period, the resident would still be coded as a "1" (Supervision). Residents who are in "feeding" or "eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self Performance in Eating.

- The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the resident's hand. If the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the resident

can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his/her mouth, this is guided maneuvering.

- ◆ If therapists are involved with the resident, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The resident may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the resident's performance. When discussing a resident's ADL performance with a therapist, make sure the therapist's information can be expressed in MDS terminology.

CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR):

- If the resident is bed bound and does not walk and there was no locomotion via bed, wheelchair or other means, then you would code an "8" for transfer and locomotion. However, if the bed is moved in order to provide locomotion on or off the unit, then you would code according to the definitions provided in Section G., 1A and B.
- For example, use code 8 when the resident did not walk in the past seven days, (in room/in corridor), for both the self-performance and the support columns.
- A resident who has not been out of bed in the past seven days could be coded 8 for (A) and (B) in MDS Sections G1b-f, unless the bed was moved (locomotion on/off unit). Other ADLs are considered individually.
- The eating item for G1h is a little more complex. If in the past seven days the resident truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a resident who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a resident who is receiving fluids for hydration, and is totally dependent, this is coded as 4, rather than 8.
- Toilet use focuses on whether or not elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur.

***The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, then compare your answers with those provided. For the purpose of this exercise, the clinician should assume that the resident has performed at the same level for the last 7 days.***

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Bed Mobility*** | | |
| Resident was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed. | 1 | 0 |
| Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons. | 1 | 3 |
| Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard. | 3 | 2 |
| To turn over, the resident always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance). | 3 | 2 |
| Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed. | 3 | 3 |
| Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable. | 4 | 3 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Transfer*** | | |
| Despite bilateral above-the-knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted, by a staff member, from the wheelchair back into the bed. | 0 | 2 |
| Resident was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed. | 0 | 1 |
| Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed. | 0 | 1 |
| Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely. | 2 | 2 |
| Transferring ability varied throughout each day. Resident received no assistance at some times and heavy weight-bearing assistance of one person at other times. | 3 | 2 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Walk in room*** | | |
| Resident walked in his/her room while holding on to furniture for support. | 0 | 0 |
| Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night. | 2 | 2 |
| Resident received non-weight bearing physical assistance of one person for all walking in own room. | 2 | 2 |
| Resident did not walk but wheeled self independently in own room. | 8 | 8 |
| ***Walk in corridor*** | | |
| A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room. | 1 | 0 |
| A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety. | 1 | 1 |
| Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person. | 1 | 0 |
| Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight-bearing assistance of 1 person for each walk. | 3 | 2 |
| Resident walked in room for short distances with extensive assistance of 2 persons but traveled independently in corridor on unit by wheelchair. | 8 | 8 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Locomotion on unit*** | | |
| Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15 - 20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own. | 0 | 0 |
| A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently. | 2 | 2 |
| Resident ambulated independently around the unit "ad lib," socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night. | 2 | 2 |
| During last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair. | 3 | 3 |
| ***Locomotion off unit*** | | |
| Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period. | 0 | 0 |
| Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building, she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session, she was wheeled back to her unit. | 0 | 2 |
| Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility. | 1 | 0 |
| Resident did not leave the residential unit during the 7-Day assessment period. | 8 | 8 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Dressing*** | | |
| Resident usually dressed self. After a seizure, she received total help from several staff members once during the week. | 0 | 3 |
| Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime. | 3 | 2 |
| Nurse assistant provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm. | 3 | 2 |
| A 325 lb. resident received total care by two persons in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc. | 4 | 3 |
| ***Eating*** | | |
| Resident arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room. | 0 | 0 |
| Resident on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff. | 0 | 1 |
| Resident with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary). | 1 | 0 |
| Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat. | 1 | 1 |
| Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item. | 1 | 1 |
| Resident fed self solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately. | 1 | 1 |
| Resident, with difficulty initiating activity, always ate independently after someone gently lifted and directed her hand with the first few bites and then offered encouragement to continue. | 3 | 2 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Eating (continued)*** | | |
| Resident with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils. | 3 | 2 |
| Resident fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal. | 3 | 2 |
| Resident who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision. | 3 | 2 |
| Resident received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse. | 4 | 2 |
| ***Toileting Use*** | | |
| Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table. | 0 | 1 |
| In the toilet room resident is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically. | 1 | 0 |
| Resident uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week. | 0 | 2 |
| When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes. | 3 | 2 |
| Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads). | 3 | 3 |
| Obese, severely physically and cognitively impaired resident receives a mechanical lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every 2 hours by 2 persons. | 4 | 3 |

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Personal Hygiene*** | | |
| New resident, in nursing facility adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2 - 3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities. | 0 | 0 |
| Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task. | 1 | 1 |
| Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully. | 1 | 0 |
| Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location. | 1 | 1 |
| Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to shave his thick beard. | 3 | 2 |
| Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene. | 3 | 2 |

## G2. Bathing (7-day look back)

Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G1A do not apply. A unique set of Self-Performance codes, to be used only in the Bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a seven-day period would be one or two baths, the coding for the other ADL Self- Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as "Independent" for Bathing.

If a facility has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the Staff Support as supervision, even if the supervision is precautionary.

The ADL Support Provided codes given in Item G1B, however, continue to apply to the Bathing activity.

***Intent:*** To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower. This item is intended to capture how much of the bathing activity the resident can perform for him/herself and how much staff assistance is needed.

***Definition:*** **Bathing -** How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair.

***Coding:*** **(A) Bathing Self-Performance Codes -** Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during bathing episodes.

**0. Independent -** No help provided
**1. Supervision -** Oversight help only.
**2. Physical help limited to transfer only**
**3. Physical help in part of bathing activity**
**4. Total dependence**
**8. Activity itself did not occur during entire 7 days**

**(B) Support -** Next, score the maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

| Examples: ADL Self-Performance and Support | Self-Perf. | Support |
|---|---|---|
| ***Bathing*** | | |
| Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight. | 1 | 0 |
| On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely. | 3 | 2 |
| Resident afraid of mechanical lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity. | 3 | 2 |
| For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. ***Rationale:*** The coding directions for bathing state, "code for most dependent in self performance and support." | 4 | 2 |

## G3. Test for Balance (7-day look back)

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

***Intent:*** To record the resident's capacity of **a.** Balance while standing (not walking) without an assistive device or assistance of a person, and **b.** Balance while sitting **without using the back or arms of the chair for support.**

***Process*** **a. Balance While Standing**

Preparation:

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later. In approaching a resident for a balance test, staff should provide privacy and an explanation. The resident may, of course, decline the test, but the

- facility should attempt to determine why the resident is refusing. Since this would affect the MDS response, it seems worthy of a short notation, which may be written directly on the MDS form. Surveyors will accept individual residents declining to participate, but will probably be suspicious if an untoward number of residents decline participation in this test.

- Place a chair directly behind the resident in case the resident needs to sit down.

- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.

- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the tests:

- **DO** each of the following tests (10 seconds each) on residents who are able to stand without physical help.

- **DO NOT** attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.

- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

Position 1 -

"I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]

"Do not move your feet until I say stop. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 2. **If the resident is NOT ABLE to maintain this position for 10 seconds, stop testing here.** Do not proceed with Position 2 for balance testing.

Position 2 -

"Now I would like you to stand with one foot halfway in front of the other like this" (demonstrate as illustrated).

"You may use either foot, whichever is more comfortable for you. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 3. **If the resident is NOT ABLE to do this, stop testing here.**

Position 3 -

"Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin."

***Coding:***

0. **Maintained Position as Required in Test -** Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.

1. **Unsteady, but Able to Rebalance Self Without Physical Support** - Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2. **Partial Physical Support During Test, or Stands but Does Not Follow Directions for Test** - While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to stand without physical help from another person or an assistive device.

**Examples of Balance Testing**

Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin."

**Results**: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

**How to proceed:** Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

**Coding: "1", Unsteady, but able to rebalance self without physical support**.
***Rationale***: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if her were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

**Results:** During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

**How to proceed:** STOP the test.

**Coding: "2", Partial physical support during test or stands, but does not follow directions for test.**

***Rationale:*** This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

**How to proceed:** DO NOT perform any standing balance tests. Ms. M cannot stand.

**Coding: "3", Not able to attempt test without physical help.**

***Process:*** **b. Balance while sitting - position, trunk control**

Preparation:

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test:

- DO NOT attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

***Coding:***

**0. Maintained Position as Required in Test** - Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.

**1. Unsteady, but Able to Rebalance Self Without Physical Support** - Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.

**2. Partial Physical Support by Others During Test or Sits but Does Not Follow Directions for Test** - While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support from other(s) or from touching the backs or sides of the chair for support.

This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

**Examples of Sitting Balance**

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support." You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

**Results:** Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

**How to proceed:** Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

**Coding:** "0", Maintained position as required in test.

## G4. Limitation in Range of Motion (7-day look back)

### (A) Limitation in Range of Motion (ROM).

***Intent:*** **Limitation in the Range of Motion**: To record the presence of (A) limitation in range of joint motion or (B) loss of voluntary movement.

***Definition:*** Functional limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

***Process:*** **Assessing for Limitations:** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g., recent fracture or joint replacement).

- Perform each test on both sides of the resident's body.

- Depending on the resident's cognitive level, use the direction most appropriate for assessing limitations in ROM such as:

    - Ask the resident to follow your verbal instructions for each movement.
    - Demonstrate each movement (e.g., Ask the resident to do what you are doing).
    - Actively assist the resident with ROM exercises.

    In active assisted exercises, the assessor will guide the resident's joints through the movements while providing support and direction with each activity. If resistance is met during the exercises stop immediately and use staff observations during the assessment period to determine the ability and/or limitations to ROM activity.

- Staff observations of the ROM activity can be used to determine whether or not a resident can actually perform the activity, regardless of whether or not the movement was "on command," provided the movement fits the criteria specified below and occurred during the assessment period of observation.

- STOP if a resident experiences pain.

**a.** **Neck** - With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, and then left ear towards left shoulder.

**b.** **Arm** - including shoulder or elbow - With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.

**c.** **Hand** - including wrist or fingers - For each hand, instruct the resident to make a fist, and then open the hand (useful actions for grasping utensils, letting go).

**d. Leg** - including hip or knee - While resident is lying supine in a flat bed instruct the resident to lift his or her leg (one at a time), bending it at the knee. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and extend it flat on the mattress.

**e. Foot** - including ankle or toes - While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot.

**f. Other Limitation or Loss** - Decreased mobility in spine, jaw, or other joints that are not listed.

***Coding:*** For each body part, code the appropriate response for the resident's active (or active assisted) range of motion during the past seven days. The process of determining the coding for G4(A) is a 2-step process. First, determine if there is a limitation in active or active assisted ROM. If "no," code "0." If "yes," then go to the next question: Does the limitation in ROM interfere with function or place the resident at risk for injury? If "no," code "0." If "yes," code either "1" or "2." If the resident is unable to assist with ROM at all, consider that body part as limited. Enter the code in the column labeled (A). **If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.**

**0. No limitation** - Resident has full function range of motion on the right and left side.

**1. Limitation on One Side of the Body (Either Right or Left Side)** - that interferes with daily functioning or places the resident at risk of injury.

**2. Limitation on Both Sides of the Body** - that interferes with daily functioning or places the resident at risk of injury.

**Example of Coding for**
**(A) Limitation in Range of Motion**

Mr. O was admitted to the nursing facility for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

| | **Coding (A)** |
|---|---|
| Neck | 0 |
| Arm | 0 |
| Hand | 0 |
| Leg | 1 |
| Foot | 0 |
| Other | 0 |

## (B) Loss of voluntary movement.

***Definition:*** **Loss of Voluntary Movement:** Impairment in purposeful (intentional) functional movement. This category refers to a range of impairments exhibited when a resident tries to perform a task and includes deficits such as uncoordinated movements, tremors, spasms, muscular rigidity, "freezing," choreiform movements (jerking) as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place a resident at risk for functional disability and injury.

***Process:*** While performing the assessment of range of motion in Item G4(A) above, observe the resident for impairment(s) in purposeful movement on each side of the resident's body. A therapist or nurse should conduct the evaluation.

***Coding:*** For each body part, code the appropriate response for the resident's function during the past seven days. Enter the code in the column labeled (B). **If the body part is missing on one side (e.g., left above knee amputation), code "1", Partial loss of voluntary movement. If missing bilaterally, code "2", Full loss of voluntary movement**.

**0. No Loss of Voluntary Movement** - Resident moves body part to complete the required task. Movements are smooth and coordinated.

**1. Partial Loss of Voluntary Movement** - Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform, frozen, etc. on one or both sides. Residents with full loss of voluntary movement on one side of the body and full range on the other would be coded (1) partial loss of voluntary movement. Residents with partial loss on one side and full loss on the other would be coded (1) partial loss of voluntary movement.

**2. Full Loss of Voluntary Movement** - Resident is not able to initiate the required task. There is no voluntary movement on either side.

**Example of Functional Limitation**

Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her right leg flat on the bed. She has no feet. She has no other limitations.

**Coding**

| | (A) Limitation in Range of Motion | (B) Loss of Voluntary Movement |
|---|---|---|
| a. Neck | 2 | 0 |
| b. Arm | 1 | 1 |
| c. Hand | 1 | 1 |
| d. Leg | 1 | 1 |
| e. Foot | 2 | 2 |
| f. Other | 0 | 0 |

In this example, the resident is only able to turn her head slightly from side to side and tip her head towards each shoulder. Cervical ROM is an important component in every day activities. For example, cervical rotation is extremely important during walking. From a safety standpoint, a person can normally walk and move one's head to look for potential obstacles, not only on the ground, but also to the side. If cervical ROM is not functional, then the person may be a potential fall risk. In this example, the resident has limited rotation and lateral flexion bilaterally.

## 5. Modes of Locomotion (7-day look back)

***Intent:*** To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

***Definition:***

**a. Cane/Walker/Crutch** - Also check this item in those instances where the resident walks by pushing a wheelchair for support, or uses an enclosed four-wheeled walker with/without a posterior seat and lap cushion.

**b. Wheeled Self -** Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

**c. Other Person Wheeled** - Another person pushed the resident in a wheelchair.

**d. Wheelchair Primary Mode of Locomotion** - Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

**e.** ***NONE OF ABOVE (is not used on the MPAF)***

***Coding:*** Check all that apply during the last 7 days. If no appliances or assistive devices were used, check *NONE OF ABOVE*.

## G6. Modes of Transfer (7-day look back)

***Intent:*** To record the type(s) of appliances or assistive devices the resident used for transferring in and out of bed or chair, and for bed mobility.

***Definition:***

**a. Bedfast All or Most of the Time -** Resident is in bed or in a recliner in own room for 22 hours or more per day. This definition also includes residents who are primarily bedfast but have bathroom privileges. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation. **Code this item when it occurs on at least 4 of the last 7 days.**

The concept of bedfast is meant to capture residents who spend 22 hours or more in a bed or recliner in their own room regardless of their level of function. Immobility, whether innate or self-inflicted, places residents at risk for a myriad of clinical problems. For example, being bedfast may also be an indicator that a resident is withdrawn from others and suffers from depression.

**b. Bed Rail(s) Used for Bed Mobility or Transfer -** Refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.** In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. When a bed rail is both a restraint and a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) and at Item G6b (bed rails used for mobility or transfer).

**c. Lifted Manually -** The resident was completely lifted by one or more persons.

**d. Lifted Mechanically -** The resident was lifted by a mechanical device (e.g., mechanical lift). Does not include a bath lift.

**e. Transfer Aid -** Includes devices such as slide boards, trapezes, canes, walkers, braces, and other assistive devices, such as gait belts when used during the transfer of a resident.

**f. *NONE OF ABOVE (is not used on the MPAF)***

***Coding:*** Check all that apply. If none of these items apply, check *NONE of ABOVE*.

## G7. Task Segmentation (7-day look back)

***Intent:*** To identify residents who are more involved and independent in personal care tasks (such as eating, bathing, grooming, dressing), because they have received help in breaking tasks down into smaller steps. Some residents become overwhelmed and anxious when there are expectations for greater independence and they are no longer able to perform the steps necessary to complete an ADL activity. Such residents are at great risk for becoming dependent on others unless activities are made easier for them to manage by task segmentation. These residents usually have some deficits in memory, thinking, or paying attention to the task consequent to problems such as dementia, head injury, CVA, or depression. Other residents receive task segmentation care because of body-control problems, poor stamina, or other physical difficulties that limit self-performance.

***Definition:*** **Task Segmentation** - Provides the resident with directions, such as verbal cues, physical cues, or verbal and physical cues - for performing each constituent step in an ADL activity.

Verbal cueing involves giving a verbal direction to complete the first step in a task, and once the step is accomplished, giving another verbal direction to complete the next step. Verbal encouragement, praise, and feedback for the resident's successful completion of the steps are usually given by the direct care staff person prior to providing the next verbal cue. For example, "That looks good. Now put on this skirt."

Physical cueing involves giving the resident an object as a reminder of what needs to be done - e.g., handing the resident some toilet paper as a cue to wipe self, or placing an item from a food tray in front of the resident and handing him or her a fork as a cue to eat the item.

Physical and verbal cueing involves use of objects and words to stimulate action - e.g., giving the resident one item of clothing at a time and saying "Put this shirt on," which is less confusing to a cognitively impaired resident than putting all clothing items before him or her and saying "Get dressed."

| Examples | |
|---|---|
| **Task Segmentation** | **No Task Segmentation** |
| • When handed a face cloth and asked, "Would you please wash your face?", the resident washes her face.<br><br>• When a nurse assistant sets a mirror in front of the resident, and hands him a brush, the resident brushes his hair.<br><br>• When the nurse assistant hands the resident a sock and says "Put this sock on this foot" and upon completion of the step hands the resident another sock and says "Put this sock on this foot," the resident dons his socks.<br><br>• When single food items and only one utensil are presented to the resident in succession, the resident eats independently.<br><br>• When a nurse assistant gives verbal directions for each step in transferring from a wheelchair (e.g., "Lock the brakes... Hold onto the arms of the chair and push yourself up... Hold onto your walker with both hands like this [demonstrates]"), the resident succeeds in transferring himself from a seated to a standing position. | • When a washbasin, a face cloth, a towel, and various grooming supplies are placed before the resident, the resident becomes overwhelmed.<br><br>• When a nurse assistant places the resident's clothes for the day on the bed and says, "Get dressed," the resident becomes confused and is unable to dress self.<br><br>• When a tray containing an entire meal and several different utensils are placed before the resident on a table, the resident becomes confused and is unable to eat by herself.<br><br>• When a nurse assistant lifts a resident from a sitting to a standing position and does not involve the resident in the process of self-care in the activity, the resident becomes more physically dependent on the nurse assistant. |
| For all above examples, **Code "1" for Yes.** | For all above examples, **Code "0" for No.** |

***Process:*** Ask the nurse assistant to think about how the resident completes activities of daily living, or ways the nurse assistant helped the resident complete an activity of daily living over the last seven days. Specifically: Did the nurse assistant break the ADL activity into subtasks (smaller steps) so that the resident could perform them? Did this occur in the last seven days?

***Coding:*** Code "**0**" if task segmentation was not done. Code "**1**" if ADLs were broken into a series of subtasks so that resident could perform them.

***Clarification:***

- Evidence of Task Segmentation (Item G7) information may be documented anywhere in the clinical record (e.g., nurse's notes or therapy notes). Some facilities may choose not to document task segmentation separately, but to use the MDS to indicate the activity. It makes sense however, that staff should be knowledgeable about how to break down task(s) for individual residents (i.e., based upon that individual's needs) so that they may integrate task segmentation into the resident's care.

## G8. ADL Functional Rehabilitation Potential (7-day look back)

***Intent:*** To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g., walk longer distances, shower independently).

***Process:*** Ask if the resident thinks he or she could be more self-sufficient given more time. Listen to and record what the resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs varies from time to time, or if ADL function or joint range of motion has declined or improved in the last three months.

Ask direct care staff (e.g., nurse assistants on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs varies from time to time. Ask if ADL function or range of motion of joints declined or improved in the last three months. You may need to prompt staff to consider such factors as:

- Has self-performance in any ADL varied over the last week (e.g., the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?

- Has resident's performance varied during the day (e.g., more involved and independent in the afternoon than in the morning)?

- Was the resident so slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time? - OR - Is the resident capable of increased self-performance when tasks are broken into manageable steps?

- Does the resident tire noticeably during most days?

- Does the resident avoid an ADL activity even though physically or cognitively capable (e.g., refuses to walk alone for fear of falling, demands that others attend to personal care because they do it better)?

- Has the resident's performance in any ADL improved?

***Coding:*** Check all that apply. If none of these items apply check *NONE OF ABOVE*.

**a. Resident believes he/she is capable of increased independence in at least some ADLs**

**b. Direct care staff believe resident is capable of increased independence in at least some ADLs**

**c. Resident able to perform tasks/activity but is very slow**

**d. Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings**

**e. *NONE OF ABOVE***

**Examples**

Mr. N, who is cognitively impaired, receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff isn't looking. **Check "a" (Resident believes he/she capable of increased independence).**

The nurse assistant who totally feeds Mrs. W has noticed in the past week that Mrs. W has made several attempts to pick up finger foods. She believes Mrs. W could become more independent in eating if she received close supervision (cueing) in a small group for restorative care in eating. **Check "b" (Direct care staff believes resident is capable of increased independence).**

Mrs. Y has demonstrated the ability to get dressed, but has missed breakfast on several occasions because she was slow getting organized. Therefore, every morning her nurse assistant physically helped her to dress so that she would be ready for breakfast. **Check "c" (Resident able to perform task but is very slow).**

Mrs. F remained continent during day shifts while receiving supervision in toileting. During the evening and night shifts she was incontinent because she was not helped out of bed to the toilet room. After incontinence episodes, direct-care staff provided total help in hygiene. **Check "d" (Difference in ADL self-performance or ADL support, comparing mornings to evenings).**

Mr. K has hemiplegia secondary to a CVA. He receives extensive assistance in bed mobility transfer, dressing, toilet use, personal hygiene and eating. He is totally dependent in locomotion (wheelchair). Whenever he has tried to do more for himself he has experienced chest pain and shortness of breath. Both Mr. K and direct care staff believe that he is involved in self-care as much as he is physically able. **Check "e" (*NONE OF ABOVE*).**

## G9. Change in ADL Function (90 days ago)

***Intent:*** To document any changes occurring in the resident's overall ADL self-performance, as compared to status of 90 days ago (or since last assessment if less than 90 days ago). This item asks for a snapshot of "today" as compared to 90 days ago (i.e., a comparison of 2 points in time). These include, but are not limited to, changes in the resident's level of involvement in ADL activities as well as the amount and the type of support received by staff. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Process:*** Review the record for indications of a change. Consult with the resident and direct care staff. Review Section G from the last assessment and compare these

findings with current findings. For new residents, consult with the primary family caregiver.

***Coding:*** Code "**0**" if there has been no change. Code "**1**" if the resident's ADL function has improved. Code "**2**" if the resident's function has deteriorated. You may find that some ADLs have improved, some deteriorated, and others remain unchanged. You must weigh all of the information and make an overall clinical judgment (e.g., in general, the resident's ADL function has...).

**Examples**

Dr. B had been highly involved in self-care in most ADL activities. Seven weeks ago he slipped, fell, and bruised his right wrist. For several weeks he received more extensive assistance with dressing, grooming, and eating. However, in the last three weeks he is functioning at the same level of involvement in ADLs as before the fall. **Code "0" for No change.**

Ms. A participated in a structured feeding group during the past six weeks. With lots of encouragement and supervision from the group leader, she has progressed from requiring extensive assistance to feeding herself under staff supervision. Her performance in other ADLs remains unchanged. **Code "1" for Improved.**

Since fracturing her left hip three weeks ago, Mrs. Z receives more weight bearing help with transfers, locomotion, dressing, toileting, personal hygiene, and bathing. However, she has made strides in OT and PT. Her improvement in self-care has been steady although she still has a long way to go to reach her Self-Performance level of 90 days ago. **Code "2" for Deteriorated.**

Mr. L's favorite nurse (Miss McC) transferred to another unit 30 days ago. Although he says he's happy for her, he has become more passive and withdrawn. He no longer dresses himself in a suit and tie. His personal hygiene habits have deteriorated and he now must be frequently coaxed to shave and wash himself and comb his hair. Because he now wears stained clothing, staff has started to select and set out his clothes each day. Despite these losses, Mr. L is now somewhat more self-sufficient in locomotion, making twice-a-week trips to see Miss McC on her new unit. **Code "2" for Deteriorated.** The ***rationale*** for the coding decision is that although some improvement is noted in one ADL activity (locomotion) it only occurs twice weekly. In general, Mr. L has deteriorated in his self-care performance in two ADL activities (dressing and personal hygiene) that require multiple daily tasks.

During a Significant Change assessment for severe mood distress, Mrs. M was found to be more dependent on others for physical assistance in personal hygiene, dressing and toileting. She also received more coaxing and encouragement to eat. These changes represented less involvement in self-care since the last assessment two months ago. **Code "2" for Deteriorated.**

# SECTION H.
# CONTINENCE IN LAST 14 DAYS

## H1. Continence Self-Control Categories (14-day look back)

***Note:*** This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days. The 14-day period allows many opportunities for assessment, but it is acceptable to establish voiding patterns in shorter periods of time.

***Intent:*** To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

***Definition***: **(a.) Bowel Continence** and **(b.) Bladder Continence**

Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self - e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in Item G1Ai.

***Process:*** Review the resident's clinical record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private. Control of bladder function and bowel function are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

- Determination of whether or not to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown. According to Dr. Courtney Lyder, Ph.D. a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure

needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure may be required to develop an ulcer." Coding incontinence is a matter of acknowledging and recording a resident's incontinence problem on the assessment, and ensuring that the care plan derived from the assessment addresses the problem. If the resident's skin gets wet with urine, or if whatever is next to the skin (i.e., pad, brief, underwear) gets wet, it should be counted as an episode of incontinence - even if it's just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care plan. In addition, since incontinence is a problem that many residents are sensitive about, intervention involves maintaining dignity and life-style.

- Validate continence patterns with people who know the resident well (e.g., primary family caregiver of newly admitted resident; direct care staff).

- Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information as a basis for coding decisions and, ultimately, care planning.

- The keys to obtaining, tracking and recording accurate information in this section are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

  - Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.

  - Focus your assessment over the last 14 days. When getting information about continence from CNAs, start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code "0" (Continent). If the resident is always wet, and has no control, code "4" (Incontinent). If incontinence occurs only once a week or less, code "1" (Usually continent). The difference between code "2" (Occasionally incontinent), and code "3" (Frequently incontinent) is that for code "3", the resident is incontinent at least daily or multiple times a day.

***Coding:*** A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more

episodes of urination per day and week, whereas bowel movements typically occur less often.

0. **Continent** - Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

1. **Usually Continent** - Bladder, incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.

2. **Occasionally Incontinent** - Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.

3. **Frequently Incontinent** - Bladder incontinent episodes tend to occur daily, but some control is present (e.g., on day shift); Bowel incontinent episodes occur two to three times per week.

4. **Incontinent** - Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern - i.e., the frequency with which the resident is wet and dry during the 14-Day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

To ensure accurate coding in H1a and H1b, assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

**Examples of Bladder Continence Coding**

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent" - Bladder.**

Mr. R had an indwelling catheter in place during the entire 14-Day assessment period. He was never found wet and is considered continent. **Code a "0" for "Continent" - Bladder.**

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent" - Bladder.**

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent" - Bladder.**

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent" - Bladder.**

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. **Code "4" for "Incontinent" - Bladder.**

## H2. Bowel Elimination Pattern (14-day look back)

***Intent:*** To record the effectiveness of resident's bowel function.

***Definition:***

a. **Bowel Elimination Pattern Regular** - Resident has at least one movement every three days.

b. **Constipation** - Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

c. **Diarrhea** - Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

d. **Fecal Impaction** - The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on an abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

**e. *NONE OF ABOVE***

***Process:*** Ask the resident and examine the resident, if necessary; review the clinical record, particularly any documentation on flow sheets of bowel elimination patterns; and consult with direct care staff (e.g., nurse assistants from all shifts).

***Coding:*** Check all that apply in the last 14 days. If no items apply, check *NONE OF ABOVE*.

***Clarification:***

- The distinction between constipation and fecal impaction has usually been the effort it takes for the resident to have a bowel movement. Most constipation will pass without manual extraction through the use of laxatives, enemas, high fiber diets, and other remedies. In constipated residents, many times just doing a digital exam will stimulate the bowel enough to move the stool.

  On the other hand, fecal impaction may require a digital rectal exam to physically break the hard stool mass into smaller parts and remove them manually. Follow-up enemas may be given to move stool higher in the bowel. Residents with fecal impactions may present with other symptoms such as fever, acute abdomen (pain, cramping, swollen abdomen), nausea, vomiting, and thin watery discharge from the rectum (a sign liquid stool is passing around the hard mass of stool).

  According to Dr. Peter Toth, MD, Ph.D. in an article entitled "Gastroenterology: Constipation and Fecal Impaction" in the University of Iowa Family Practice Handbook, 4th Edition, Chapter 5, a fecal impaction is "a firm, immobile mass of stool most often in the rectum but may also occur in the sigmoid or descending colon." It is also possible for stools to pass around an impaction. Item H2d must be checked whenever a fecal impaction was present during the 14-Day assessment period, regardless of how the determination was made (e.g., digital rectal examination, x-ray, CAT scan or other method). In the presence of symptoms of fecal impaction, the facility is obligated to determine whether or not the resident is, in fact, impacted, and to provide appropriate treatment. Information regarding the article can be found at: **http://www.vh.org/providers/clinref/FPhandbook/outline.html**.

## H3. Appliances and Programs (14-day look back)

***Definition:***

**a. Any Scheduled Toileting Plan** - A plan for bowel and/or bladder elimination whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes bowel habit training and/or prompted voiding.

**b. Bladder Retraining Program** - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

**c. External (Condom) Catheter** - A urinary collection appliance worn over the penis.

**d. Indwelling Catheter** - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

**e. Intermittent Catheter** - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder-emptying program (e.g., every shift in a resident with an under active or a contractile bladder muscle).

**f. Did Not Use Toilet Room/Commode/Urinal** - Resident never used any of these items during the last 14 days, nor used a bedpan.

**g. Pads/Brief Used** - Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

**h. Enemas/Irrigation** - Any type of enema or bowel irrigation, including ostomy irrigations.

**i. Ostomy Present** - Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.

**j.** ***NONE OF ABOVE (Not Used on the MPAF)***

***Process:*** Check the clinical record. Consult with the nurse assistant and the resident. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).

***Coding:*** Check all that apply. These items should be coded if a resident has, or has had any of the items during the 14-day observation period. Items that were in use during the observation period but were discontinued should be included. For example, if the resident had an indwelling catheter at the beginning of the observation period and it was later discontinued, the indwelling catheter would be coded. If none of the items apply, check *NONE OF ABOVE*.

***Clarifications:***

- There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void.

  If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

  For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting program.

  Feeding tubes/gastrostomies are coded in Sections K and P. Only appliances used for elimination are coded here.

## H4. Change in Urinary Continence (90 days ago)

***Intent:*** To document changes in the resident's urinary continence status as compared to 90 days ago (or since the last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. This item asks for a snapshot of "today" as compared to that of 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Process:*** Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

***Coding:*** Code "**0**" for No change, "**1**" for Improvement, or "**2**" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. A resident who was continent 90 days ago is on a bladder retraining program, but is leaking urine during the new observation period would be coded deteriorated (2).

**Examples of Change in Urinary Continence**

During an outbreak of gastroenteritis at the nursing facility six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.** ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

# SECTION I.
# DISEASE DIAGNOSES

***Intent:*** To code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan.

- The disease conditions in this section **require a physician-documented diagnosis in the clinical record**. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

- **Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan**. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Check condition only if the resident's condition meets the description in I1.

***Definition:*** **Nursing Monitoring** - Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

## I1. Diseases (7-day look back)

***Definition:*** **ENDOCRINE/METABOLIC/NUTRITIONAL**

**a. Diabetes Mellitus** - Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

**b. Hyperthyroidism**

**c. Hypothyroidism**

**HEART/CIRCULATION**

**d. Arteriosclerotic Heart Disease (ASHD)**

**e. Cardiac Dysrhythmias** - Disorder of heart rate or heart rhythm.

**f. Congestive Heart Failure**

**g. Deep Vein Thrombosis**

**h. Hypertension**

**i. Hypotension**

**j. Peripheral Vascular Disease** - Vascular disease of the lower extremities that can be of venous and/or arterial origin including diabetic PVD.

**k. Other cardiovascular disease**

**MUSCULOSKELETAL**

**l. Arthritis** - Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

**m. Hip Fracture** - Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

**n. Missing Limb (e.g., Amputation)** - Includes loss of any part of any upper or lower extremity. Missing digits should be coded in I3.

**o. Osteoporosis**

**p. Pathological Bone Fracture** - Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

**NEUROLOGICAL**

**q. Alzheimer's Disease**

**r. Aphasia** - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA.

**s. Cerebral Palsy** - Paralysis related to developmental brain defects or birth trauma. Includes spastic quadraplegia secondary to cerebral palsy.

**t. Cerebrovascular Accident (CVA/Stroke)** - A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, and emboli.

**u. Dementia Other Than Alzheimer's** - Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic

diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

v. **Hemiplegia/Hemiparesis** - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

w. **Multiple Sclerosis** – Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.

x. **Paraplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

y. **Parkinson's Disease**

z. **Quadriplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia. Do not code quadriparesis here.

aa. **Seizure Disorder**

bb. **Transient Ischemia Attack (TIA)** - A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

cc. **Traumatic Brain Injury** - Damage to the brain as a result of physical injury to the head.

**PSYCHIATRIC/MOOD**

dd. **Anxiety Disorder**

ee. **Depression**

ff. **Manic Depressive (Bipolar Disease)** - Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

gg. **Schizophrenia**

**PULMONARY**

**hh. Asthma**

**ii. Emphysema/COPD** - Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), and chronic restrictive lung diseases such as asbestosis and chronic bronchitis.

**SENSORY**

**jj. Cataracts**

**kk. Diabetic Retinopathy**

**ll. Glaucoma**

**mm. Macular Degeneration**

**OTHER**

**nn. Allergies** - Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

**oo. Anemia** - Includes anemia of any etiology.

**pp. Cancer**

**qq. Renal Failure**

**rr.** ***NONE OF ABOVE (Not Used on the MPAF)***

***Process:*** Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I, close to the scheduled MDS. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item AA9 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

***Coding:*** Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-9-CM code) under I3. Coders in long-term care facilities should refer to official coding guidance in assigning and reporting code numbers.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the

resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

**For example:** If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing facility.

***Clarifications:***

- Residents with communication problems as a result of Alzheimer's, Parkinson's or multi-infarct dementia need to be carefully assessed. These diagnoses may result in impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening, reading, speaking, writing and gesturing.

- Depression secondary to Alzheimer's disease should be coded only if there is physician documentation in clinical record to support the diagnoses.

  If the resident with a diagnosis of Alzheimer's disease has expressions/features defined in Section E, Mood and Behavior Patterns, code accordingly. The resident's diagnosis of depression should have physician's documentation supporting the diagnosis. In addition, staff should address the resident's mood and behavior in the resident's record.

  In situations such as this, always ask the resident's physician to provide clarification to assure proper coding of the disease or condition.

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## I2. Infections (7-day look back)

*Definition:*

a. **Antibiotic Resistant Infection (e.g., including but not limited to Methicillin Resistant Staphylococcus Aureus (MSRA), Methycillin Amnioglycocite Resistant Staphylococcus Aureus, and Vancomycin Resistant Enterococcus (VRE), and Extended Spectrum Beta-Lactalase Organisms)** - An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

b. **Clostridium Difficile (C.diff)** - Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

c. **Conjunctivitis** - Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

d. **HIV Infection** - Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS. If a state has a policy to omit transmission of HIV information, the State policy supercedes the MDS requirement.

e. **Pneumonia** - Inflammation of the lungs; most commonly of bacterial or viral origin.

f. **Respiratory Infection** - Any upper or lower acute respiratory infection other than pneumonia.

g. **Septicemia** - Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the resident's clinical record.

h. **Sexually Transmitted Diseases** - Check this item only if there is supporting documentation of a current diagnosis including but not limited to gonorrhea, or syphilis. DO NOT include HIV in this category. If a state has established statutory or regulatory privacy policies precluding transmission of sexually transmitted diseases information, the State policy supercedes the MDS requirement.

i. **Tuberculosis** - Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

**j. Urinary Tract Infection** - Includes chronic and acute symptomatic infection(s) in the last 30 days. "Symptomatic" refers to both chronic and acute infections; if symptoms are not present, do not code this item. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.

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

**k. Viral Hepatitis** - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.

**l. Wound infection** - Infection of any type of wound (e.g., postoperative; traumatic; pressure) on any part of the body.

**m.** ***NONE OF ABOVE***

***Process:*** Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS.

Physician involvement in this part of the assessment process is crucial.

**This page revised – January 2008, April 2004, August 2003**

***Coding:*** Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis, check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

## I3. Other Current Diagnoses and ICD-9-CM Codes (7-day look back except for all Quarterly Assessment forms which require a 90-day look back)

***Intent:*** To identify additional conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. If space permits, may also be used to record more specific designations for general disease categories listed under I1 and I2. When using Quarterly Assessment Forms (MDS Quarterly Assessment Form, MDS Quarterly Assessment Form Optional Version for RUG-III, or MDS Quarterly Form Optional Version for RUG-III 1997 Update), Section I3 is coded using a 90-day look back period. The intent of this item on the Quarterly Assessment Form is to update newly diagnosed diseases; however, only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, mood or behavior status, medical treatments, nursing monitoring, or risk of death should be coded in this section.

***Coding:*** Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes. V codes may be used if they affect the resident's current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

# SECTION J.
# HEALTH CONDITIONS

## J1. Problem Conditions (7-day look back)

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

**INDICATORS OF FLUID STATUS**

***Definition:***

a. **Weight Gain or Loss of 3 or More Pounds Within a 7-Day Period** - This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weights, and for these residents you will be unable to determine if there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.

b. **Inability to Lie Flat Due to Shortness of Breath** - Resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air (orthopnea). This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check Item J1l, "Shortness of breath." If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up), do not check Item J1l.

c. **Dehydrated; Output Exceeds Intake** - Check this item if the resident has 2 or more of the following indicators:

1. Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups). Note: The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.

2. Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).

3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

d. **Insufficient Fluid; Did NOT Consume All/Almost All Liquids Provided During Last 3 Days** - Liquids can include water, juices, coffee, gelatins, and soups. This item should be coded only when the resident is receiving, but not consuming, the proper amount of fluids to meet their daily minimum or assessed requirements. The item should not be coded for residents who may request excessive amounts above and beyond what could reasonably be expected to be consumed.

**OTHER**

e. **Delusions** - Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

f. **Dizziness/Vertigo** - The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

g. **Edema** - Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

h. **Fever** – A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date.

i. **Hallucinations** - False sensory perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

j. **Internal Bleeding** - Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded as internal bleeding.

k. **Recurrent Lung Aspirations in Last 90 Days** - Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (i.e., esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

**l. Shortness of Breath** - Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check Item J1b ("Inability to lie flat due to shortness of breath.").

**m. Syncope (Fainting)** - Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

**n. Unsteady Gait** - A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

**o. Vomiting** - Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

**p.** ***NONE OF ABOVE (Not Used on the MPAF)***

***Process:*** It is often difficult to recognize when a frail, chronically ill elder is experiencing dehydration or, alternatively, fluid overload that could precipitate congestive heart failure. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows: Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

***Coding:*** Check all conditions that occurred within the past seven days unless otherwise indicated (i.e. lung aspirations in the last 90 days). If no conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*.

## J2. Pain Symptoms (7-day look back)

***Intent:*** To record the **frequency** and **intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

**MDS 2.0 only captures pain symptoms.** Documentation of pain management/interventions are recorded elsewhere in the resident's clinical record, such as in the nurses' notes, progress notes, medication records, and care plans.

CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-Day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-Day assessment window, the assessor would indeed code "0", no pain. Remember that the assessment covers a 7-day period and should reflect the highest level of pain reported by any staff member, not just the assessment of the professional completing the MDS.

***Definition:*** **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

**Shows Evidence of Pain** - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

***Process:*** Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain in the last week.

***Coding:*** Code for the frequency of pain during the observation period in J2a. Code the highest intensity of pain that occurred during the observation period in J2b. Code for the presence or absence of pain, regardless of pain management efforts; i.e., breakthrough pain. If the resident has no pain, code "0" (No Pain) then Skip to Item J4.

**a. FREQUENCY** - How often the resident complains or shows evidence of pain.

**Codes:**
**0. No pain (Skip to Item J4)**
**1. Pain less than daily**
**2. Pain daily**

**b. INTENSITY** - The severity of pain as described or manifested by the resident.

**Codes:**
**1. Mild Pain** - Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

**2. Moderate Pain** - Resident experiences "a medium" amount of pain.

**3. Times When Pain is Horrible or Excruciating** - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. ***Rationale*:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement. The 5 coding examples shown below were designed to assist you in making appropriate coding decisions. Please note that the last 3 examples are new, and did not appear in the original MDS manual.

| Examples | Pain Frequency | Pain Intensity |
|---|---|---|
| Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain. | 2 | 1 |
| Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation. | 2 | 3 |
| Mr. C is cognitively intact. He has long-term degenerative joint disease and his pain is well managed on Celebrex daily. He stated that on most days he feels little to no pain. However, Mr. C was unable to ambulate for long distances on two days last week, as he was experiencing moderate pain in his knees. Mr. C stated that he needed additional assistance from the CNA to walk to the dining room on those days and required additional pain medication. He says that he no longer feels that intensity of pain. | 1 | 2 |

| Examples (continued) | Pain Frequency | Pain Intensity |
|---|---|---|
| Mrs. S is severely cognitively impaired. She is unable to make decisions and requires extensive assistance in daily ADL care. The CNA responsible for her care and daily ambulation reports to the charge nurse that she has noticed Mrs. C to have "pain in her back" when the CNA attempts to position her in bed and transfer her to a chair. The nurse observes Mrs. C's physical, facial and verbal expressions during care and determines that the resident is experiencing moderate pain. The physician is notified and orders Tylenol q 6 hours. The resident appears relieved later in the day. The resident is observed by nursing staff and they determine that she is no longer experiencing a moderate level of pain. The physician determines that the resident should continue on the medication for several days. | 1 | 2 |
| Mr. W had abdominal surgery 5 days ago. He is alert with short-term memory problems. He is on pain medication daily and is able to participate in daily activities. On the evening shift, Mr. W complained to the nurse that he was experiencing severe pain near his wound site. Upon examination, the nurse determined that the wound appeared clean with no signs of infection. The physician was notified and determined that Mr. W required a change in the type of medication. Mr. W reported relief and remained on the new medication for 3 additional days. | 1 | 3 |

## J3. Pain Site (7-day look back)

***Intent:*** To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes it is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

***Definition:*** **a. Back Pain -** Localized or generalized pain in any part of the neck or back.

b. **Bone Pain** - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c. **Chest Pain While Doing Usual Activities** - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d. **Headache** - The resident complains or shows evidence (clutching or rubbing the head) of headache.

e. **Hip Pain** - Pain localized to the hip area. May occur at rest or with physical movement.

f. **Incisional Pain** - The resident complains or shows evidence of pain at the site of a recent surgical incision.

g. **Joint Pain (Other Than Hip)** - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h. **Soft Tissue Pain** - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

i. **Stomach Pain** - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j. **Other** - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

***Process:*** Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.

***Coding:*** Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

## J4. Accidents (30 and 180 day look backs)

***Intent:*** To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly nursing facility residents. Residents who have sustained at least one fall are at risk of future falls.

***Definition:*** **a. Fell in past 30 Days**

**b. Fell in Past 31-180 Days**

**c. Hip Fracture (from any cause) in Last 180 Days** - Note time frame (last 180 days).

**d. Other Fracture (from any cause) in Last 180 Days** - Any fracture other than a hip fracture. Note time frame (last 180 days).

**e. *NONE OF ABOVE***

***Process:*** **New Admissions** - Consult with the resident and the resident's family. Review transfer documentation.

**Current Residents** - Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on the clinical records but also ask the resident directly if he or she has fallen during the indicated time frame.

***Coding:*** Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

***Clarification:*** ◆ Current CMS policy regarding falls includes:

a) An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.

b) The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.

c) When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred.

d) The distance to the next lower surface (in this case, the floor) is not a factor in determining whether or not a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall.

The point of accurately capturing occurrences of falls on the assessment is to identify and communicate resident problems/potential problems, so that staff will consider and implement interventions to prevent falls and injuries from falls. In the instance of a resident rolling off a mattress that is close to the floor - even though this is still recorded as a fall, it might

be true that staff have already assessed and intervened, and that placing a bed close to the floor to avoid injuries from falls is the intervention that best suits this individual resident.

## J5. Stability of Conditions (7-day look back)

***Intent:*** To determine if the resident's disease or health conditions present over the last seven days are acute, unstable, or deteriorating.

***Definition:***

a. **Conditions/Diseases Make Resident's Cognitive, ADL, Mood or Behavior Patterns Unstable (Fluctuating, Precarious, or Deteriorating)** - Denotes the changing and variable nature of the resident's condition. For example, a resident may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On "good days" over the last seven days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On "bad days," he or she will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.

b. **Resident Experiencing an Acute Episode or a Flare-Up of a Recurrent or Chronic Problem** - Resident is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g., aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g., shortness of breath, edema, and confusion in a resident with congestive heart disease; acute joint pain and swelling in a resident who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, and requires physician evaluation and a significant increase in licensed nursing monitoring.

c. **End-Stage Disease, 6 or Fewer Months to Live** - In one's best clinical judgment, the resident with any end-stage disease has only 6 or fewer months to live. This judgment should be substantiated by a well documented disease diagnosis and deteriorating clinical course. A doctor's certification that the resident has six months or less to live must be present in the record before coding the resident as terminal on the MDS.

d. ***NONE OF ABOVE***

***Process:*** Observe the resident. Consult staff members, especially the resident's physician. Review the resident's clinical record.

***Coding:*** Check all that apply during last seven days. If none apply, check *NONE OF ABOVE*.

**Examples**

Mrs. M is diabetic. She requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. She has been confused on one occasion in the past week when she was hypoglycemic. **Check "a" for unstable - fluctuating, precarious, or deteriorating.**

If Mrs. M (above) were also to have pneumonia and fever during her assessment period, **check "a" for unstable and "b" for acute**.

Ms. F had been doing well and was ready for discharge to her apartment in elderly housing until she came down with the flu. Currently she has a low-grade fever, general aches and pains, and respiratory symptoms of productive cough and nasal congestion. Although she has taken to bed for a few days she has had no change in ADL function, mood, etc. and is looking forward to discharge in a few days. **Check "b" for acute.**

Mrs. T was admitted to the unit with a diagnosis of chronic congestive heart failure. During the past few months she has had 3 hospital admissions for acute CHF. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival beyond the next couple of months is poor. **Check "c" for end-stage disease.**

Mr. R is a diabetic who receives a daily dose of NPH insulin 20 units sc QAM. He requires only monthly blood sugar determinations for follow-up, and has no current acute illness. **Check "d" for *NONE OF ABOVE***.

# SECTION K.
# ORAL/NUTRITIONAL STATUS

Residents in nursing facilities challenge the staff with many conditions that could affect their ability to consume food and fluids to maintain adequate nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional intervention. Prevention is the goal, and early detection and modification of interventions is the key. Section K, Oral and Nutritional Status, should assist the nursing facility staff in recognizing nutritional deficits that will need to be addressed in a resident's care plan. Nurse assessors will need to collaborate with the dietitian and dietary staff to ensure that some items in this section have been assessed and calculated accurately.

Keep in mind that Section 1.13 states that the RAI must be conducted or coordinated with the appropriate participation of health professionals…facilities have flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

## K1. Oral Problems (7-day look back)

***Intent:*** To record any oral problems present in the last seven days.

***Definition:***

**a. Chewing Problem -** Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., resident uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint [TMJ] pain, or a painful tooth). Code chewing problem even when interventions have been successfully introduced.

**b. Swallowing Problem -** Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling. Code swallowing problem even when interventions have been successfully introduced.

**c. Mouth Pain -** Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold).

**d.** ***NONE OF ABOVE (Not Used on the MPAF)***

***Process:*** Ask the resident about difficulties in these areas. Observe the resident during meals. Review the medical record for staff observations about the residents; e.g.,

"pockets food," etc. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

***Coding:*** Check all that apply. If none apply, check *NONE OF ABOVE*.

## K2. Height and Weight (30-day look back)

***Intent:*** To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

### a. Height

***Process:*** **New Admissions** - Measure height in inches.

**Current Resident** - Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

***Coding:*** Round height upward to the nearest whole inch. Measure height consistently over time in accord with standard facility practice (shoes off, etc.). If a resident cannot stand to obtain a current height or is missing limbs, use another means of determining height per current standards of clinical practice.

### b. Weight

***Process:*** Check the clinical records. If the last recorded weight was taken more than one month ago or previous weight is not available, weigh the resident again. If the resident has experienced a decline in intake at meals, snacks, or fluid intake, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

***Coding:*** Round weight upward to the nearest whole pound. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.). There may be circumstances when a resident cannot be weighed, for example: extreme pain, immobility, or risk of pathological fractures. If, as a matter of professional judgment, a resident cannot be weighed, use the standard no-information code (-). Document rationale on resident's record.

## K3. Weight Change (30 and 180-day look backs)

***Intent:*** To record variations in the resident's weight over time.

### a. Weight Loss

***Definition:*** **Weight Loss in Percentages** (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

***Process:*** **New Admission -** Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

**Current Resident -** Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

***Coding:*** Code "**0**" for No or "**1**" for Yes. If there is no weight to compare to, enter the unknown code (**-**).

**b. Weight Gain**

***Definition:*** **Weight Gain in Percentages** (i.e., 5% or more in last 30 days, or 10% or more in up to the last 180 days).

***Process:*** **New Admission -** Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

**Current Resident -** Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

***Coding:*** Code "**0**" for No or "**1**" for Yes. If there is no weight to compare to, enter a dash (**-**).

***Clarifications:***

- The first step in calculating percent weight gain or loss is to obtain the actual weights for the 30-day and 180-day time periods from the resident's clinical record. Calculate percentage for weight loss and weight gain based on the resident's actual weight. Do not round the actual weight. The calculation is as follows:

  1. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than 5%, code a "1" for Yes.
  2. Start with the resident's weight from 180 days ago and multiply it by the proportion (0.10). If the resident has gained or lost more than 10%, code a "1" for Yes.

- Residents experiencing a 7½% weight change (gain or loss) 90 days ago must be evaluated to determine how much of the 7½% weight change occurred over the last 30 days.

- MDS coding for items K3a and K3b captures the resident's weight at the 30- and 180-day time points. K3a and K3b capture the resident's weight at two distinct points in time only and note if there has been a weight loss or gain in either of those time periods.

- There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F 326) and 483.20(b)2(xi), resident assessment nutritional status and requirements (F 272), which corresponds to the MDS 2.0 Section K, Oral/Nutritional status.

  The parameters for weight loss identified in the guidelines referenced above are:

  1 month 5% significant >5% severe

  3 months 7.5% significant >7.5% severe

  6 months 10% significant >10% severe

  The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process.

  However, if the resident is losing/gaining a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in one month, 7.5% in three months, or 10% in six months should prompt a thorough assessment of the resident's nutritional status. An adequate assessment should result in a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs and expressed desires.

## K4. Nutritional Problems (7-day look back)

***Intent:*** To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

***Definition:***

a. **Complains About the Taste of Many Foods** - The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based - e.g., someone used to eating spicy foods may find nursing facility meals bland.

b. **Regular or Repetitive Complaints of Hunger** - On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

c. **Leaves 25% or More of Food Uneaten at Most Meals** (even when substitutes are offered) at least 2 out of 3 meals a day. This assumes the resident is receiving the proper amount of food to meet their daily requirements and not excessive amounts above and beyond what they could be expected to consume.

d. ***NONE OF ABOVE***

***Process:*** Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, and dietary progress notes/assessments. Consult with direct-care staff, dietary staff and the consulting dietitian. Ask the resident if he or she experienced any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating? Would you eat if something else was offered?" Observe if resident winces or makes faces while eating. **NOTE:** Facilities are required to offer substitutions when residents do not eat or like the food being served. Observe whether or not residents have refused offers for substitute meals.

***Coding:*** Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

## K5. Nutritional Approaches (7-day look back)

***Definition:*** **a. Parenteral/Intravenous (IV)** Include only fluids administered for **nutrition or hydration**, such as:

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids administered via heparin locks
- IV fluids contained in IV Piggybacks
- IV fluids used to reconstitute medications for IV administration

**Do NOT include:**

- IV medications
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- IV fluids administered solely as flushes
- Parenteral/IV fluids administered during chemotherapy or dialysis

For coding IV medications, see page 3-182

b. **Feeding Tube** - Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

c. **Mechanically Altered Diet -** A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below. Enteral feeding formulas are not coded here.

d. **Syringe (Oral Feeding)** - Use of syringe to deliver liquid or pureed nourishment directly into the mouth. All efforts should be made to utilize other feeding methods (e.g., rubber tipped spoon) as this can result in lowered resident dignity.

e. **Therapeutic Diet -** A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals. Code enteral feeding formulas here when they meet this definition.

f. **Dietary Supplement Between Meals** - Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

g. **Plate Guard, Stabilized Built-Up Utensils, Etc.** - Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

h. **On Planned Weight Change Program** - Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).

i. ***NONE OF ABOVE (Not Used on the MPAF)***

***Coding:*** Check all that apply. If none apply, check *NONE OF ABOVE*.

***Clarification:***

- If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in this item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and b, which refer to the caloric and fluid intake the resident received in the last 7 days. Additives such as electrolytes and insulin which are added to the resident's TPN or IV fluids should be counted as medications and documented in Section O1, Number of Medications AND P1ac, IV Medications.

## K6. Parenteral or Enteral Intake (7-day look back) Skip to Section L on the MDS if neither Item K5a nor K5b is checked.

***Intent:*** To record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last seven days.

### a. PROPORTION OF TOTAL CALORIES

***Definition:*** **Proportion of Total Calories Received** - The proportion of all calories ingested during the last seven days that the resident **actually received** (not ordered) by parenteral or tube feedings. Determined by calorie count.

***Process:*** Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

***Coding:*** Code for the best response:

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

**Example of Calculation for Proportion of Total Calories from IV or Tube Feeding**

Mr. H has had a feeding tube since his surgery. He is currently more alert, and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitian has totaled his calories per day as follows:

**Step #1:**

| | Oral | | Tube |
|---|---|---|---|
| Sun. | 500 | + | 2000 |
| Mon. | 250 | + | 2250 |
| Tues. | 250 | + | 2250 |
| Wed. | 350 | + | 2250 |
| Thurs. | 500 | + | 2000 |
| Fri. | 800 | + | 800 |
| Sat. | 800 | + | 1800 |
| **TOTAL** | 3450 | + | 14350 |

**Step #2:** Total calories = 3450 + 14350 = 17800

**Step #3:** Calculate percentage of total calories by tube feeding.

14350/17800 = .806 X 100 = 80.6%

**Step #4:** Code "4" for 76% to 100%

## b. AVERAGE FLUID INTAKE

***Definition:*** Average fluid intake per day by IV or tube feeding in last seven days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

***Process:*** Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Also include the water used to flush as well as the "free water" in the tube feeding (based upon the percent of water in the specific enteral formula). The amount of heparinized saline solution used to flush a heparin lock **is not** included in the average fluid intake calculation, while the amount of fluid in an IV piggyback solution **is** included in the calculation. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day.

***Coding:*** Code for the average number of cc's of fluid the resident received per day by IV or tube feeding. Record what was actually received by the resident, not what was ordered.

**Codes:**

0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

**Example of Calculation for Average Daily Fluid Intake**

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

**Step #1:**

| | |
|---|---|
| Sun. | 1250 cc |
| Mon. | 775 cc |
| Tues. | 925 cc |
| Wed. | 1200 cc |
| Thurs. | 1200 cc |
| Fri. | 1200 cc |
| Sat. | 1000 cc |
| **TOTAL** | 7550 cc |

**Step #2:** 7550 divided by 7 = 1078.6 cc

**Step #3:** Code "3" for 1001 to 1500 cc/day

***Clarifications:***

- The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Item K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications and should be coded in O1.
- The amount of heparinized saline solution used to flush a heparin lock is not included in the average fluid intake calculation. The amount of fluid in an IV piggyback solution is included in the calculation.

# SECTION L.
# ORAL/DENTAL STATUS

## L1. Oral Status and Disease Prevention (7-day look back)

***Intent:*** To document the resident's oral and dental status as well as any problematic conditions.

**a. Debris (Soft, Easily Movable Substances) Present in Mouth Prior to Going to Bed at Night**

**b. Has Dentures or Removable Bridge**

**c. Some/All Natural Teeth Lost-Does Not Have or Does Not Use Dentures (or Partial Plates)**

**d. Broken, Loose, or Carious Teeth**

**e. Inflamed Gums (Gingiva); Swollen or Bleeding Gums; Oral Abcesses; Ulcers, Rashes or Lesions**

**f. Daily Cleaning of Teeth/Dentures or Daily Mouth Care-by Resident or Staff**

**g. *NONE OF ABOVE***

***Definition:*** **Carious** - Pertains to tooth decay and disintegration (cavities).

***Process:*** Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems.

***Coding:*** Check all that apply. If none apply, check *NONE OF ABOVE*.

# SECTION M.
# SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days. Skin does not include eyes or oral mucosa.

For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.

## M1. Ulcers (7-day look back)

***Intent:*** To record the number of skin ulcers, at each ulcer stage, on any part of the body.

***Definition:*** For coding in this section, a skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Skin ulcers that develop because of circulatory problems or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin, ulcers related to diseases such as syphilis and cancer, and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.

**a. Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

**b. Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater.

**c. Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

**d. Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

***Process:*** Review the resident's record and consult with the nurse assistant about the presence of any skin ulcers. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, a skin ulcer can be missed.

**This page revised – January 2008, June 2005, April 2004, August 2003**

Assessing a Stage 1 skin ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

***Coding:*** Record the number of skin ulcers at each stage on the resident's body, in the last 7 days. If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no skin ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 skin ulcers at any one stage, enter a "9" in the appropriate box.

***Clarifications:***

- All skin ulcers present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of skin ulcers, as observed during the assessment period.

- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The skin ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments). Do not code the debrided skin ulcer as a surgical wound.

- If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

**Example**

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 pressure ulcer over her sacrum and two Stage 1 pressure ulcers over her heels.

| Items M1, Ulcers | Stage | Code |
|---|---|---|
| | a. 1 | 2 |
| | b. 2 | 0 |
| | c. 3 | 1 |
| | d. 4 | 0 |

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds do not meet the criteria provided in Item M1 (Ulcers) coding definitions. Code the resident's condition as follows:

| Items M1, Ulcers | Stage | Code |
|---|---|---|
| | a. 1 | 0 |
| | b. 2 | 0 |
| | c. 3 | 0 |
| | d. 4 | 0 |

**Items M2, Type of Ulcer:**
Code "0" (highest stage ulcer is not a pressure ulcer)

**Items M4, Other Skin Problems or Lesions Present:**
Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 and M6, (Foot Problems and Care) as appropriate.

## M2. Type of Ulcer (7-day look back)

***Intent:*** To record the highest stage for two types of skin ulcers, Pressure and Stasis, that was present in the last 7 days.

***Definition:*** **a. Pressure Ulcer** - Any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers

**b. Stasis Ulcer** - A skin ulcer, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

***Process:*** Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

***Coding:*** Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1 may not necessarily be recorded in Item M2 (see last example below).

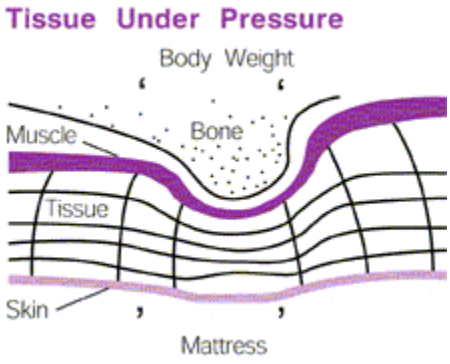
More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: **http://www.ahrq.gov/consumer/bodysys/edbody6.htm**.

## What are Pressure Ulcers?

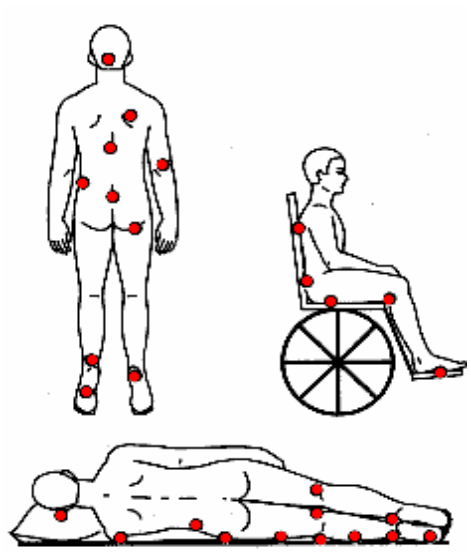
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



## Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

**NOTE:** It is also common for pressure ulcers to form on the ears and scrotum.

The full AHCRP guideline for clinicians can be found at:

**http://www.ahcpr.gov/clinic/cpgonline.htm.**

***Clarifications:***

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

- If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. <u>If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer.</u> Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's

mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

**Example**

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

| **Items M1, Ulcers** | **Code (# at stage)** |
|---|---|
| a. Stage 1 | 3 |
| b. Stage 2 | 1 |
| c. Stage 3 | 0 |
| d. Stage 4 | 0 |

| **Items M2, Type of Ulcer** | **Code (highest stage)** |
|---|---|
| a. Pressure Ulcer | 2 |
| b. Stasis Ulcer | 0 |

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

| **Items M1, Ulcers** | **Code (# at Stage)** |
|---|---|
| a. Stage 1 | 0 |
| b. Stage 2 | 0 |
| c. Stage 3 | 1 |
| d. Stage 4 | 0 |

| **Items M2, Type of Ulcer** | **Code (highest stage)** |
|---|---|
| a. Pressure ulcer | 0 |
| b. Stasis ulcer | 0 |

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

## M3. History of Resolved/Cured Ulcers (90 days ago)

***Intent:*** To determine if the resident previously had a skin ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers. The definition of "skin ulcer" for this item is the same as the definition used for item M1.

***Process:*** Review clinical records, including the last Quarterly or Medicare PPS assessment.

***Coding:*** Code "**0**" for No or "**1**" for Yes.

## M4. Other Skin Problems or Lesions Present (7-day look back)

***Intent:*** To document the presence of skin problems or lesions (other than pressure or circulatory skin ulcers) and conditions that are risk factors for more serious problems. Skin does not include eyes or oral mucosa.

***Definition:***

a. **Abrasions, Bruises** - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

b. **Burns (Second or Third Degree)** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

c. **Open Lesions/Sores (e.g. cancer lesions)** - Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here.

d. **Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)** - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

e. **Skin Desensitized to Pain or Pressure** - The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and

neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."
- Compare the sensations in symmetrical areas on both sides of the body.
- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.
- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

**f. Skin Tears or Cuts (Other Than Surgery) -** Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.

**g. Surgical Wounds -** Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include surgical wounds of the eyes or oral mucosa, healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.

**h. *NONE OF ABOVE***

***Process:*** Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.

**This page revised—January 2008, August 2003**

***Coding:*** Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should **NOT** be coded here. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE*.

***Clarification:***

- It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

## M5. Skin Treatments (7-day look back)

***Intent:*** To document any specific or generic skin treatments the resident has received in the past seven days.

***Definition:***

a. **Pressure Relieving Device(s) for Chair** - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.

b. **Pressure Relieving Device(s) for Bed** - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.

c. **Turning/Repositioning Program** - Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."

d. **Nutrition or Hydration Intervention to Manage Skin Problems** - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to mange a potential or active skin problem, should be coded here.

e. **Ulcer Care** - Includes any intervention for treating skin problems coded in M1, M2, and/or M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. **Surgical Wound Care** - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

g. **Application of Dressings (With or Without Topical Medications) Other Than to Feet** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

h. **Application of Ointments/Medications (Other Than to Feet)** - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. **Other Preventative or Protective Skin Care (Other Than to Feet)** - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).

j. ***NONE OF ABOVE***

***Process:*** Review the resident's records. Ask the resident and nurse assistant.

***Coding:*** Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*.

***Clarifications:***

- Good clinical practice dictates that staff should document treatments provided (e.g., the items listed in M5 and M6). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

- Dressings do not have to be applied daily in order to be coded on the MDS. If any dressing meeting the MDS definitions provided for MDS Items M5e-h was applied even once during the 7-day period, the assessor would check the appropriate MDS item.

## M6. Foot Problems and Care (7-day look back)

***Intent:*** To document the presence of foot problems and care to the feet during the last seven days.

***Definition:***

a. **Resident Has One or More Foot Problems (e.g., Corns, Callouses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems** – includes ulcerated areas over plantar's warts on the foot.

b. **Infection of the Foot** – e.g., Cellulitis, Purulent Drainage

c. **Open Lesions On the Foot** - Includes cuts, ulcers, fissures.

d. **Nails or Calluses Trimmed During the Last 90 Days** - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist. A CNA is not considered a "health professional" for the purpose of coding this item.

e. **Received Preventative or Protective Foot Care** - Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

f. **Application of Dressings (With or Without Topical Medications)** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. ***NONE OF ABOVE***

***Process:*** Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

***Coding:*** Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*.

***Clarification:***

- For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in Item M5.
- Good clinical practice dictates that staff should document treatments provided. Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

# SECTION N.
# ACTIVITY PURSUIT PATTERNS

***Intent:*** To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility.

***Definition:*** **Activity Pursuits** - Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

## N1. Time Awake (7-day look back)

***Intent:*** To identify those periods of a typical day (over the last seven days) when the resident was awake all or most of the time, i.e., no more than a total of a one-hour nap during any such period. For care planning purposes this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).
- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

***Process:*** Consult with direct care staff, the resident, and the resident's family.

***Coding:*** Check all periods when resident was awake all or most of the time.

**a. Morning** - is from 7 a.m. (or when resident wakes up, if earlier or later than 7 a.m.) until noon.

**b. Afternoon** - is from noon to 5 p.m.

**c. Evening** - is from 5 p.m. to 10 p.m. (or bedtime, if earlier).

**d.** ***NONE OF ABOVE*** – If resident is comatose, code as "d", None of the Above, and skip all other Section N items on the MDS and go to Section O on the MDS.

***Clarifications:*** ◆ When coding this item, check each time period, as defined for that resident, during which he or she did not nap for more than one hour. Some examples of coding are as follows:

- A resident wakes up every morning at 7 a.m. He typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10 a.m. until 11:30 a.m. Item N1a (Morning) should NOT be checked, since this resident typically naps for more than 1 hour during the morning.
- A resident typically wakes up at 6 a.m. She is busy with therapy and activities most of the day, and does not take naps. She goes to bed by 7 p.m. every evening. Items N1a (Morning), N1b (Afternoon) and N1c (Evening) should all be checked, since this resident does not take naps.

- A resident who is bedfast and has end-stage Alzheimer's disease wakes up at 6 a.m. daily. She typically dozes off throughout the day, napping for more than 1 hour before noon, and again from 3:30 p.m. to 5:30 p.m. every afternoon. She is typically awake from 5:30 p.m. until 9 p.m. After that, she's asleep for the night. Items N1a (Morning) and N1b (Afternoon) should NOT be checked, since this resident naps for more than one hour during each of these periods. Item N1c (Evening) should be checked as time awake. Although this resident sleeps until 5:30 p.m., that is only a 30-minute nap time in the evening period.

◆ Accurate coding relies on the use of appropriate information-gathering techniques. Coding Items N1a, b, and c based on only the assessor's personal knowledge of a resident's typical day may result in an inaccurate response to this item. Documentation review is important. However, we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times.

◆ It is important to observe the resident across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a resident across a 24-hour period. It's important to supplement observation with interviews of the resident, their family members, other staff across shifts, and in particular, the nursing assistants caring for the resident.

## N2. Average Time Involved in Activities (7-day look back)

***Intent:*** To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern. This time refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities and could have been involved in activity pursuits and Therapeutic Recreation.

***Definition:*** Include the amount of free time a resident has while awake and is not involved in receiving nursing care, treatments, or engaged in ADL activities. Examples of activity pursuits and therapeutic recreation of his/her choice could include watering plants; reading; letter-writing; social contacts/visits or phone calls from family, staff, and volunteers; recreational pursuits in a group, one-on-one or on an individual basis; and involvement in therapeutic recreation. Keep in mind that the definition of "activity pursuits" refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. Efforts should be made to provide activities suited to the resident's preferences and capabilities.

Activity staff should work with cognitively impaired residents to identify what types of activities are suitable. Some impaired persons prefer to walk through the corridors rather than engaging in a seated activity. Based on the resident's activity plan, certain activities, although not structured, may still be considered

activities. The MDS Coordinator should work with the activities staff to determine which behaviors are considered appropriate activities for engaging the resident.

Many cognitively impaired persons continue to "pursue" their interests and also develop new interests. Activities must be tailored to their cognitive abilities. Record the amount of time the person spends in structured and non-structured activities.

Although dining is a social experience for some residents, and at times, meals may be planned around certain events or occasions, eating is not to be counted as an activity.

***Process:*** Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

***Coding:*** In coding this item, exclude time spent in receiving treatments (e.g., medications, heat treatments, bandage changes, rehabilitation therapies, or ADLs). Include time spent in pursuing independent activities (e.g., watering plants, reading, letter-writing); social contacts (e.g., visits, phone calls) with family, other residents, staff, and volunteers; recreational pursuits in a group, one-on-one or an individual basis; and involvement in Therapeutic Recreation.

**0. Most-More Than 2/3 of Time**

**1. Some-from 1/3 to 2/3 of Time**

**2. Little-Less Than 1/3 of Time**

**3. None**

## N3. Preferred Activity Settings (7-day look back)

***Intent:*** To determine activity circumstances/settings that the resident prefers, including (though not limited to) circumstances in which the resident is at ease.

***Process:*** Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful, but only provides part of the answer. Do not limit the preference list to areas to which the resident now has access, but try to expand the range of possibilities for the resident.

**Example**

Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that the resident frequents or where he or she appears to be most at ease.

***Coding:*** Check all responses that apply. If the resident does not wish to be in any of these settings, check *NONE OF ABOVE*.

**a. Own Room**

**b. Day/Activity Room**

**c. Inside NH/Off Unit**

**d. Outside Facility**

**e. *NONE OF ABOVE***

## N4. General Activity Preferences (adapted to resident's current abilities) (7-day look back)

***Intent:*** Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident, or whether the resident currently engages in the activity or not.

***Definition:*** **a. Cards/Other Games** - Activities involving games, such as trivia games.

**b. Crafts/Arts**

**c. Exercise/Sports** - Includes any type of physical activity such as dancing, weight training, yoga, walking, sports (e.g., bowling, croquet, golf, or watching sports).

**d. Music** - Includes listening to music or being involved in making music (singing, playing piano, etc.)

**e. Reading/Writing** - Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g., letter-writing or poetry writing) or done as part of a group program (e.g., recording oral histories). Or a volunteer can

record the thoughts of a blind, hemiplegic, or apraxic resident in a letter or journal.

f. **Spiritual/Religious Activities** - Includes participating in religious services as well as watching them on television or listening to them on the radio.

g. **Trips/Shopping**

h. **Walking/Wheeling Outdoors**

i. **Watching TV**

j. **Gardening or Plants** - Includes tending one's own or other plants, participating in garden club activities, regularly watching a television program or video about gardening.

k. **Talking or Conversing** - Includes social-type activities such as talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

l. **Helping Others** - Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

m. ***NONE OF ABOVE***

***Process:*** Consult with the resident, the resident's family, activities staff members, and nurse assistants. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities. Explain that many activity pursuits are adaptable to the resident's capabilities. For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the care plan (e.g., bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program) check the item on the form.

***Coding:*** Check each activity preferred. If none are preferred, check *NONE OF ABOVE*. Explore other possible sources of information, such as a responsible party that admitted the resident into the facility, or a surrogate decision maker who might know the resident's preferences. Is there any useful information in records that precede admission to the facility, such as hospital, community or home care records? If all resources are exhausted and you still do not have information,

code the responses as information not available (**-**). If the resident appears content during an activity (e.g., smiling, clapping during a music program), check the item on the form.

## N5. Prefers Change in Daily Routine (7-day look back)

***Intent:*** To determine if the resident has an interest in pursuing activities not offered at the facility (or on the nursing unit), or not made available to the resident. This includes situations in which an activity is provided but the resident would like to have other choices in carrying out the activity (e.g., the resident would like to watch the news on TV rather than the game shows and soap operas preferred by the majority of residents; or the resident would like a Methodist service rather than the Baptist service provided for the majority of residents). Residents who resist attendance/involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement.

***Process:*** Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her in their current format. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer slight or major changes in daily routines, or is everything OK?

***Coding:*** For each of the items, code for the resident's preferences in daily routines using the codes provided.

**0. No Change** - Resident is content with current activity routines.

**1. Slight Change** - Resident is content overall but would prefer minor changes in routine (e.g., a new activity, modification of a current activity).

**2. Major Change** - Resident feels bored, restless, isolated, or discontent with daily activities or resident feels too involved in certain activities, and would prefer a significant change in routine.

**Example**

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offers to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

| | | Code |
|---|---|---|
| **a.** | **Type of activities in which resident is currently involved** | 1 (Slight change) |
| **b.** | **Extent of resident involvement in activities** | 1 (Slight change) |

# SECTION O. MEDICATIONS

## O1. Number of Medications (7-day look back)

***Intent:*** To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past seven days.

***Process:*** Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Topical preparations that are used for preventative skin care (i.e. moisturizers and moisture barriers) should not be coded here. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. Antigens and vaccines also are counted here.

***Coding:*** Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. Do not count medications ordered but not given.

***Clarifications:***

- If a dietary supplement, given to a resident between meals, has a vitamin as one of its ingredients, code it as a dietary supplement, *not* as a medication.

  Coding Examples:

  - If a resident receives a daily Vitamin C capsule, add it to the medication count in number of medications (O1).
  - If a resident receives a dietary supplement between meals and the label contents specify that Vitamin C (or any other vitamin, etc) is one of the ingredients, code (K5f = check) for dietary supplement between meals.
  - The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Section K., Oral Nutritional Status. Medications, such as electrolytes, vitamins, or insulin, which have been added to the TPN solution, are considered medications and should be coded in this section.

- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted in this item. These substances may be coded at MDS Item K5f, provided they meet the definition of dietary supplement for this Item. Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications. More information on dietary supplements identified by the FDA can be found at the following web site: **http://www.nih.gov/health**.

- All medications used by the resident in the 7-Day assessment period need to be counted in Section O. All medications administered off-site (e.g., while receiving dialysis or chemotherapy) must be considered when completing this item. The facility is responsible for communicating with the outpatient site to identify the use of any medications received while the resident was under their care, and for monitoring the effect, including any adverse effects, of medications after the resident's return to the facility.

- Combination products such as Corzide (which contains a diuretic and a beta-blocker) are counted as one medication.

- Administration of Epogen should be recorded in several places in Section O, depending on its route of administration and date of initiation. It should be counted at MDS Item O1 (Number of Medications), and if it was initiated during the last 90 days, it should also be indicated at MDS Item O2 (New

Medication). If the Epogen was given subcutaneously, also record it in Item O3 (Injections). If it is given intravenously, it should be indicated at MDS Item P1ac (IV medication).

- Heparin included in a saline solution used to irrigate a "heparin lock" is not counted in this item.
- Each type of insulin that a resident receives should be counted separately. For example, Lente, Neutral Protamine Hagedorn (NPH), and Regular are different types of insulin and are considered different medications.
- Ensure or any nutritional supplement is not counted as a medication for coding in Section O. The dietary supplement could be recorded in Section K5f, provided it fits the definitions.
- If the resident received an injection of Vitamin B12 prior to the observation period, code in Item O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics. Determine if a specific long-acting medication is still active based on physician, pharmacist, and/or PDR input. Do not code Vitamin B12 injections in Item O3 (Injections) if it was given outside of the observation period.
- Record suppositories in Item O1, Number of Medications. For facilities in states using Section U, also record in Section U.

**Example**

Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. **Code "1" (one medication received).**

## O2. New Medications (90-day look back)

***Intent:*** To record whether or not the resident is currently receiving medications that were initiated in the last 90 days.

***Coding:*** Code "**1**" if the resident received (and continues to receive) new medications in the last 90 days. Code "**0**" if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code "0" (no new medication).

## O3. Injections (7-day look back)

***Intent:*** To determine the number of days during the past seven days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are

considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1ac, IV medications.

***Coding:*** Record the number of DAYS in the answer box.

***Clarifications:***

- Subcutaneous pumps would be coded as follows:

  O1 - Count the medication as a medication;
  O2 - Identify if this was a new medication or not;
  O3 - Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

- If a test or vaccination is provided on one day and another vaccine provided on the next day, code "2" for the number of days when the resident received injections. If both injections were administered on the same day, code "1".

**Example**

During the last 7 days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin $B_{12}$ injection on Wednesday. **Code "3" for Resident received injections on three days during the last seven days**.

During the last 7 days, Miss C received a flu shot and her vitamin $B_{12}$ injection on Thursday. **Code "1" for resident received 2 injections on the same day in the last 7 days.**

## O4. Days Received the Following Medication (7-day look back)

***Intent:*** To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. See Appendix E for list of drugs by category. Includes any of these medications given to the resident by any route (po, IM, or IV) in any setting (e.g., at the nursing facility, in a hospital emergency room).

***Process:*** Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

***Coding:*** Enter the number of days each of the listed types of medications was received by the resident during the past seven days. In the case of a new admission, if it is clearly documented that the resident received any type of medication (listed in this item) at the sending facility, record the number of days each listed medication was received during the past seven days. If transmittal records are not clear or do not reference that the resident received one of these medications, record "**0**" (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter "**0**". If the resident uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (Fluphenazine deconoate) or Haldol (Haloperidol deconoate) given every few weeks or monthly) enter "**1**".

**a. Antipsychotic**

**b. Antianxiety**

**c. Antidepressant**

**d. Hypnotic**

**e. Diuretic**

***Clarification:***

- Code medications according to a drug's pharmacological classification, not how it is used. For example, Oxazepan (Serax) may be used as a hypnotic, but it is classified as an antianxiety. Serax would be coded as an antianxiety. Over-the-counter sleeping medications are not coded in this item, as they are not classified as hypnotic drugs.

**Example 1**

**Medication Record for Mrs. P**

- Haldol 0.5 mg po BID p.r.n.: Received once a day on Monday, Wednesday, and Thursday [Note: Haldol = Antipsychotic drug]
- Ativan 1 mg po QAM: Received every day [Note: Ativan = Antianxiety drug]
- Restoril 15 mg po QHS p.r.n.: Received at H.S. on Tuesday and Wednesday only [Note: Restoril = Hypnotic]
- Mrs. P became severely short of breath in the middle of the night during the last seven days. She was transferred (but not admitted) to the emergency room (ER) at the local hospital. Upon her return to the nursing facility the ER transmittal record stated that she had received 1 dose of IV Lasix [Note: Lasix = Diuretic].

***Coding***

| Medication | No. of days received |
|---|---|
| a. Antipsychotic: | "3" (days) |
| b. Antianxiety: | "7" (days) |
| c. Antidepressant: | "0" (days) |
| d. Hypnotic: | "2" (days) |
| e. Diuretic: | "1" (days) |

**Example 2**

Mr. S was admitted to the nursing facility on 9/12/02 (Date of Entry) from an acute care hospital. The clinical staff established that 9/16/02 would be the MDS Assessment Reference Date (last day of MDS observation period). By establishing 9/16/02 as the reference date, the observation period of 7 days extended back to 9/10/02 when Mr. S was still in the hospital. His hospital discharge summary mentioned that Mr. S was started on a daily dose of Prozac (an antidepressant) on 8/20. The hospital discharge summary was too sketchy to accurately determine if Mr. S received other medications during his hospital stay. Since admission to the nursing facility Mr. S continues to receive the same dose of Prozac.

***Coding***

| Medication | No. of days received |
|---|---|
| a. Antipsychotic: | "0" (days) |
| b. Antianxiety: | "0" (days) |
| c. Antidepressant: | "7" (days) |
| d. Hypnotic: | "0" (days) |
| e. Diuretic: | "0" (days) |

# SECTION P.
# SPECIAL TREATMENTS AND PROCEDURES

## P1. Special Treatments, Procedures, and Programs

***Intent:*** To identify any special treatments, therapies, or programs that the resident received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.**

### a. SPECIAL CARE (14-day look back)

**TREATMENTS -** The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc.

***Definition:***

**a. Chemotherapy -** Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

**b. Dialysis -** Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

**c. IV Medication -** Includes any drug given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy.

**d. Intake/Output** - The measurement and evaluation of all fluids the resident received and/or excreted for at least three consecutive shifts (i.e., 24 hours).

**e. Monitoring Acute Medical Condition** - Includes observation by a licensed nurse for ANY acute physical or psychiatric illness. Note that this is a determination regarding the resident's clinical status. Payer source is not a factor.

**f. Ostomy Care** - This item refers only to care that requires nursing assistance. Includes both ostomies used for intake and excretion. Do not include tracheostomy care. Code tracheostomy care by checking Item P1aj.

**g. Oxygen Therapy** - Includes continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy).

**h. Radiation** - Includes radiation therapy or having a radiation implant.

**i. Suctioning** - Includes nasopharyngeal or tracheal aspiration **only**. Oral suctioning should **not** be coded here.

**j. Tracheostomy Care** - Includes cleansing of tracheostomy and cannula.

**k. Transfusions** - Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered during dialysis or chemotherapy.

**l. Ventilator or Respirator** - Assures adequate ventilation in residents who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

**PROGRAMS** - The following programs refer to those received within a nursing facility ONLY.

**m. Alcohol/Drug Treatment Program** - A comprehensive interdisciplinary program within an entire or contiguous unit, wing, or floor where interventions are designed specifically for the treatment of alcohol or drug addictions.

**n. Alzheimer's/Dementia Special Care Unit** - Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

**o. Hospice Care** - The resident is identified as being in a hospice program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

**p. Pediatric Unit** - Any identifiable part of the nursing facility, such as an entire or contiguous unit or wing where staffing patterns and resident care interventions are designed specifically for persons aged 22 or younger.

**q. Respite Care** - Resident's care program involves a short-term stay in the facility for the purpose of providing relief to a nursing facility-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.

**r. Training in Skills Required to Return to the Community** - Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living). May include training family or other caregivers.

**s.** ***NONE OF ABOVE***

***Process:*** Review the resident's clinical record.

***Coding:*** Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check *NONE OF ABOVE*.

***Clarifications:***

- Residents with sleep apnea may undergo treatments with a mask-like device that is being used to keep the airway open during sleep. This service cannot be coded as a ventilator or a respirator. According to the American Academy of Otolaryngology-Head and Neck Surgery, Inc., a CPAP (Continuous Positive Airway Pressure) device delivers air into your airway through a specially designed mask or pillows. The mask does not breathe for you; the flow of air creates enough pressure when you inhale to keep your airway open. Ventilators are sometimes used to deliver this type of non-invasive ventilation when CPAP or BIPAP machines are not available. In these cases, the ventilator is merely providing air, not traditional life support via invasive measures and does not require the same level of intensity of care that life support ventilation demands.

- Do not code services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

## b. THERAPIES (7-day look back)

Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision).

The licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.

***Intent:*** To record the **(A) number of days**, and **(B) total number of minutes** each of the following therapies was administered to residents (for at least 15 minutes a day) in the last 7 days.

***Definition:***

a. **Speech-Language Pathology, Audiology Services** - Services that are provided by a licensed speech-language pathologist.

b. **Occupational Therapy** - Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed occupational therapist.

c. **Physical Therapy** - Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.

d. **Respiratory Therapy** – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.") A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act.

e. **Psychological Therapy** - Therapy provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric Technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the State does not license a certain category of professionals working in your facility, you may not count the services of those unlicensed therapists in this item.

***Process:*** Review the resident's clinical record and consult with each of the qualified therapists.

***Coding:*** **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

**Box B:** In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days, even if you entered "0" in Box A (e.g., less than 15 minutes of therapy provided). The time should include only the actual treatment time (not time waiting or writing reports). Enter "0" if none.

A therapist's initial evaluation time may not be counted, but subsequent evaluations, conducted as part of the treatment process, may be counted.

***Clarifications:*** **Coding Minutes of Therapy:**

- Includes only therapies that were provided once the individual is actually living/being cared for at the facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. If a resident returns from a hospital stay and a readmission assessment is done, count only those therapies that occurred since readmission to the facility.

- If a whirlpool treatment is specifically ordered by a physician to be performed by or under the supervision of a physical therapist, it may be coded as therapy.

- Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded in Item P1b when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should not be coded as therapy, even when performed by therapists.

- Qualified professionals for the delivery of respiratory services include "**trained nurses**." A trained nurse refers to a nurse who received specific

training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.

- The MDS instructions clearly require reporting the actual minutes of therapy received by the resident.

  - The resident's treatment time starts when he/she begins the first treatment activity or task and ends when he/she finishes with the last apparatus and the treatment is ended.

  - The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident, is the set-up time and may be included in the count of minutes of therapy delivered to the resident.

  - The therapist's time spent on documentation or on initial evaluation may not be included.

  - Time spent on periodic reevaluations conducted during the course of a therapy treatment may be included.

  - Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as a family-funded services) may not be counted in Item P1b, even when performed by a licensed therapist.

- Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. For MDS reporting purposes, conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion of Item P1b. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in Item P1b, since the specific interventions would be considered restorative nursing services when performed by nurses or aides.

- **For Medicare A only:** A licensed therapist starts work directly with one resident beginning a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a different task, while continuing to supervise the first

resident. The treatment ends for each resident 30 minutes after it begins. For each resident, record 30 minutes therapy time for each resident at Item P1bB. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy. Medicare B only recognizes individual (one-on-one) therapy and group therapy.

- In some cases, the resident will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the resident is a part of total treatment time. For example, as the last treatment task of the day, a resident uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the resident up on the apparatus. The therapist or assistant, under the supervision of a PT, may then leave the resident to help another resident in the same exercise room. However, the therapist still has eye contact with the resident and is providing supervision, verbal encouragement and direction to the resident on the bicycle. Therefore, if it took 2 minutes to set the resident up with the cycling apparatus, the resident was supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the resident did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the MDS assessment is 60 minutes. The key is that the resident was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process.

- Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts. Split the time between the two disciplines as appropriate. For example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA, and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in Item P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes.

**Group Therapy (for Speech-Language Pathology and Occupational and Physical Therapies):**

- For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time. **Note:** The 25% rule applies only to Medicare A residents.

**Supervision (Medicare A only):**

- Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

- Therapy students are recognized as skilled providers under Medicare A only. They must be "in line of sight" supervision (**Federal Register** November 4, 1999).

**Maintenance Therapy/Nursing Rehabilitation:**

- Once the licensed therapist has designed a maintenance program and discharged the resident from the rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the aide should no longer be reported at Item P1b as skilled therapy. The services of the aide may be reported on the MDS assessment as restorative nursing at Item P3, provided they meet the requirements for restorative therapy.

- There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice. The therapist's time cannot be reported as skilled therapy in Item P3.

**Example**

Following a stroke Mrs. F was admitted to the nursing facility in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

| Coding | A | B |
|---|---|---|
| a. Speech-language pathology, audiology services | 2 | 60 |
| b. Occupational therapy | 2 | 60 |
| c. Physical therapy | 5 | 300 |
| d. Respiratory therapy | 0 | 70 |
| e. Psychological therapy | 0 | 0 |

## P2. Intervention Programs for Mood, Behavior, Cognitive Loss
**(7-day look back)**

***Definition:***

**a. Special Behavior Symptom Evaluation Program -** A program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms (such as the symptoms described in Item E4). The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

**b. Evaluation by a Licensed Mental Health Specialist in the Last 90 Days -** An assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not code this item for routine visits by the facility social worker. Evaluation may take place at the nursing facility, private office, clinic, community mental health center, etc.

Each state **licenses** independent providers of mental health services who can provide care in the facility, at home, office or clinic. The term "psychiatric social worker," (synonymous with clinical social worker) refers to someone with training in clinical mental health practice that is qualified to practice as a psychotherapist. Depending on State licensure requirements, a psychiatric/clinical social worker functions as an independent practitioner or under consultation, usually to a psychiatrist.

c. **Group Therapy** - Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the nursing facility (e.g., support group run by the facility's social worker) or outside the facility (e.g., group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support group at local hospital). This item does not include group recreational or leisure activities.

d. **Resident-Specific Deliberate Changes in the Environment to Address Mood/Behavior/Cognitive Patterns** - Adaptation of the milieu focused on the resident's individual mood/behavior/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings in other residents' rooms along the way.

e. **Reorientation** - Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provides orienting information and reminders.

f. ***NONE OF ABOVE***

***Process:*** Review the resident's clinical record for documentation of intervention programs. These interventions also should be documented in the care plan.

***Coding:*** Check all that apply. If none apply, check *NONE OF ABOVE*.

## P3. Nursing Rehabilitation/Restorative Care (7-day look back)

***Intent:*** To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when he/she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. Restorative nursing does not require a physician's order.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

***Definition:*** **Rehabilitation/Restorative Care** - Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in Item P1b. In addition, **to be included in this section, a rehabilitation or restorative care must meet all of the following additional criteria:**

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include groups with more than four residents per supervising helper or caregiver.

**a. Range of Motion (Passive)** - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. A program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a resident get dressed does not, in and of itself, constitute a range of motion exercise session.

**b. Range of Motion (Active)** - Exercises performed by a resident, with cuing, supervision or physical assist by staff, that are planned, scheduled, and documented in the clinical record. Include active ROM and active assisted ROM. Any participation by the resident in the ROM activity should be coded here.

**c. Splint or Brace Assistance** - Assistance can be of 2 types: 1) where staff provides verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff

have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

**TRAINING AND SKILL PRACTICE IN: -** Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

**d. Bed Mobility** - Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

**e. Transfer** - Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

**f. Walking** - Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

**g. Dressing or Grooming** - Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

**h. Eating or Swallowing** - Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

**i. Amputation/Prosthesis Care** - Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.

**j. Communication** - Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

**k. Other** - Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

***Process:*** Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation/restorative care schedule, and implementation record sheet on the nursing unit.

***Coding:*** For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The time provided for Items P3a-k must be coded separately, in time blocks of 15 minutes or more. For example, to check Item P3a, 15 or more minutes of PROM must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift) however; 15-minute time increments cannot be obtained by combining P3a, P3b, and P3c. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

***Clarifications:***

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- When not contraindicated by State practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services **may not** be coded as therapy in Item P1b, since the specific interventions are considered restorative nursing services when performed by nurses or aides. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

- Active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures.

- The use of Continuous Passive Motion (CPM) devices as Rehabilitation /Restorative Nursing is coded when the following criteria are met: 1) ordered by a physician, 2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and 3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff required to apply the device and monitor.

- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to have goals, objectives and documentation of progress included in the clinical record.

**Examples of Nursing Rehabilitation/Restoration**

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive), **enter "7" as the number of days these nursing rehabilitative techniques were provided.**

Mrs. K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

**(continued on next page)**

**Examples of Nursing Rehabilitation/Restoration (continued)**

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided**.

Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**

Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, **enter "0" as the number of days training and skill practice for eating was provided.**

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has proven very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

## P4. Physical Restraints (7-day look back)

***Intent:*** To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the assessment process whether or not a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the resident.

***Definition:*** Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

a. **Full Bed Rails** - Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). Include in this category veil screens (used in pediatric units) and enclosed bed systems.

b. **Other Types of Bed Rails Used** - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above "full bed rail" category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c. **Trunk Restraint** - Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d. **Limb Restraint** - Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e. **Chair Prevents Rising** - Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled walkers with or without a posterior seat and lap cushions that a resident cannot easily remove.

***Process:*** Check the resident's clinical records. Consult nursing staff. Observe the resident. To determine whether or not an item is a physical restraint, the assessor should evaluate whether or not the resident can easily remove the device, material or equipment. If the resident cannot easily remove the item, continue with the assessment to determine whether or not the device meets the other provisions in the definition of a physical restraint. The assessor should not focus on the intent or reason behind the use of the device, but on the effect the device

has on the resident. Does the device, material, or equipment meet the definition of a physical restraint? If yes, code the item in the appropriate category.

***Coding:*** For each device type, enter:

**0.** Not used in last 7 days

**1.** Used, but used less than daily in last 7 days

**2.** Used on a daily basis in last 7 days

Because the coding categories are limited, we have given some direction on which category to code particular devices. While the device may not be completely representative of the category description, follow the coding instruction as given. There may be devices that we have not given coding instructions for and there is not a category that is representative of the device. For those devices, do not code at this time, but note that in subsequent versions of the MDS, CMS will include an "other" category that would be an appropriate place to code these devices. **NOTE:** Any device, material or equipment that meets the definition of a physical restraint must have: a medical symptom that warrants the use of the restraint; a physician's order for use; and must be care planned whether or not there is a category to code the physical restraint on the MDS.

Exclude from this P4 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.

***Clarifications:***

- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by restraints. It is vital that restraints used on this population be carefully considered and monitored. In some cases, the risk of using the device may be greater than the risk of not using the device.

- Should enclosed framed wheeled walkers, with or without a posterior seat, such as the Merry Walker® Ambulation Device and other devices like it, be coded in section P4e: "Chair prevents rising?"

  As will be set forth in the guidance to surveyors, the Merry Walker® Ambulation Device and similar devices should not be categorically classified as a restraint. The following coding information provides further detailed guidance on how to code utilization of the device that might for a particular resident be considered a restraint. If these devices assist ambulation for a particular resident, they should be coded as a cane/walker/crutch at Item G5a, whether or not they are coded as a restraint.

(1) **Coding When Not a Restraint**

If a resident is able to easily open the front gate and exit the device, the device should **not** be coded as a restraint for this particular resident. It would be coded at Item G5a as a Cane/walker/crutch.

(2) **Coding When a Restraint**

(a) Only if the device has the effect of restricting the resident's freedom of movement, should the device be considered a restraint. If the resident's freedom of movement is restricted because the resident cannot open the front gate and exit the device (due to cognitive or physical limitations that prevents him or her from exiting the device), then the device should be coded as a restraint in Item P4 of the MDS.

(b) The current version of the MDS (Version 2.0) does not contain a category for a restraint in which this device obviously falls. We understand that these devices do not prevent a resident from standing. Nevertheless, until CMS releases the next version of the MDS, when the device restricts freedom of movement, code the device at Item P4e, Chair prevents rising, with either a "1" (Used less than daily), or a "2" (Used daily). In subsequent versions of the MDS, CMS will include an "other" category, which would be an appropriate place to code this type of device.

(c) Coding the device at Item P4e does not preclude the facility from also coding the device at Item G5a (Cane/walker/crutch) if the resident used the device to walk during the last 7 days.

**Request for Restraints:**

While a resident, family member, legal representative or surrogate may request that a restraint be used, the facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of 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 the Code of Federal Regulation (CFR) at 42 CFR 483.13(a), "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 restrained for discipline or convenience. Prior to employing any restraint, the nursing facility must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal

surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation solely based on a 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 intervention or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

**Are Restraints Prohibited?**

The regulations and CMS' guidelines do not prohibit the use of restraints in nursing facilities, except when they are imposed for discipline or convenience and not required to treat the resident's medical symptoms. The regulation states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that the belief that restraints ensure safety is often unfounded. In practice, restraints have many negative side effects and risks that, in some cases, far outweigh any possible benefit that can be derived from their use. Prior to using any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom that the restraint is being employed to address. If a restraint is needed to treat the resident's medical symptom, the facility is responsible to assess the appropriateness of that restraint. When the decision is made to use a restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use. While a restraint-free environment is not a Federal requirement, the use of restraints should be the exception, not the rule.

**Bed Rails Used as Positioning Devices:**

In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the purpose or intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. **If the side rail has the effect of restraining the resident and meets the definition of a physical restraint for that individual, the facility is responsible to assess the appropriateness of that restraint**. Prior to employing any restraint, the facility must assess the resident to properly identify the resident's needs and the medical symptom the restraint is being employed to address. When the facility decides that a restraint is needed to treat the resident's medical symptom, CMS encourages, to the extent possible, gradual restraint reduction because of the many negative outcomes associated with restraint use. While

bed rails may serve more than one function, the assessor should code Items P4a or P4b when the bed rails meet the definition of a restraint. When a bed rail is *both* a restraint *and* a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) *and* at Item G6b (Bedrails used for mobility or transfer).

**Devices Used with Residents Who Are Immobile:**

**Side Rails -** Physical restraints are defined as "any manual method, physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body." If the resident is immobile and can not voluntarily get out of bed due to a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not meet the definition of a restraint.

For residents who have no voluntary movement, the staff needs to determine if there is any 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 towards the edge of the bed. 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 restraint, they may affect the resident's quality of life and create an accident hazard.

**Geriatric Chairs** - For a resident who has no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint and should not be coded at Item P4e. If the resident has the ability to transfer from other chairs, but cannot transfer from a geriatric chair, a geriatric chair is a restraint to that individual, and should be coded at Item P4e. If the resident has no ability to transfer independently, then the geriatric chair does not meet the definition of a restraint, and should not be coded at Item P4e.

## P5. Hospital Stay(s) (90-day look back)

***Intent:*** To record how many times the resident was admitted to the hospital with an overnight stay in the last 90 days or since the last assessment if less than 90 days [regardless of payment status for these days either by the hospital or by the nursing facility]. If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.

***Definition:*** The resident was formally admitted by a physician as an inpatient with the expectation that he or she will stay overnight. It does not include day surgery, outpatient services, etc.

***Process:*** Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a nursing facility admission from the community.

***Coding:*** Enter the number of hospital admissions during the 90-day observation period prior to admission to the nursing facility. Enter "**0**" if no hospital admissions.

**Examples**

Mrs. D, an insulin-dependent diabetic, was admitted to the nursing facility yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. **Code "2" for two hospital admissions in the last 90 days.**

Mr. W has been a resident of the nursing facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month, Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. **Code "1" for one hospital admission in the last 90 days.**

## P6. Emergency Room (ER) Visit(s) (90-day look back)

***Intent:*** To record if during the last 90 days the resident visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time. If the resident is a new admission to the facility, this item includes emergency room visits during the period prior to admission.

***Definition:*** **Emergency Room Visit -** A visit to an emergency room not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc.

***Process:*** Review the resident's clinical record. For new admissions, ask the resident and the resident's family and review the transmittal record.

***Coding:*** Enter the number of ER visits in the last 90 days (or since last assessment if less than 90 days). Enter "**0**" if no ER visits.

**Examples**

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the nursing facility the next afternoon. **Code "0" for No ER visits.** The **rationale** for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the nursing facility within several hours. **Code "1" for 1 ER visit.**

Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and nursing facility staff was unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. **Code "1" for ER visit.**

## P7. Physician Visits (14-day look back)

***Intent:*** To record the **number of days** during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

***Definition:*** **Physician** - Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.

**Physician Exam** - May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)"

***Coding:*** Enter the number of days the physician examined the resident. If none, enter "**0**".

***Clarification:***

- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician visit. Documentation of the physician's evaluation should be included in the clinical record. The physician's evaluation can include partial or complete

examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.

Do not include physician visits that occurred during the resident's acute care stay.

## P8. Physician Orders (14-day look back)

***Intent:*** To record the **number of days** during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

***Definition:*** **Physician** - Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician.

**Physician Orders** - Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

***Coding:*** Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "**0**".

***Clarifications:***

- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- Do not count visits or orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. And do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.
- A monthly Medicare Certification is a renewal of an existing order and should not be included when coding this item.
- If a resident has multiple physicians: e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable; e.g., for a new or altered treatment. An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed. Orders written to increase the resident's RUG-III classification and facility payment are not acceptable.

- When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item.

- Orders for transfer of care to another physician may not be counted.

## P9. Abnormal Lab Values (90-day look back)

***Intent:*** To document whether the resident had any abnormal laboratory values during the last 90 days or since admission to the nursing facility. This item refers only to laboratory tests performed after admission to the nursing facility. "Abnormal" refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident.

**Example**

An elevated prothrombin time in a resident receiving coumadin therapy is coded "1" for Yes (Abnormal) even though this may be the desired effect.

***Process:*** Check medical records, especially laboratory reports.

***Coding:*** Enter "**0**" if no abnormal value was noted in the record, and "**1**" if the resident has had at least one abnormal laboratory value. Abnormal blood glucose levels, including levels obtained via finger-sticks are included in this item.

# SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

## Q1. Discharge Potential

***Intent:*** To identify residents who are potential candidates for discharge within the next three months. Some residents will meet the "potential discharge" profile at admission; others will move into this status as they continue to improve during the first few months of residency. Section Q provides data on discharge potential. Depending on the resident's clinical status and circumstances, additional assessment to determine why the resident is not a candidate for discharge at this time and what plan can be implemented to improve discharge potential may be warranted.

***Definition:*** **Discharge** - Can be to home, another community setting, another care facility, or a residential setting. A prognosis of death should not be considered as an expected discharge.

**Support Person** - Can be a spouse, family member, or significant other.

***Process:*** For new and recent admissions, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community. After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgment. Listen to what the resident brings up (e.g., Calls out, "I want to go home"). Ask indirect questions that will give you a better feel for the resident's preferences. For example, say, "It's been about 1 year that we've known each other. How are things going for you here at (facility)."

Consult with primary care and social service staff, the resident's family, and significant others. Review clinical records. Discharge plans are often recorded in social service notes, nursing notes, or medical progress notes.

***Coding:***

a. **Resident Expresses/Indicates Preference to Return to the Community** - Enter "**0**" for No or "**1**" for Yes.

b. **Resident has a Support Person who is Positive Towards Discharge** - Enter "**0**" for No or "**1**" for Yes.

c. **Stay Projected to be of a Short Duration** - Discharge projected within 90 days (do not include expected discharge due to death). Enter "**0**" for No, "**1**" for within 30 days, "**2**" for within 31-90 days, or "**3**" for discharge status uncertain.

**Examples**

Mrs. F is a 65 year-old married woman who sustained a CVA 2 months ago. She was admitted to the nursing facility one week ago from a rehabilitation facility for further rehab, particularly for transfer, gait training, and wheelchair mobility. Mrs. F is extremely motivated to return home. Her husband is supportive and has been busy making their home "user friendly" to promote her independence. Their goal is to be ready for discharge within 2 months.

| **Discharge Potential** | **Coding** |
|---|---|
| a. Resident expresses/indicates preference to return to the community. | 1 (Yes) |
| b. Resident has a support person who is positive towards discharge. | 1 (Yes) |
| c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death). | 2 (within 31-90 days) |

Mrs. D is a 67 year-old widow with end-stage metastatic cancer to bone with pathological fractures. Currently her major problems are pain control and confusion secondary to narcotics. Mrs. D periodically calls out for someone to take her home to her own bed. Her daughter is unwilling and unable to manage her hospice care at home. Because of the fractures, Mrs. D is totally dependent in all ADLs except eating (she can hold a straw).

| **Discharge Potential** | **Coding** |
|---|---|
| a. Resident expresses/indicates preference to return to the community | 1 (Yes) |
| b. Resident has a support person who is positive towards discharge | 0 (No) |
| c. Stay projected to be of short duration - discharge projected within 90 days (do not include expected discharge due to death). | 0 (No) |

***Rationale for coding:***
Although Mrs. D is near death, you should apply a code of "0" (No).
This MDS item instructs you "do not include expected discharge due to death."

**(continued on next page)**

**Examples**
**(continued)**

Mr. S is a 70 year-old married gentleman who was admitted to the facility 2 weeks ago from the hospital following surgical repair of a left hip fracture. Mr. S has a long history of alcoholism and cirrhosis of the liver. His daughter reports that when he is drinking he is abusive towards his wife of 40 years. Though he has a strong wish to return home, his wife states she can't take it anymore and doesn't want him to return home. He has basically worn out all his family options. Other social support options are being explored. At this time plans for discharge remain uncertain.

| Discharge Potential | Coding |
|---|---|
| a. Resident expresses/indicates preference to return to the community. | 1 (Yes) |
| b. Resident has a support person who is positive towards discharge. | 0 (No) |
| c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death). | 3 (Uncertain) |

## Q2. Overall Change in Care Needs (90-day look back)

***Intent:*** To monitor the resident's overall progress at the facility over time. Document changes as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). This item asks for a snapshot of "today" as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

***Definition:*** **Overall Self-Sufficiency** - Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

***Process:*** Review clinical record, transmittal records (if new admission or readmission), previous MDS assessments (including Quarterly assessment), and care plan. Discuss with direct caregivers.

***Coding:*** Record the number corresponding to the most correct response. Enter "**0**" for No change, "**1**" for Improved (receives fewer supports, needs less restrictive level of care), or "**2**" for Deteriorated (receives more support).

**Examples**

Mr. R is a 90 year-old comatose gentleman admitted to the facility from a 6 months stay at another nursing facility to be closer to his wife's residence. His condition has remained unchanged for approximately 6 months. **Code "0" for No change.**

Mrs. T has a several year history of Alzheimer's disease. In the past four months her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is improved. She seems happier, less agitated, sleeps more soundly at night, and is more socially involved in daily activity programming. **Code "1" for Improved.**

Mr. D also has a several year history of Alzheimer's disease. Although for the past year he was quite dependent on others in most areas, he was able to eat and walk with supervision until recently. In the past 90 days he has become more dependent. He no longer feeds himself. Additionally, he fell two weeks ago and has been unable to learn how to use a walker. He requires a 2-person assist for walking even short distances. **Code "2" for Deteriorated.**

# SECTION R.
# ASSESSMENT INFORMATION

## R1. Participation in Assessment

***Intent:*** To record the participation of the resident, family and/or significant others in the assessment, and to indicate reason if the resident's assessment is incomplete.

***Definition:*** **Family** - A spousal, kin (e.g., sibling, child, parent, nephew), or in-law relationship.

**Significant Other** - May include close friend, partner, housemate, legal guardian, trust officer, or attorney. Significant other does not, however, include staff at the nursing facility.

***Process:*** Preparing residents and family members to participate in the care planning process begins with assessment. When staff members explain the assessment process to a resident, they should also explain that the outcome of assessment is care delivery guided by a care plan. Every assessment team member can establish an expectation of resident participation by asking for and respecting the resident's perspective during assessment.

Asking family members about their expectations of the nursing facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate nonverbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

***Coding:***

a. **Resident** - Enter zero "**0**" for No or "**1**" for Yes to indicate whether or not the resident participated in the assessment. This item should be completed last.

b. **Family** - Enter zero "**0**" for No or "**1**" for Yes to indicate whether or not the family participated; enter "**2**" for No family.

c. **Significant Other** - Enter "**0**" for No or "**1**" for Yes to indicate whether or not a significant other participated; enter "**2**" for None if there is no significant other.

## R2a. and b. Signatures of Persons Coordinating the Assessment

***Intent:*** Federal regulations at 42 CFR 483.20 (i) (1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.

***Process:*** The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

***Coding:*** Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If for some reason the MDS cannot be signed on the date it is completed it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record. Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.

***Clarifications:***

- The use of signature stamps is allowed. The facility must have policies in place to ensure proper use and secure storage of the stamps. The State may have additional regulations that apply.

- The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment."

  For facilities that use a sign-in form for care planning and MDS completion, the facility would need to have a written policy that explains how the sign-in process and format are used. It would have to provide attestation by the registered nurse regarding the completion of the assessment, and for each individual, who must certify the accuracy of the portion of the assessment that they completed. The State may have additional regulations that apply.

## Section R. - Assessment/Discharge Information:

## R3. Discharge Status (Item appears on the Discharge Tracking Form)

***Coding:*** **a.** Code for resident disposition on discharge.

***Definition:***

1. **Private Home or Apartment with No Health Services** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

7. **Rehabilitation Hospital** - An Inpatient Rehabilitations Hospital (IRF) that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.

8. **Deceased**

9. **Other** - Includes hospices and chronic disease hospitals.

8. **Other**

***Coding:*** **b. Optional State Code**

## R4. Discharge Date (Item appears on the Discharge Tracking Form)

***Coding:*** Date of death or discharge. *Use all boxes*. For a one-digit month or day, place a zero in the first box. For example: February 3, 2002, should be entered as:

| 0 | 2 | | 0 | 3 | | 2 | 0 | 0 | 2 |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

# SECTION S.
# STATE-DEFINED SECTION

**SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL VERSION 2.0 MDS FORM. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.**

# SECTION T.
# THERAPY SUPPLEMENT FOR MEDICARE PPS

Nursing facilities are required to complete Section T. if included in the State's RAI, for all comprehensive assessments: Admission, SCSA, and Annual reassessment. Some states may also require facilities to complete this section for each Quarterly assessment. Contact your State RAI Coordinator for State-specific requirements.

## T1. Special Treatments and Procedures

**a. RECREATION THERAPY (7-day look back)**

***Intent:*** To record the **(A) number of days** and **(B) total number of minutes** recreation therapy was administered (for at least 15 minutes a day) in the last 7 days.

***Definition:*** **Recreation Therapy** - Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

***Process:*** Review the resident's clinical record and consult with the qualified recreation therapists.

***Coding:*** **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven days. Enter "0" if none.

**Box B:** In the second column, enter the total number (#) of minutes recreational therapy was provided in the last seven days. The time should include only the actual treatment time (not resident time waiting for treatment or therapist time documenting a treatment). Enter "0" if none.

### b. ORDERED THERAPIES (first 14 days)

***Skip these items unless this is a Medicare 5-Day assessment or a Medicare Readmission/Return assessment.***

***Coding:*** **Ordered Therapies** – Code "1", Yes, if the physician has ordered any of the following therapy services to begin in the first 14 days of the stay – physical therapy, occupational therapy, or speech pathology services. If No, enter "0" and skip to T2.

***Intent:*** To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] during the early days of the resident's stay. Often therapies are not initiated until after the end of the observation assessment period. For the Medicare 5-Day or Readmission/Return assessment, this section provides an overall picture of the amount of therapy that a resident will likely receive through the fifteenth day from admission.

***Process:*** For Item T1b: Review the resident's clinical record to determine if the physician has ordered one or more of the medically necessary therapies to begin in the first 14 days of stay. Therapies include physical therapy (PT), occupational therapy (OT), and/or speech pathology services. If not, skip to Item T2. If orders exist, consult with the therapists involved to determine if the initial evaluation is

completed and therapy treatment(s) has been scheduled. If therapy treatment(s) will **not** be scheduled, skip to Item T2.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A.

### c. ESTIMATE OF NUMBER OF DAYS (Through day 15)

***Coding:*** **Estimate of Number of Days** - Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number or days through day 15, even if the resident is discharged prior to day 15. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

***Clarifications***:

- Do not count the evaluation day in the estimate number of days unless treatment is rendered.
- When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7.

### d. ESTIMATE OF NUMBER OF MINUTES (Through day 15)

***Coding:*** **Estimate of Number of Minutes** - Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission. Include the number of minutes already provided from MDS Items P1ba(B), P1bb(B), and P1bc(B). Calculate the expected number of minutes through day 15, even if the resident is discharged prior to day 15.

***Clarification:***

- Do not include evaluation minutes in the estimate of number of minutes.

**Example of Ordered Therapies on Medicare 5-Day Assessments**

Mr. Z was admitted to the nursing facility late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5-Day assessment. Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

**Enter "8" in Item T1c for the number of days that at least one therapy service is expected to be delivered.**
**Enter "720" in Item T1d for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.**

Mrs. C was admitted to the facility Tuesday with an evaluation order for all three therapies. The physical therapist completed the evaluation for physical therapy on Wednesday and scheduled treatment to begin on Thursday, five days a week for 30 minutes each day. The occupational therapist completed the evaluation on Friday and scheduled therapy to begin on Monday, 3 days a week for one hour each day. The speech language pathologist's evaluation did not recommend speech therapy for the resident so speech therapy was not scheduled. The RN Assessment Coordinator identified Monday as the end of the observation assessment period. Within the observation assessment period, the resident received 3 days of physical therapy for a total of 90 minutes. The resident received one occupational therapy treatment for a total of 60 minutes. It was expected that Mrs. C would receive 6 more days of physical therapy within the 15 days after the resident's admission for a total of 180 minutes and 3 more days of occupational therapy within the 15 days after the resident's admission for a total of 180 minutes.

**Enter "9" in Item T1c for the number of days that at least one therapy service is expected to be delivered.**

**Enter "510" in Item T1d for the estimated total number of minutes that both physical therapy and occupational therapy is expected to be delivered.**

## T2. Walking when most self-sufficient (7-day look back)

***Intent:*** Physical therapy treatment plans and nursing rehabilitation programs are often implemented to improve a resident's ability to walk. This includes residents with different problems (e.g. stroke, Parkinson's disease, hip replacement) and at different stages of recovery (e.g. 1 week post-hip fracture versus 3 weeks post-hip fracture). It is important to monitor the gait pattern and walking progress for residents and how functional walking is integrated into the resident's activities of daily living on the nursing unit.

Four important walking components to be monitored are the **distance** a resident walks, the amount of **time** it takes to walk that distance, and the amount of **assistance** and **support** received. Assessment of the resident's ability to walk using these four components should be viewed in combination with information in Section G (walking in room, walking in corridor, locomotion on unit, balance test, functional range of motion, modes of locomotion and transfer, and rehabilitation potential); Section I (diagnoses that impact ability to walk such as cerebral palsy, hip fracture, stroke); and Section J (unsteady gait). This information will provide a picture of the resident's problems and level of functioning for comparison to the most self-sufficient walking episode. This information will assist all members of the interdisciplinary care team to differentiate the resident's "best walking effort" and the resident's usual walking performance. Discussions between the physical therapist working with the resident on walking and the RN Assessment Coordinator regarding these differences should lead to better coordination of care and foster continuity of physical therapy treatment for the resident on the nursing unit.

Assessment of the resident's most self-sufficient walking episode can be used to evaluate 1) the effectiveness of physical therapy and nursing rehabilitation, 2) the continued need for therapy and nursing rehabilitation, and 3) maintenance of walking ability after therapy or nursing rehabilitation was discontinued.

**Complete Item 2 when the following conditions are present. Otherwise, skip to Item 3.**

- **ADL self-performance score for TRANSFER (G1bA) is 0, 1, 2, or 3**

  **AND**
- **Resident receives physical therapy (P1bc) involving gait training;**

  **OR**
- **Physical therapy is ORDERED for gait training (T1b)**

  **OR**
- **Resident is receiving nursing rehabilitation for walking (P3f)**

  **OR**
- **Physical therapy involving gait training has been discontinued within the past six months.**

***Definition:*** **Most Self-Sufficient Episode** - In the last seven days, the episode in which the resident used the LEAST amount of assistance and support while walking the longest and farthest **without sitting down.** The most self-sufficient episode can include physical help from others or assistive devices. Only episodes using a safe, functional gait should be used in determining the walking episode that was the most self-sufficient.

**Assistive Devices:** Prostheses, different types of canes and walkers, crutches, splints, parallel bars, and pushing a wheel chair for support.

**Examples for Most Self Sufficient Episode**

Mrs. G had a hip replacement three weeks ago and was admitted to the nursing facility one week after the surgery. During the 7-Day assessment period of the initial comprehensive assessment, Mrs. G could only stand and transfer from bed to chair on the nursing unit with the assistance of one person. Physical therapy was initiated several days after admission for gait training. By the sixth day of admission, Mrs. G could walk two lengths of the parallel bars (20 feet) with stand by assistance from the therapist. The physical therapists and RN assessment coordinator conferred and together determined that Mrs. G's most self-sufficient walking episode took place in therapy using the parallel bars.

Following intensive physical therapy for gait training for weakness and paralysis from a stroke, Mr. T was discharged from physical therapy with the ability to walk using an appropriate and safe gait pattern, using a short leg brace and a quad cane. Mr. T's revised care plan includes a nursing rehabilitation program for walking. His walking rehabilitation program requires a nursing assistant to walk with Mr. T in the morning after breakfast and after dinner for 15 minute walking sessions using a measured "walking route" on the nursing unit. Mr. T's stamina during the walking sessions varied daily during the 7-Day assessment period. Sometimes he could only walk several feet before needing to sit down. On three occasions, Mr. T walked half the length of the corridor (75 feet) in 5 minutes without sitting down and using the gait pattern he was taught. This was his most self-sufficient walking episode.

During a brief meeting during morning report, the physical therapist, nursing staff on 2 South, and the RN assessment coordinator determined Mr. A's most self-sufficient walking episode during the last seven days. It was reported that Mr. A walked 50 feet in 7 minutes with a walker, cueing, and physical guidance on the nursing unit and walked 60 feet in 10 minutes with a walker and cueing for correct heel strike in physical therapy. The staff agreed that the walking episode in physical therapy was Mr. A's most self-sufficient episode.

Mrs. W requires weight bearing support (G1bA=3) and the assistance of two persons (G1bB=3) to transfer her from the bed to a chair. Due to her obesity and overall weakness, the nursing staff cannot safely walk her on the nursing unit, therefore she received a code of "8", "activity did not occur" for walking in room (G1cA) and walking in corridor (G1dA). However, Mrs. G is able to walk the length of the parallel bars with the assistance of two persons when she is in physical therapy, which would be Mrs. G's most self-sufficient walking episode.

***Process:*** There are four components to determining a resident's most *self-sufficient walking episode*: **distance, time, self-performance, and support**. During the 7-Day assessment period, it is likely that nursing and therapy staff will have had numerous opportunities to assess the resident's walking status. Staff is encouraged to use all of the assessment days to determine the resident's most self-sufficient walking episode. Needless to say, it is important that all staff observes the resident and contributes to the determination the resident's most self-sufficient walking episode during the 7-Day assessment period.

During each shift report, staff should be informed which residents are being assessed for their most self-sufficient walking effort. This will remind staff to look for episodes when the resident does better than usual, to observe the distance the resident walks, check the time it takes for the resident to walk that distance, and note the support and assistance that the resident requires. For recently admitted residents receiving physical therapy for gait training, the most self sufficient walking episode will frequently occur during a physical therapy session. However, the best walking effort can occur on the nursing unit, off the unit, in therapy, or even outside the facility.

**Distance Walked:** Determining the distance a resident walks involves knowing the distance between usual places the resident may walk (e.g. number of feet from the bed to the toilet room; number of feet from the resident's room to the dining room, day room, or nurses station). Some facilities may have a section of the corridor designated for walking residents that is measured for distance. Some facilities may be able to use floor tiles or ceiling tiles in determining the distance a resident walks. Take time to determine the distances associated with typical walking places in your facility and communicate these distances to staff. For example, if the distance from the resident's bed to a toilet room in your facility is 8 feet and the nursing assistant reported that the resident walked from the bed to the toilet room, it can be interpreted that the resident walked 8 feet during that walking episode.

**Time Walked:** Staff should determine the time it takes a resident to walk a distance using a timepiece with a second hand.

**Self-Performance in Walking:** This assessment item is similar to the self-performance ADL items in Section G, except this item refers **only to the ONE most self-sufficient walking episode** in the past seven days, rather than ALL of the walking episodes in the past seven days.

**Walking Support Provided:** This assessment item is OPPOSITE the ADL support items in Section G. In determining a resident's most self-sufficient walking episode, the episode with the LEAST amount of support used is identified. Section G requests scoring the MOST amount of support used for an ADL activity during any episode over the last 7 days.

***Coding:***

**a. Furthest Distance Walked** - For the most self-sufficient episode using a safe and functional gait pattern, record the distance that the resident walked. Use the following codes:

**0.** 150 or more feet
**1.** 51-149 feet
**2.** 26-50 feet
**3.** 10-25 feet
**4.** Less than 10 feet

**b. Time Walked** - For the same episode (T3a), record the time it took the resident to walk the distance. Use the following codes:

**0.** 1-2 minutes
**1.** 3-4 minutes
**2.** 5-10 minutes
**3.** 11-15 minutes
**4.** 16-30 minutes
**5.** 31 or more minutes

**c. Self-Performance in Walking** - For the same episode (T3a), record the amount of assistance the resident received during the walking episode. Use the following codes:

**0.** INDEPENDENT - No help or oversight provided while walking.
**1.** SUPERVISION - Oversight, encouragement, or cuing provided while walking.
**2.** LIMITED ASSISTANCE - Resident highly involved in walking; received physical help in guided maneuvering of limbs or other non weight-bearing assistance.
**3.** EXTENSIVE ASSISTANCE - Resident received weight-bearing assistance while walking.

**d. Walking Support Provided** - For the same episode (T3a), record the amount of support the resident received during the walking episode. Use the following codes:

**0.** No setup or physical help from staff
**1.** Setup help only
**2.** One person physical assist
**3.** Two or more persons physical assist

**e. Parallel Bars Used During Walking** - For the same episode (T3a), record if parallel bars were used. Code "0" if parallel bars were NOT used and "1" if parallel bars were used.

## CODING EXAMPLES FOR WALKING WHEN MOST SELF SUFFICIENT

Mrs. D was admitted to the nursing facility 1 month ago for rehabilitation following a CVA. She has left sided hemiplegia and receives physical therapy 5 days a week for a 45-minute session twice daily. Mrs. D enjoys her PT sessions and puts forth her best efforts in walking when her therapist is present. During the last 7 days, Mrs. D's most self-sufficient episode was during a physical therapy session when she walked the length of the hallway outside the physical therapy room (approximately 50 feet) in 15 minutes without sitting down. Mrs. D used a short leg brace to prevent foot drop and a quad cane for support. The physical therapist walked beside Mrs. D, encouraging her and cueing her to pick up her left foot, but not providing physical support.

Code a (furthest distance walked) as "2"

Code b (longest time) as "3"

Code c (self-performance) as "1"

Code d (walking support provided) as "0"

**********

Mr. G was admitted to the nursing facility following a lengthy hospitalization related to injuries sustained in a motor vehicle accident. Mr. G received physical therapy for 8 weeks to strengthen his lower extremities. Physical therapy was discontinued last week. Mr. G tires during the day, requiring more assistance with ambulation as the day progresses. During the morning, Mr. G walks from his bed to the toilet room (8 feet) with oversight from a staff person. It takes about 6 minutes for Mr. G to reach the toilet room. He uses a brace, that the staff put on for him, on his right leg and a walker.

During the night shift, Mr. G has much difficulty in bearing weight and manipulating his lower extremities. To walk to the toilet room, two nursing assistants are needed to provide weight-bearing support and to help Mr. G position his legs in taking steps. It takes approximately 6 minutes to reach the toilet room.

Code a (furthest distance) as "4"

Code b (longest time) as "2"

Code c (self-performance) as "1"

Code d (walking support provided) as "1"

## T3. Case Mix Group

***Intent:*** Records the RUG-III Classification calculated from the facility software.

a. **Medicare**
The software calculated RUG-III Classification for the Medicare program using the 53 Group Version 5.2. The first three characters entered in the boxes represent one of the 53 RUG-III groups. The last two numbers are an indicator of the version of the RUG-III Classification system. Currently, this version is **09**. This **09** comes directly from the software and will appear on every assessment.

b. **State**
The software calculated RUG-III Classification for the State case mix field using the State-specified RUG-III Classification system. For states using the RUG-III Classification system for case mix reimbursement, this item may be required. States have the option of using either the 34 or 44 RUG-III Classification systems, or a different version of the RUG-III Classification system. The first three characters entered in the boxes represent one of the RUG-III groups. This could vary from the Medicare case mix field if the state is using the 34 RUG-III Classification system. The last two numbers may vary depending on the version of the RUG-III Classification system specified in the state. Please contact your State representatives for your State requirements.

# SECTION U. MEDICATIONS (7-day look back)

**PLEASE NOTE: This section is not required by CMS. Some states have required completion of Section U. Please contact your State RAI Coordinator for State-specific instructions.**

Nursing facility residents are highly susceptible to adverse drug reactions and drug interactions. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in nursing facilities when there is no regular and careful monitoring of residents' prescribed medications.

***Intent:*** This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing. For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

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In addition to using the medication information collected in Section U for resident care planning purposes, this section can be integrated into a facility's quality assurance program to monitor for quality care issues such as polypharmacy, overuse of different medications, and medication administration errors and omissions.

***Definition:*** **Amount Administered** - The number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident.

**NDC** - The National Drug Code (NDC) is a standardized system for coding medications. An individual NDC provides coded information on the drug name, dose, and form of the drug.

**Medication Administration Record (MAR)** - The part of the resident's clinical record that is used by the nurse administering medications to record the medication administered. The MAR typically is the form or document used specifying the medication, dose, frequency, and route for each medication that a resident is to receive on a scheduled or PRN basis.

***Process:*** Recording all of the information required in this section can be done efficiently by having the following information: 1) current physician order sheets; 2) current Medication Administration Record (MAR), 3) NDC codes. Use the Medication Administration Record (MAR) as your **primary** document for identifying all medications administered in the last seven days. Check the physician's order sheet to determine if any medications had recently been ordered.

In some facilities, the pharmacist may complete some portions of Section U, particularly the NDC codes and the amount administered. The pharmacy may also be able to supply you with the NDC codes for the medications ordered for each resident. Talk to the pharmacist for your facility and engage their participation in assisting with the completion of this section. If the pharmacist does not complete any portions of the medication section of the MDS, you will need to consult the list of NDC codes. The manual provides the NDC codes for medications frequently used in nursing facilities. In addition, NDC codes can be found in the *Physicians Drug Reference (PDR)* or you may be able to obtain a list of NDC codes from your pharmacy.

Take special care to ensure that you have identified and recorded all medications that were administered in the last 7 days. Often residents can have several MAR pages, especially if medications have been discontinued and new ones ordered or if there are a lot of PRN medications ordered. Recheck the MAR at least twice to avoid missing any medications administered in the last seven days. Make sure you count medications that may have been discontinued, but were administered in the last seven days.

To accurately complete the NDC codes and amount administered, it will be necessary to look at the actual medications that are given to the resident. For

example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

If Section U is completed by the pharmacist or other nursing facility personnel, these persons must certify its accuracy with their signature in AA9, Attestation Statement. The RN Assessment Coordinator must review Section U to ensure that it is complete.

***Coding:*** The coding instructions are extensive. Review them carefully. Study the examples. Complete the coding exercises at the end of this section.

**1. Medication Name and Dose Ordered**. Identify and record all medications that the resident **received** in the last seven days. Also identify and record any medications that may not have been given in the last seven days, but are part of the resident's regular medication regimen (e.g. monthly B-12 injections). Do **not** record PRN medications that were **not** administered in the last seven days.

Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose ordered *EXACTLY* as it appears on the MAR. For example, if the MAR indicates Acetaminophen 650 mg, **do not** write Acetaminophen 325 mg. 2 tabs, even if two 325mg. tablets are administered to the resident.

Occasionally, dosages of medications may be changed during the 7-Day assessment period. The medication with dosage changes should be recorded separately.

***Clarifications:***

- Code only medications that the physician orders at the facility. If a facility medication order is carried out off premises, (e.g., a dose administered at a dialysis center), that should be included in Section U. In this example, the facility should be made aware (e.g., via report) of medication administered at the Dialysis Center, but there is no item on the MDS to capture this information. Dialysis itself is captured in P1ab.

- There should be 9 digits in an NDC code. Check or re-check the source of an 8 digit NDC code to see if a zero might have been dropped. Begin recording the code in the leftmost box on the MDS. Many NDC codes begin with one or more zeros. The zeros are important. Do not omit them. Some NDC codes have 11 digits. In this case, disregard the last 2 digits, (they are package size codes).

- Code the NDC for the medication that was administered during the observation period. If during the observation period, both the generic and the brand name medications were administered (under the same order), it's up to the facility to decide which to code. For example, the facility may decide to routinely code the generic in such instances. Whatever the decision, it should be carried out consistently. Do not code both, a brand and generic name, as it would give the appearance of a double order of the same medication.

- When a medication dosage involves 2 separate NDC codes, (e.g., for a physician's order of Coumadin 3 mg., the pharmacy sends (1) 1 mg and (1) 2 mg tablet), code only the NDC for the highest dose. Record the ordered dose (in this example, 3 mg) in column 1 of Section U.
- When an oral medication is crushed and administered via G-tube, use code 9, enteral tube. A note of caution: some oral medications should not be crushed.
- Stat orders are coded as 1 in the PRN column.
- All medications received by the resident, including over-the-counter medications, should be ordered by the physician and included in Section U.
- Record the total number of doses, not days, in the last 7 days, which the PRN medication was given.

**EXAMPLE FOR MEDICATION NAME AND DOSE ORDERED**

**Medications as listed on MAR for assessment period of 8/11/02-8/17/02**

A. Lasix 40 mg. daily p.o.
B. Acetaminophen 325 mg. 2 tabs q3-4 hrs PRN p.o. (given 3 times in last 7 days)
C. B-12 1cc q month IM (given 8/8/02)
D. Isopto Carbachol 1.5% 2 drops OD TID
E. Robitussin-DM 5cc HS PRN p.o. (not given in last 7 days)
F. Motrin 300 mg. QID p.o. (discontinued 8/15/02)
G. Dilantin 300 mg. HS p.o. (ordered 8/15/02)
H. Theo-Dur 200 mg. BID p.o. (given 8/11-8/13/02 and then order discontinued)
I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/02 and then order discontinued)
J. Theo-Dur 400 mg BID p.o. (given 8/02)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| Lasix 40 mg. | | | | | |
| Acetaminophen 325 mg. 2 tabs | | | | | |
| B-12 1cc | | | | | |
| Isopto Carbachol 1.5% 2 drops | | | | | |
| Motrin 300 mg. | | | | | |
| Dilantin 300 mg. | | | | | |
| Theo-Dur 200 mg. | | | | | |
| Theo-Dur 200 mg. | | | | | |
| Theo-Dur 400 mg. | | | | | |

*Note that Robitussin-DM was not recorded because it was not given in the last 7 days.

2. **Route of Administration.** Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

1=by mouth (PO)
2=sub lingual (SL)
3=intramuscular (IM)
4=intravenous (IV)
5=subcutaneous (SQ)
6=rectal (R)
7=topical
8=inhalation
9=enteral tube
10=other

**EXAMPLE FOR ROUTE OF ADMINISTRATION**

**Medications as listed on MAR for assessment period of 8/11/02-8/17/02**

A. Mylanta 15 cc after meals p.o.
B. Zantac 150 mg. q 12 hrs. Per tube
C. Transderm nitro patch 2.5 1 patch daily
D. NPH 15 U before breakfast daily SQ
E. Lasix 80 mg. IV STAT
G. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 7 days)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| Mylanta 15cc | 1 | | | | |
| Zantac 150 mg. | 9 | | | | |
| Transderm nitro patch 2.5<br>1 patch | 7 | | | | |
| NPH 15 U | 5 | | | | |
| Lasix 80 mg. | 4 | | | | |
| Acetaminophen suppository<br>650 mg. | 6 | | | | |

**3. Frequency.** Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

PR=(PRN) as necessary
1H=(QH) every hour
2H=(Q2H) every two hours
3H=(Q3H) every three hours
4H=(Q4H) every four hours
6H=(Q6H) every six hours
8H=(Q8H) every eight hours
1D=(QD or HS) once daily

2D=(BID) two times daily (includes every 12 hrs)
3D=(TID) three times daily
4D=(QID) four times daily
5D=five times daily

1W=(Q week) once each wk
2W=two times every week
3W=three times every week

QO=every other day
4W=4 times each week
5W=five times each week
6W=six times each week
1M=(Q mo) once every month

2M=twice every month
C=continuous
O=other

Be careful to differentiate between similar frequencies. For example, some nursing facilities have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for T.I.D. (3D) and q 8 hrs (8H). In this case, the frequency code would be 8H (q 8 hrs.).

If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

**EXAMPLE FOR FREQUENCY**

**Medications as listed on MAR for assessment period of 8/11/02-8/17/02**

A. Ampicillin 250 mg. q 6 hrs x 10 days p.o. (8/10-8/20)
B. Beconase nasal inhaler 1 puff BID
C. Compazine suppository 5 mg. STAT
D. Lanoxin 0.25 mg. p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.
E. Peri-colace 2 capsules HS p.o.
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| Ampicillin 250 mg. | 1 | 6H | | | |
| Beconase nasal inhaler 1 puff | 8 | 2D | | | |
| Compazine suppository 5 mg. | 6 | PR | | | |
| Lanoxin 0.25 mg. | 1 | QO | | | |
| Lanoxin 0.125 mg. | 1 | QO | | | |
| Peri-colase 2 capsules | 1 | 1D | | | |
| NPH 15 U | 5 | 1D | | | |
| NPH 5 U | 5 | PR | | | |
| NPH 10 U | 5 | PR | | | |

4. **Amount Administered (AA).** Determine the amount of medication administered each time the medication was given. Amount administered **is not always** the dose. Rather, it is the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident. For **tablets, capsules or suppositories**, enter the ***number*** of tablets or capsules that were given for each *administration* in column 4 (e.g. 1, 2, 1.5). For **liquids**, enter the ***number*** of cc's, mls, or units that were given for each *administration* in column 4 (e.g. 0. 5 ml, 2.5 cc, 10 units). For **topical medications** (e.g. creams, ointments, eye drops), **inhalation medications**, and **oral medications that are dissolved in water**, enter the numeric code **999** in column 4. If a half of tablet or half of cc is administered, enter it as a decimal (0.5) rather than a fraction.

**EXAMPLE FOR AMOUNT ADMINISTERED (AA)**

**Medications as listed on MAR for assessment period of 8/11/02-8/17/02**

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (received 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
E. Acetaminophen 325 mg. 3 tabs q3-4 hrs PRN for pain p.o. (received 5 times in last 7 days)
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305)
H. Elase ointment to necrotic tissue on left heel TID
I. Diazepam 3 mg. HS p.o.
J. Dilantin 300 mg. HS p.o.
K. Metamucil powder 1 tbsp. in a.m. p.o.

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| Lanoxin 0.125 mg. | 1 | 1D | 1 | | |
| Haldol 1 mg. | 1 | PR | .5cc | | |
| Ampicillin 250 mg. | 1 | 6H | 5ml | | |
| Acetaminophen 650 mg. | 1 | 4D | 2 | | |
| Acetaminophen 325 mg. 3 tabs | 1 | PR | 3 | | |
| NPH 15 U | 5 | 1D | 15U | | |
| NPH 5 U | 5 | PR | 5U | | |
| NPH 10 U | 5 | PR | 10U | | |
| Elase ointment | 7 | 3D | 999 | | |
| Diazepam 3 mg. | 1 | 1D | 1.5 | | |
| Dilantin 300 mg. | 1 | 1D | 3 | | |
| Metamucil powder 1 tbsp. | 1 | 1D | 999 | | |

5. **PRN-Number of Doses (PRN-n).** The PRN-n column is only completed for medications that have a route of administration coded as PR. Record the **number of times** in the past seven days that each medication coded as PR was given. STAT medications are recorded as a PRN medication. Remember, if a PRN medication was **not** given in the past seven days, it should **not** be listed in Section U.

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| Mylanta 15 cc | 1 | PR | 15cc | 12 | |
| Haldol 1 mg. | 1 | PR | 0.5cc | 2 | |
| Hydrocortisone cream 1% | 7 | PR | 999 | 5 | |
| Lasix 80 mg. | 4 | PR | 8cc | 1 | |
| NPH 5 Units | 5 | PR | 5U | 2 | |
| NPH 10 Units | 5 | PR | 10U | 1 | |
| Nitroglycerin 0.3 mg. | 2 | PR | 1 | 2 | |

6. **National Drug Code (NDC).** It is very important that all of the information about the medication (medication name, dose ordered, frequency, and amount administered) corresponds with the NDC code. A medication usually has more than one NDC code. The different types of NDC codes are based on the **strength** of the medication and the **form** of the medication (e.g. solution; tablets, ampules, syringes, ointment, cream, vial, spray, drops). For example, there are 21 NDC codes for morphine. If the resident was receiving 2 mg of morphine IM and the pharmacy sent it in an ampule form, the NDC code is 006411180; if the pharmacy sent the morphine in a vial, the NDC code is 006412343. If your pharmacist is involved in completing this section, the pharmacist would be able to provide the appropriate NDC code.

   There will be occasions when a medication dosage will involve two NDC codes. For example, if Coumadin 3 mg. was ordered, the pharmacy would send a 1 mg. tablet and a 2 mg. tablet, each having a different NDC code. In cases such as this, use the NDC code for the largest dose (2 mg).

   Code investigational drugs as 999999999. Code compounds (topical mixtures prepared by the pharmacist) as 888888888.

   Record the NDC code in column 6. Begin writing in the left hand box entering one digit per box. There should be 9 numbers in the NDC code recorded in column 6. Recheck the number to be sure you have entered the digits correctly. Many NDC codes begin with one or more zeros. These zeros are important; do not omit them. If the NDC codes you are using have eleven (11) digits, disregard the last two digits, as these are the package codes.

**EXAMPLE FOR NDC CODES**

**Medications as listed on MAR for assessment period of 8/11/02-8/17/02**

A. Lanoxin 0.125 mg. daily p.o.
B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
C. Ampicillin 250 mg. q 6 hrs. liquid p.o.
D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
F. NPH 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: NPH 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/02 for BS of 255; 5 units given on 8/13/02 for BS of 233; 10 units given on 8/17/02 for BS of 305).
H. Transderm Nitro 1 Patch QD
I. Lasix 80 mg. IV STAT
J. Diazepam 3 mg. HS p.o.
K. Dilantin 300 mg. HS p.o.

| 1. Medication Name and Dose Ordered | 2.RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Lanoxin 0.125 mg. | 1 | 1D | 1 | | 0 | 0 | 0 | 8 | 1 | 0 | 2 | 4 | 2 |
| Haldol 1 mg. | 1 | PR | .5cc | 2 | 0 | 0 | 0 | 4 | 5 | 0 | 2 | 5 | 0 |
| Ampicillin 250 mg. | 1 | 6H | 5ml | | 0 | 0 | 0 | 4 | 7 | 2 | 3 | 0 | 2 |
| Acetaminophen 650 mg. | 1 | 4D | 2 | | 0 | 0 | 7 | 8 | 1 | 1 | 2 | 9 | 4 |
| NPH 15 U | 5 | 1D | 15U | | 0 | 0 | 0 | 0 | 2 | 8 | 3 | 1 | 5 |
| NPH 5 U | 5 | PR | 5U | 2 | 0 | 0 | 0 | 0 | 2 | 8 | 2 | 1 | 5 |
| NPH 10 U | 5 | PR | 10U | 1 | 0 | 0 | 0 | 0 | 2 | 8 | 2 | 1 | 5 |
| Transderm Nitro 1 patch | 7 | 1D | 999 | | 0 | 0 | 0 | 8 | 3 | 2 | 0 | 2 | 5 |
| Lasix 80 mg. | 4 | PR | 8cc | 1 | 0 | 0 | 0 | 3 | 9 | 0 | 0 | 6 | 3 |
| Diazepam 3 mg. | 1 | 1D | 1.5 | | 0 | 0 | 3 | 6 | 4 | 0 | 7 | 7 | 4 |
| Dilantin 300 mg. | 1 | 1D | 3 | | 0 | 0 | 0 | 7 | 1 | 0 | 3 | 6 | 2 |

# Coding Exercises for Section U

Complete Section U for the following medications during a 7-day period (9/1/02-9/7/02):

1. Inderal 40 mg. BID p.o.
2. Sinemet 10/100 TID p.o.
3. Artificial Tears 1 drop OU QID
4. Anusol HC suppository 1 PRN (given 1 time in last 7 days)
5. Amoxicillin 500 mg q 6 hrs per tube
6. Benylin cough syrup 2 tbs. PRN p.o. (given 10 times in last 7 days)
7. Darvocet-N 100 2 tabs q 4-6 hrs PRN p.o. (given 5 times in last 7 days)
8. Heparin lock flush 10 U daily
9. Ditropan syrup 2.5 mg daily p.o.
10. Nitrotransdermal .4 mg 1 patch daily
11. Novolin N 24 U before breakfast SQ
12. Check blood sugar before breakfast. Sliding scale insulin: Novolin R 10 units if blood sugar over 200. (10 units given on 2 days in last 7 days)
13. Questran 1 packet with each meal p.o.
14. Quinine sulfate 325 mg. HS
15. Coumadin 2.5 mg daily p.o. (discontinued 9/3/02)
16. Coumadin 5 mg. daily p.o. (ordered to start on 9/4/02)
17. Maalox 15 cc PRN for indigestion p.o. (not administered in last 7 days)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|---|---|---|---|---|---|
| | | | | | |
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**Compare your responses to the coding exercises with the responses on the next page.**

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Inderal 40 mg. | 1 | 2D | 1 | | 0 | 0 | 0 | 4 | 6 | 0 | 4 | 2 | 4 |
| Sinemet 10/100 | 1 | 3D | 1 | | 0 | 0 | 0 | 0 | 6 | 0 | 6 | 4 | 7 |
| Artificial Tears 1 drop | 7 | 4D | 999 | | 0 | 0 | 3 | 4 | 9 | 8 | 6 | 1 | 5 |
| Anusol HC suppository 1 | 6 | PR | 1 | 1 | 0 | 0 | 0 | 7 | 1 | 1 | 0 | 8 | 8 |
| Amoxicillin 500 mg. | 9 | 6H | 10 ml | | 0 | 0 | 3 | 0 | 4 | 0 | 5 | 8 | 7 |
| Benylin cough syrup 2 Tbs. | 1 | PR | 30 cc | 10 | 0 | 0 | 0 | 7 | 1 | 2 | 1 | 9 | 5 |
| Darvocet-N 100 2 tabs | 1 | PR | 2 | 5 | 0 | 0 | 0 | 0 | 2 | 0 | 3 | 6 | 3 |
| Heparin lock flush 10 U | 4 | 1D | 1 ml | | 0 | 0 | 4 | 6 | 9 | 3 | 0 | 0 | 1 |
| Ditropan syrup 2.5 mg | 1 | 1D | 2.5ml | | 0 | 0 | 0 | 8 | 8 | 1 | 3 | 7 | 3 |
| Nitrotransdermal .4 mg. | 7 | 1D | 999 | | 4 | 7 | 2 | 0 | 2 | 2 | 8 | 3 | 2 |
| Novolin N 24 U | 5 | 1D | 24 U | | 0 | 0 | 0 | 0 | 3 | 1 | 8 | 3 | 4 |
| Novolin R 10 U | 5 | PR | 10 U | 2 | 0 | 0 | 0 | 0 | 3 | 1 | 8 | 3 | 3 |
| Questran 1 packet | 1 | 3D | 999 | | 0 | 0 | 0 | 8 | 7 | 0 | 5 | 8 | 0 |
| Quinine sulfate 325 mg. | 1 | 1D | 1 | | 0 | 0 | 0 | 0 | 2 | 0 | 6 | 2 | 9 |
| Coumadin 2.5 mg. | 1 | 1D | 1 | | 0 | 0 | 0 | 5 | 6 | 0 | 1 | 7 | 6 |
| Coumadin 5 mg. | 1 | 1D | 1 | | 0 | 0 | 0 | 5 | 6 | 0 | 1 | 7 | 2 |

# SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing facility resident's care plan.

Following completion of the MDS and review of the triggered RAPs, a decision is made by the interdisciplinary team to proceed to care planning for each of the triggered RAPs. The RAPs were created by clinical experts in each of the RAP areas. Chapter 4 provides detailed instructions on the RAP and care planning process.

The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

## A. RAP Problem Area

***Purpose:*** The RAP Summary documents the decisions from the interdisciplinary team on which of the "triggered" conditions will be addressed in the care plan.

***Process:*** Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column (VAa) on the RAP Summary form. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.

Describe:

- Nature of the condition (may include presence or lack of objective data and subjective complaints).

- Complications and risk factors that affect your decision to proceed to care planning.
- Factors that must be considered in developing individualized care plan interventions.
- Need for referrals/further evaluation by appropriate health professionals.
- Documentation should support your decision-making regarding whether or not to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
- Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
- Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.

***Coding:*** For each triggered RAP, indicate whether or not a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment (VAb). The Care Planning Decision column must be completed within 7 days of completing the RAI as indicated by the date in VB2 (RAPs Completion Date).

## B. Signature and Completion Dates

**VB1:** Signature of the RN coordinating the RAP assessment process.

**VB2:** Date that the RN coordinating the RAP assessment process certifies that the RAPs have been completed. The RAP review must be completed no later than day 14 from the admission date for an Admission assessment and within 14 days of the Assessment Reference Date (A3a) for an Annual assessment, Significant Change in Status assessment, or a Significant Correction of a Prior Full assessment. This date is considered the date of completion for the RAI (i.e., the date used to determine compliance with Federal time frames for assessment and the date that drives future due dates for when the RAI needs to be completed).

**VB3:** Signature of the staff person facilitating the care planning decision-making. It does not have to be an RN.

**VB4:** The date on which a staff member completes the care planning decision column (VAb), which is done after the care plan is completed. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and RAPs) as indicated by the date in VB2.

Following completion of the care plan, the MDS, triggers (VAa), and care planning decisions (VAb) must be transmitted to the MDS State database within 31 days of the VB4 date.

***Clarifications:*** ◆ The signatures at VB1 and VB3 can be the same person, provided that person actually completed both functions. It is not a requirement that the same person complete both.

- If a resident is discharged prior to the completion of Section V, a comprehensive assessment may be in progress when a resident is discharged. Even though the resident has been discharged, the facility may complete and submit the assessment. The following guidelines apply to completing a comprehensive assessment when the resident has been discharged:

  (1) Complete all required MDS items from Section AA through Section U (as they apply in your state) and indicate the date of completion in R2b. Encode and verify these items.

  (2) Complete the RAPs (Section V, Column A) and code whether each was triggered or not (VAa).

  (3) Enter the date the RAP triggers were computed at VB2.

  (4) Dash fill all of the care planning decision items in Section VAb (indicating that the decisions are unknown).

  (5) Enter the same date in VB4 as was used in VB2.

  (6) Submit the record.

# SECTION W.
# SUPPLEMENTAL ITEMS

## W1. National Provider Identifier (NPI)

**Intent:** To record the NPI of the facility.

**Definition:** The NPI is a unique identifier for health care providers of health care services, supplies, and equipment. The HIPAA legislation required the Secretary of the Department of Health and Human Services (HHS) to establish a standard unique identifier for health care providers. The National Plan and Provider Enumeration System (NPPES), developed by CMS, has begun assigning NPIs to health care providers.

**Process:** After the NPPES assigns an NPI to a provider, like a nursing facility, the NPI applies to the facility for all of its residents.

**Coding:** When the NPI is available, enter the 10-digit NPI in the spaces provided. The NPI has no embedded dashes or spaces. Recheck the number to ensure you have entered the 10 digits correctly. The facility is encouraged to begin using this number once it has obtained it.

## W2. Influenza Immunization

**Intent:** To determine the rate of vaccination and causes for non-vaccination.

Section W2 must be completed for all residents on all assessment types (OBRA and/or PPS) with Assessment Reference Dates and all discharge tracking forms with Discharge Dates from October 1 through June 30. Discharge tracking forms are included in order to capture flu vaccines administered to residents whose flu vaccines were not captured on an MDS assessment.

Although flu season currently is defined as October 1 through March 31, assessments with an ARD and discharges with a discharge date through June 30 are included in order to capture any record that provides the only report of a vaccination received during the flu season.

> **Example:** A flu vaccine is administered to a resident in March, not within the window of an MDS assessment. Extending the date for completing W2 to June 30 provides the facility the ability to capture that flu vaccine on the next Quarterly, even if it is not due for another 92 days or on a discharge before the Quarterly is due.

**Process:** **Review the resident's medical record and interview the resident or**

**responsible party/legal guardian to determine Influenza vaccination status during this flu season, defined as October 1 through March 31. Use the following steps:**

- **Step 1.** Review the resident's medical record to determine whether an Influenza vaccination was received during the flu season. If vaccination status is unknown, proceed to the next step.

- **Step 2.** Ask the resident if he/she received a dose of Influenza vaccine outside of the facility for this year's flu season. If vaccination status is still unknown, proceed to the next step.

- **Step 3.** If the resident is unable to answer, then ask the same question of the responsible party/legal guardian. If vaccination status is still unknown, proceed to the next step.

- **Step 4.** If vaccine status cannot be determined, administer the vaccination to the resident according to standards of clinical practice.

The CDC has evaluated inactivated Influenza vaccine co-administration with the pneumococcal polysaccharide vaccine systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm[2,3]. If the resident is an amputee or if intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to standards of clinical practice.

**Coding:** **W2a**

Enter **"0" for a 'No' response and proceed to item W2b**

- If the resident did not receive the Influenza vaccine in this facility from October 1 – March 31.

  **Example:** Mrs. J. received the Influenza vaccine in January 2005. The ARD of this assessment is October 2005. The facility has not yet administered the Influenza vaccine for the current flu season. W2a would be coded "0", No.

Enter **"1" for a 'Yes' response and proceed to item W3**

- If the ARD of this assessment or the discharge date of this discharge tracking form is from January 1 through June 30, include Influenza vaccine administered in the facility from October 1 of last year through March 31 of the current year.

  **Example:** Mrs. T. received the Influenza vaccine in

November 2004. The ARD of this assessment is February 2005. Include the November 2004 vaccination on this assessment and code W2a "1", Yes.

- If the ARD of this assessment or the discharge date of this discharge tracking form is on or after October 1, include the Influenza vaccine administered in the facility on or after October 1 of the current flu season.

  **Example:** Mr. C received the Influenza vaccine in October 2005. The ARD of this assessment is December 2005. Include the October 2005 vaccination on this assessment and code W2a "1", Yes.

**Skip item W2 and go to item W3**

- If the ARD of this assessment or the discharge date of this discharge tracking form is from July 1 through September 30.

  **Example:** Mr. P. received the Influenza vaccine in February 2005. The ARD of this assessment is in August 2005. Skip this item and go to item W3.

**W2b**
**If the resident has not received the Influenza vaccine in the facility, code the reason from the following list:**

**1. Not in facility during this year's flu season** - Resident not in the facility from October 1 – March 31.

**2. Received outside of this facility** - Includes Influenza vaccinations administered from October 1 through March 31 in any other setting (e.g. physician office, health fair, grocery store, hospital, fire station).

**3. Not eligible** – Due to contraindications including:

- allergic reaction to eggs or other vaccine component(s)
- a physician order not to immunize
- or an acute febrile illness is present; however, the resident should be vaccinated if contraindications end

**4. Offered and declined** – Resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

**5. Not offered –** Resident or responsible party/legal guardian not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

**6. Inability to obtain vaccine –** Vaccine unavailable at the facility due to declared vaccine shortage; however, the resident should be vaccinated once the vaccine is received. The annual supply of inactivated Influenza vaccine and the timing of its distribution cannot be guaranteed in any year.

**If none of the above reasons apply, enter a dash (-)**.

## W3. Pneumococcal Immunization

**Intent:** To determine the rate of vaccination and causes for non-vaccination.

Section W3 must be completed for all residents on all assessment types (OBRA and/or PPS) and all discharge tracking forms.

- The CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm[2,3]. If the resident is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

- Persons less than 65 years of age who are living in environments or social settings (e.g. nursing homes and other long-term care facilities) in which the risk for invasive pneumococcal disease or its complications is increased should receive the PPV[2].

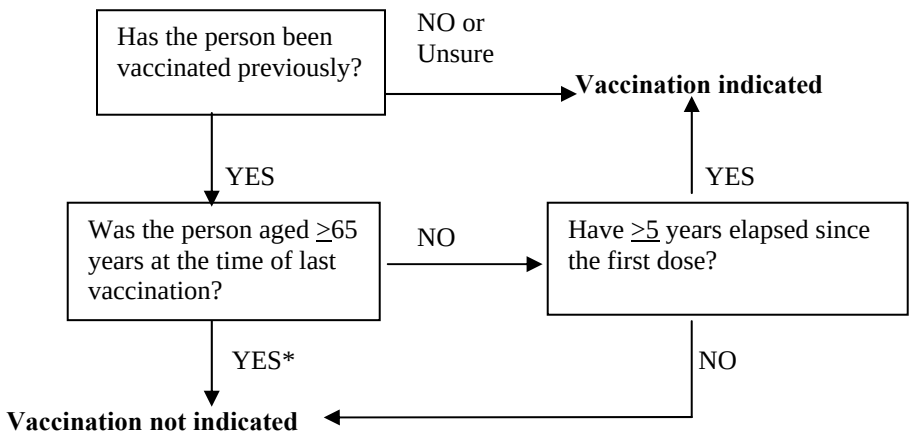
- All adults 65 years of age or older should get the PPV. PPV is given once in a lifetime, with certain exceptions[1].

- Persons 65 years or older should be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time[1,2].

**Note: Please refer to the following algorithm for PPV administration ONLY**

**Figure 1** Adopted from the CDC Recommendations and Reports. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.

FIGURE 1. Algorithm for vaccinating immunocompetent persons aged ≥65 years




***For any immunocompetent person who has received a dose of pneumococcal polysaccharide vaccine at age ≥65 years, revaccination is not indicated.**

1 CDC. Pneumococcal Polysaccharide Vaccine. What you need to know. Pneumococcal Vaccine Information Statement July 1997.
2 CDC. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.
3 Recommendations and Reports. Prevention and control of influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR May 28, 2004/ 53(RR06);1-40.

- The CDC recommends a second (booster) dose for immunocompromised persons due to[1]
  - A damaged spleen or no spleen
  - Sickle-cell disease
  - HIV infections or AIDS
  - Cancer, leukemia, lymphoma, multiple myeloma
  - Kidney failure
  - Nephrotic syndrome
  - History of an organ or bone transplant
  - Medication regimens that lowers immunity (such as chemotherapy or long-term steroids)

  When any of the above conditions are present, persons older than 10 years old (including those 65 years of age and older) should get the second (booster) dose 5 years after the first dose. Children 10 years old and younger may get this second (booster) dose 3 years after the first dose.

**Process:** **Review the resident's medical record and interview resident or responsible party/legal guardian to determine PPV status, using the following steps.**

- **Step 1.** Review the resident's medical record to determine whether PPV has been received. If vaccination status is unknown, proceed to the next step.

- **Step 2.** Ask the resident if he/she received a PPV. If vaccination status is still unknown, proceed to the next step.

- **Step 3.** If the resident is unable to answer, ask the same question of a responsible party/legal guardian. If vaccination status is still unknown, proceed to the next step. See pages 3-36 & 37 for types of responsibility/legal guardian.

- **Step 4.** If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice.

**Coding:** **W3a**

**Enter "0" for a 'No' response and proceed to item W3b**

- If the resident's PPV status is not up to date

**Enter "1" for a 'Yes' response and skip item W3b**

- If the resident's PPV status is up to date

**W3b**
**If the resident has not received a PPV, code the reason from the following list:**

1. **Not eligible** – Due to contraindications including:
   - allergic reaction to vaccine component(s)
   - a physician order not to immunize
   - an acute febrile illness is present; however, the resident should be vaccinated after contraindications end

2. **Offered and declined** – Resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

3. **Not offered -** Resident or responsible party/legal guardian were not offered the vaccine. See pages 3-36 & 37 for types of responsibility/legal guardian.

**If none of the above reasons apply, enter a dash (-)**.

# CHAPTER 4: PROCEDURES FOR COMPLETING THE RESIDENT ASSESSMENT PROTOCOLS (RAPs) AND LINKING THE ASSESSMENT TO THE CARE PLAN

**Assessment (MDS/other) → Decision-Making (RAPs/other) → Care Plan Development → Care Plan Implementation → Evaluation**

**This chapter provides instructions on how to use the Resident Assessment Protocols (RAPs) to assess conditions identified by the Minimum Data Set (MDS) triggering mechanism. The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental and psychosocial needs of residents.**

## 4.1 What are the Resident Assessment Protocols (RAPs)?

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing facility resident's care plan. The RAPs were created by clinical experts in each of the RAP areas.

RAPs are not required for Medicare assessments. RAPs are ONLY required for comprehensive clinical assessments (Admission assessment, Annual assessment, Significant Change in Status Assessment (SCSA), or Significant Correction of Prior Full assessment (SCPA). However, when a Medicare assessment is combined with a comprehensive clinical assessment, the RAPs must be completed in order to meet the requirements of the comprehensive clinical assessment. RAPs may also be used any time the facility wishes to provide indepth focused review of any area for which RAPs have been developed.

The care delivery system in a facility is complex yet critical to successful resident care outcomes. It is guided by both professional standards of practice and regulatory requirements. The basis of care

delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.

The RAI (MDS and RAPs) is an integral part of this process. It ensures that facility staff collects minimum, standardized assessment data for each resident at regular intervals. The main intent is to drive the development of an individualized plan of care based on the identified needs, strengths and preferences of the resident.

It is helpful to think of the RAI as a process. The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. A risk factor increases the chance of having a negative outcome, or complication. For example, compromised bed mobility increases the risk of a pressure ulcer. In this example, compromised bed mobility is the specific risk factor, and the pressure ulcer is the complication. RAP guidelines may contain cues regarding risk factors and complications associated with the RAP condition. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

RAPs function as decision facilitators, which means they lead to a more thorough understanding of possible problem situations by providing educational insight and structure to the assessment process. The RAPs will give the interdisciplinary team a sound basis for the development of the resident's care plan. After the comprehensive assessment process is completed, the interdisciplinary team will be able to decide if:

- The resident has a troubling condition that warrants intervention, and if addressing this problem is a necessary condition for other functional problems to be successfully addressed;
- Improvement of the resident's functioning in one or more areas is possible;
- Improvement is not likely, but the present level of functioning should be preserved as long as possible, with rates of decline minimized over time;
- The resident is at risk of decline and efforts should emphasize slowing or minimizing decline, and avoiding functional complications (e.g., contractures, pain); or
- The central issues of care revolve around symptom relief and other palliative measures during the last months of life.

OBRA 1987 mandated that facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

## 4.2 How are the RAPs Organized?

As shown in Appendix C, there are four parts to each RAP:

**Section I - The Problem** gives general information about how a condition affects the nursing facility population. The Problem statement often describes the focus or objectives of the protocol. It is important when reviewing a "triggered" RAP not to overlook information in the Problem section. Although **Section III - The Guidelines** contain the "detail," the Problem section should be reviewed for information relevant to the assessment.

**Section II - The Triggers** identify one or a combination of MDS item responses specific to a resident that alert the assessor to the resident's possible problems, needs, or strengths. The specific MDS response indicates that clinical factors are present that may or may not represent a condition that should be addressed in the care plan. Triggers merely "flag" conditions necessary for the interdisciplinary team members to consider in making care planning decisions.

When the resident's status on a particular MDS item(s) matches one of the "triggers" for a RAP, the RAP is "triggered" and a review (with the possibility of additional data gathering and assessment) is required using the RAP Guidelines.

**Section III - The Guidelines** present comprehensive information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. The Guidelines help facility staff decide if a triggered condition actually does limit the resident's functional status or if the resident is at particular risk of developing the condition.

If the condition is found to be a problem for the resident, the Guidelines will assist the interdisciplinary team in determining if the problem can be eliminated or reversed, or if special care must be taken to maintain a resident at his or her current level of functioning.

In addition to identifying causes or risk factors that contribute to the resident's problem, the Guidelines may assist the interdisciplinary team to:

- Find associated causes and effects. Sometimes a problem condition (e.g., falls) is associated with just one specific cause (e.g., new drug that caused dizziness). More often, a problem (e.g., falls) stems from a combination of multiple factors (e.g., new drug, resident forgot walker, bed too high, etc.).

- Determine if multiple triggered conditions are related.

- Suggest a need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests, consulting psychiatrist, etc.

- Determine if a resident is a good candidate for rehabilitative interventions.

- Identify the need for a referral to an expert in an area of resident need.
- Begin to formulate care plan goals and approaches.

**Section IV - The RAP Key** has two parts. The first part is a review of the items on the MDS that triggered a review of the RAP. The second part is a summary, but sometimes also provides a clarification of the information in the Guidelines section of the RAP. The RAP Key should be used as a reference, but does not take the place of the main body of the RAP.

**There are 18 RAPs in the Resident Assessment Instrument, Version 2.0:**

Delirium
Cognitive Loss/Dementia
Visual Function
Communication
ADL Function /Rehabilitation
Urinary Incontinence and Indwelling Catheter
Psychosocial Well-Being
Mood State
Behavior Symptoms
Activities
Falls
Nutritional Status
Feeding Tubes
Dehydration/Fluid Maintenance
Dental Care
Pressure Ulcers
Psychotropic Drug Use
Physical Restraints

## 4.3 What does the RAP Process Involve?

There are various models for completing the RAP in-depth assessment process for a resident with a particular problem. Assessment of the resident in "triggered" RAP areas may be performed solely by the RN Coordinator (i.e., as the RAI must be completed or coordinated by an RN per the OBRA statute). Generally, the RAPs will be completed by various members of clinical disciplines as appropriate to the needs of individual residents. Facilities may also establish procedures in which certain RAPs are always reviewed by a particular discipline (e.g., the dietitian completes the Nutritional Status and Feeding Tube RAPs, if triggered). The interdisciplinary team may also review RAP Guidelines in a joint manner and have the assessment process flow seamlessly into care planning. There are no mandates regarding the "process" of how facility staff uses the RAPs.

Rather, facility staff should be creative and experiment until they find "what works" most efficiently and effectively for them in achieving the desired outcome (i.e., a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident).

**The RAP process includes the following steps:**

1. Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary form.

2. Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information, including items not automatically triggered, as needed, to determine the nature of the problem and understand the causes specific to the resident.

3. Staff documents key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:

   - Nature of the condition (may include presence or lack of objective data and subjective complaints).

   - Complications and risk factors that affect the staff's decision to proceed to care planning.

   - Factors that must be considered in developing individualized care plan interventions. Include appropriate documentation to justify the decision to care plan or not to care plan for the individual resident.

   - Need for referrals or further evaluation by appropriate health professionals.

   Documentation about the resident's condition should support clinical decision-making regarding whether or not to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

   The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

4. Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention.

5. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

## 4.4 Identifying Need for Further Resident Assessment by Triggering RAP Conditions (RAP Process - Step 1)

A RAP may have several MDS items or sets of items that are defined as triggers. Only one of the trigger definitions must be present for a RAP to be triggered, although for many RAPs, each of the specific trigger items that are present must be investigated (e.g., address each of the potential side effects for the Psychotropic Drug Use RAP).

The **trigger definitions** can be found in:

- Section II of each RAP;
- The RAP Key found at the end of each RAP; and
- The RAP Trigger Legend.

The **Trigger Legend** is a **2-page form** that summarizes all of the MDS items that trigger the 18 RAPs. **It is not a required form that must be maintained in the resident's clinical record.** Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.

Most facilities use automated systems instead of the trigger legend form to trigger RAPs. The resulting set of triggered RAPs that is generated by your software program should be matched against the trigger definitions to make sure that triggered RAPs have been correctly identified.[1] CMS has also developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but it is the facility's responsibility to ensure that the software is triggering correctly. At a minimum, ask whether or not the triggered RAPs are what you would have expected. Did the software miss some RAPs you thought should have been triggered? Do some of the RAPs seem to be missing and are there other RAPs triggered that you did not expect?

**To identify the triggered RAPs manually using the Trigger Legend:**

1. Compare the completed MDS with the Trigger Legend to determine which RAPs are "triggered" for review. Begin by looking at the **KEY** in the upper left corner of the trigger legend form. Note that there are four possible ways for a RAP to trigger:

   The **first**, indicated by a **solid black circle**, is the predominant method and requires only one MDS item to trigger a RAP.

   The **second**, indicated by a "**2" within a solid circle**, requires two MDS items to trigger a RAP.

   The **third**, indicated by an asterisk (*), requires one of three types of **psychotropic medications** (antipsychotic, antianxiety or antidepressant), and one other item in the Psychotropic Drug Use column indicated by a **solid black circle**.

[1] This process should be performed on a sample of assessment records any time changes have been made in the MDS software.

The **fourth** is indicated by a **small case "a" within a circle**. This is a special ADL trigger that will focus the RAP review on rehabilitation or on the maintenance of current function.

Find the ADL-Rehabilitation Trigger A and the ADL-Maintenance Trigger B columns by scanning the top of the trigger legend form. Notice each ADL column title is marked with a circled "a".

If there are solid circles in both ADL columns, the ADL Maintenance column will take precedence.

2. Look at the two left columns of the Trigger Legend. These columns list the letter and number codes as well as the name of the MDS items to be considered. The third column lists the specific resident codes that will trigger a RAP. The remaining columns list the individual RAP titles.

   To identify a triggered RAP, match the resident's MDS item responses with the "Code" column. If there is a "match," follow horizontally to the right until a trigger is indicated by one of the key symbols. If, for example, there is a solid circle in the column, the RAP titled at the top of that column is "triggered." This means that further assessment using the RAP Guideline is required for that particular condition.

3. Note which RAPs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.

4. Continue down the left column of the Trigger Legend matching recorded MDS item responses with trigger definitions until all triggered RAPs have been identified.

5. When the Trigger Legend review is completed, document on the RAP Summary form which RAPs triggered by checking the boxes in the column titled "Check if Triggered."

**EXAMPLES**

When Mrs. D returns to her room after eating breakfast, she cannot recall eating breakfast, and always asks the nurse when breakfast will be served. MDS item Short-Term Memory, B2a, has been coded 1 (Memory Problem), and the Cognitive Loss/Dementia RAP is triggered for further assessment.

Mr. F is independent in cognitive skills for daily decision-making. His transferring ability varies throughout each day. He receives no assistance at some times and heavy weight-bearing assistance of one person at other times. The MDS item Decision-making, B4, is coded 0 (Independent). The MDS item Transferring, G1bA, is coded 3 (Extensive Assistance). The ADL-Rehabilitation RAP is triggered for further assessment, focusing on a possible rehabilitative intervention. Rationale for trigger: Mr. F. has good cognitive skills for learning new ways to function and realize his potential.

**EXAMPLES**
**(continued)**

Mr. P is receiving an antipsychotic medication two times per day. He has fallen within the last 30 days. The MDS item Antipsychotics, O4a, is coded 7 (Received 7 days a week). The MDS item Falls (in past 30 days), J4a, is checked. The Psychotropic Drug Use RAP is triggered for further assessment. (Note: Because J4a is checked, the Falls RAP will also be triggered.)

Mrs. T is highly involved in activities of the facility. When structured activities are not scheduled, she keeps busy reading, crocheting and writing a journal. Mrs. T awakens early in the morning and rarely takes a nap. MDS item Awake Mornings, N1a, is checked. MDS item Involved in Activities, N2, is coded 0 (most of time). Both of these MDS items are required to trigger the Activities RAP; these factors in combination suggest that the focus of the assessment should be on reviewing the current activities plan.

Mrs. C is limited in bed mobility (MDS Item G1aA), with a physical restraint used during part of the day. The presence of any of these items is sufficient to trigger the Pressure Ulcer RAP, focusing on issues of problem avoidance in the future. (Note: other RAPs triggered include ADLs and Physical Restraints.)

Different types of triggers can change the focus of the RAP review. There are four types of triggers:

1. **Potential Problems -** Those factors that suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention. These are usually "narrowly" defined as factors that warrant additional assessment. They include clinical factors commonly seen as indicative of possible underlying problems and consequently have generally been well understood by facility staff members. Examples include the presence of a pressure ulcer or use of a trunk restraint, both of which indicate the need for further review to determine what type of intervention is appropriate or whether underlying behavioral symptoms can be minimized or eliminated by treatment of the underlying cause (e.g., agitated depression).

2. **Broad Screening Triggers** - These are factors that assist staff to identify hard to diagnose problems. Because some problems are often difficult to assess in the elderly nursing facility population, certain triggers have been "broadly" defined and consequently may have a fair number of "false positives" (i.e., the resident may trigger a RAP which is not automatically representative of a problem for the resident). Examples include factors related to delirium or dehydration. At the same time, experience has shown that many residents who have these problems were not identified prior to having triggered for review. Thus careful consideration of these triggered conditions is warranted.

3. **Prevention of Problems** - Those factors that assist staff to identify residents at risk of developing particular problems. Examples include risk factors for falling or developing a pressure ulcer and contractures.

4. **Rehabilitation Potential** - Those factors that are aimed at identifying candidates with rehabilitation potential. Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths. In general, these factors suggest consideration of programs to improve a resident's functioning or minimize decline. For example, MDS item responses indicating "Resident believes he or she is capable of increased independence in at least some ADLs" (G8a) may focus the assessment and care plan on functional areas most important to the resident or on the area with the highest potential for improvement.

Facility staff who are assessing a resident whose condition "triggers" a RAP should know what item responses on the MDS triggered that RAP. This step is often missed, especially if someone other than the person(s) who completed the MDS reviews the trigger legend or the triggering is automated. Referring to the triggers section of the RAP to identify relevant triggers can help to "steer" the assessment to factors particular to the individual resident. For example, if a staff member assigned to assess a resident who has fallen or is at risk for falls knows that the Falls RAP was triggered because the resident had been dizzy during the MDS assessment period (MDS Item J1f - Dizziness was checked), the RAP review would include a focus on causal factors and interventions for dizziness. While reviewing the RAP, other factors may come to light regarding the resident's risk for falls, but knowing the trigger condition clarifies or possibly rules out certain avenues of approach to the resident's problem.

At the same time, there can also be a tendency to believe that the RAP review is limited to only those MDS items that triggered the RAP. Such a view is false and can lead to key causal factors being unnoticed and a less than appropriate plan of care being initiated. Many of the trigger conditions serve to initiate a more comprehensive review process including specific causal factors (as referenced in the Guidelines) that are to be considered relative to the resident's status.

## 4.5 Assessment of the Resident Whose Condition Triggered RAPs (RAP Process - Step 2)

"Reviewing" a triggered RAP means doing an in-depth assessment of a resident who has a particular clinical condition in terms of the potential need for care plan interventions. The RAP is used to organize or guide the assessment process so that information needed to fully understand the resident's condition is not overlooked.

The triggered RAPs are used to glean information that pertains to the resident's condition. While reviewing the RAP, facility staff considers what MDS items caused the RAP to trigger and what type of trigger it is (i.e., potential problem, broad screen, prevention of problem or rehabilitation potential). This focuses the review on information that will be helpful in deciding if a care plan intervention is necessary, and what type of intervention is appropriate.

The information in the RAP is used to supplement clinical judgment and stimulate creative thinking when attempting to understand or resolve difficult or confusing symptoms and their causes. The Guidelines are an aide, a tool, a starting point. It is the understanding and insight of members of the interdisciplinary team that will help integrate these factors into a meaningful resident assessment and care plan.

## 4.6 Decision-Making and Documentation of the RAP Findings (RAP Process - Steps 3 and 4)

It is recommended that staff who have participated in the assessment and who have documented information about the resident's status for triggered RAPs be a part of the interdisciplinary team that develops the resident's care plan. The team, including the resident, family or resident representative, makes the final decision to proceed to address the "triggered" condition on the care plan.

In order to provide continuity of care for the resident and good communication to all persons involved in the resident's care, it is important that information from the assessment that led the team to their care planning decision be clearly documented.

It is not necessary to record all of the items referred to in the RAP Guidelines, listing all factors that do and do not apply. Rather, documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident's daily functioning?
- Why did you decide the resident is at risk, or that improvement is possible, or that decline can be minimized?
- How could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

Or, for triggered conditions that do not warrant care planning:

- Why did you determine that the triggered condition is not a problem for the resident?

**Written documentation of the RAP findings and decision-making process may appear anywhere in the resident's record. It can be written in discipline specific flowsheets, progress notes, in the care plan summary notes, in a RAP summary narrative, on a RAP questionnaire, etc. Facilities should use a format that provides the information as outlined in SOM #272. If it is not clear that a facility's documentation provides this information, surveyors should ask facility staff to provide such evidence. As stated in 482.20(b)(1)(xvii), "Documentation of participation in assessment: The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed staff members on all shifts."**

**No matter where the information is recorded, use the "Location and Date of RAP Assessment Documentation" column on the RAP Summary form to note where the RAP review and decision-making documentation can be found in the resident's record. Also indicate in the column "Care Plan Decision" if the triggered problem is addressed in the care plan.**

***Clarification:***

- The RAP documentation requires information from the resident's assessment and staff's decision-making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired caregiver for this resident, will I be able to find and understand the assessment and decision-making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note.

  While interpretations of CMS's requirements have varied, the RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed--RAPs guide further assessment of residents who have or are at risk of developing problems (triggered areas). This assessment is supposed to lend further insight into the problems identified by the MDS. RAP "documentation" involves only what should already be taking place, such as clearly written assessments, decision-making by staff knowledgeable about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.

  What does clear documentation and decision-making mean? Decision-making is a written account of the team's clinical thought processes about the resident assessment findings. To accomplish this process, many people have searched for "user friendly" alternatives to RAP documentation. As a result, an industry of workbooks, flow sheets, checklists and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and made the process more complicated than necessary. Each facility should establish a documentation process that "works" for them and incorporate additional tools only if they are deemed of clear benefit in facilitating documentation and clinical decision-making.

**Examples of Resident Assessment Documentation Using RAP Guidelines as a Framework:**

The following examples illustrate different ways to document resident status information that the assessor(s) gleaned using RAP Guidelines. This documentation would be referenced by facility staff on the RAP Summary form under the "Location of Information" column, or it could be referenced in a RAP Summary note. Please note that these examples are not related to any particular resident or case example. Also, they are not related to one another. They merely depict samples of written notes.

**EXAMPLE #1:** This is an example of a note that substantiates the initiation of problem evaluation using RAP Guidelines.

**PROBLEM: BEHAVIORAL SYMPTOMS**

In the past week Ms. E has resisted physical care, puts up a good struggle with the nurse assistants, hits them and swears at them whenever they try to help her. Prior to admission four weeks ago Ms. E had a stroke that has affected her right side. She also has aphasia. During the first few weeks Ms. E was lethargic and passive. She accepted total care from staff. She was difficult to evaluate in many areas because of her communication difficulties. She has been receiving physical therapy for range of motion exercises without difficulty. These behavioral symptoms with nursing staff are new. When I observed her interactions with staff today it appears that if she is approached from the right she lashes out; from the left she is fine. On a positive note, we are seeing that Ms. E is beginning to have some response to her environment and situation and requires further evaluation regarding a new approach to nursing care, ophthalmology evaluation to rule out visual field deficits, speech therapy referral. We will discuss Ms. E's care at nursing rounds tomorrow and develop a revised plan to address these issues.

**EXAMPLE #2:** This is an example of 1) documentation in the progress notes of the clinical record clarifying that a problem is present and has been discussed with the resident, and 2) another note that describes the beginning of a work-up to evaluate and treat causes of the problem.

**PROBLEM: URINARY INCONTINENCE**
**Nursing note:**

Mrs. D's clothing has been found wet during the night on 3 occasions in the past two weeks. Her nurse assistants have also found that she has been tucking washcloths in her underwear. I spoke with her this morning. She admitted that she has been having some urinary accidents for some time but was hiding them. She cried, saying, "I am so ashamed." I reassured her that although incontinence is not normal, it is common, and should be evaluated for possible treatments. I proceeded to review the type of step-by-step evaluation that could be done, some which could be done here at the facility and, if necessary, she would see some specialists. Mrs. D seemed relieved and asked me to call her daughter with the information. I spoke with Ms. D who agreed with the evaluation. She said that she has been noticing a faint odor of urine when she visits, but her mother always denied any problems. Will contact physician.

G. Hope, RN
8/21/01

**EXAMPLE #3:** This is an example of a note in a clinical record that could be referenced on the RAP Summary form to substantiate a team's decision to proceed to care planning when a RAP is triggered.

**PROBLEM: DELIRIUM**
**Physician Progress note:**

Mr. F has had new symptoms in the past week of altered perceptions (thinks someone keeps jumping through his window at night when the curtain moves), restlessness (pacing) and agitation, and is more confused. A review of his medication sheet shows that his Digoxin dose

was increased from 0.125 mg every other day to 0.25 mg. daily two weeks ago during an episode of congestive heart failure. His appetite has also decreased and he says food is making him sick. He is delusional in his thinking that his food is poisoned. Mr. F's exam is unremarkable for signs of an acute illness or other causes of delirium. His symptoms are consistent with probable Digoxin toxicity. We will obtain a Digoxin level in the morning. In the meantime, I have asked the nursing staff to hold the Digoxin and encourage fluids until we reevaluate in the morning. I will temporarily put him on a low dose of Haldol 0.5 mg twice daily in order to reduce his delusions and distress. I will review his status daily with the goal of tapering him off the Haldol once his mental status returns to baseline.

Ben Todd, M.D.
8/30/01

**PROBLEM: DELIRIUM**
**Nursing note:**

Until the acute confusion subsides, Mr. F will receive close observation, monitoring of his intake with encouragement of fluids, cueing during ADLs to help him focus. He will be allowed to pace in the confines of the unit and restricted to the unit until his confusion resolves.

J. Doe, RN
8/30/01

**EXAMPLE #4:** This case illustrates summary documentation using RAP Guidelines to assess the resident's progress related to a previously noted condition, as well as the success of the care plan over time.

**PROBLEM: PRESSURE ULCER OVER RIGHT TROCHANTER**

Three months ago, Mr. H developed a Stage III pressure ulcer over his right trochanter when he fell asleep on the spirals of a notebook while reading in bed (pressure). Mr. H had been receiving Ambien 10 mg at bedtime for sleep because he had difficulty falling asleep with a roommate who snores loudly. He was friendly with the roommate and did not want to switch rooms when the opportunity was offered. Deep sleep most likely contributed to his not responding to the spiral by shifting his weight. Mr. H has since agreed to move in with a quieter roommate and discontinue the Ambien. We have been treating the ulcer with surgical debridement as necessary and wet to dry saline dressings three times daily, and the ulcer has cleared up nicely to a dime-size area with clean granulation tissue present. Dr. K discontinued wet to dry dressings and it is being managed with a transparent dressing. Mr. H is back to his usual activities and is adherent to his repositioning program when in bed. We will continue the current care plan.

**EXAMPLE #5**: This case illustrates documentation, using RAP Guidelines, to assess the progress of a long-stay resident who has chronic Urinary Incontinence AND Pressure Ulcer risk.

**PROBLEM: LONG-STANDING URINARY INCONTINENCE AND PRESSURE ULCER RISK**

Mr. F is a severely demented gentleman who suffers from immobility secondary to dementia and disuse. He has tight contractures of his elbows, hips, knees, and ankles making toileting difficult. Mr. F is frail, primarily bed- and recliner chair-bound. He is totally dependent on staff for care in ADLs, including eating. He has long-standing incontinence that has been managed for the past year with an external catheter to protect his skin (He has a history of rashes). When transferred, he is always placed on pressure relieving devices. He receives a turning and positioning regimen. This regimen has been working and he is free of rashes and skin breakdown. His family and we are in agreement about continuing the current palliative approach to urinary incontinence and preventive approach to ulcer formation.

**EXAMPLE #6:** This example illustrates that it is not necessary to use the titles of the RAPs to document resident assessment information using RAP Guidelines. The most important goal of documentation is to describe events in a way that everyone can understand what is happening to the resident.

**PROBLEM: SIDE EFFECTS FROM ZYPREXA**

Mrs. L has been disimpacted of hard, pasty stool twice during the last 6 days. Bowel elimination records show that she has been having infrequent movements. Staff says that she strains at stool. Mrs. L has a long history of schizophrenia. Her psychosis has been managed with various antipsychotics over the years. Most recently (last 6 weeks) we switched her from Haldol to Zyprexa 10 mg. QD for its sedative effects, as she was agitated, wandering, and delusional. The Zyprexa has calmed her down to the point that she is able to sit in on some unit activities without leaving them. The dose was then reduced, but when symptoms recurred, we went back to 10 mg. QD. Her blood pressure has been stable at 138/86 - 146/90 and she has had no falls. The constipation is most likely related to the Zyprexa. However, as her emotional state is currently stable and she is functioning better, we will maintain the current dose, add Colace 100 mg. bid, assure adequate fluid intake, and consult with dietary for suggestions.

**EXAMPLE #7:** This is an example of a note that illustrates the assessment of multiple problems that were triggered by the MDS. The rationale for combining the assessment into one note is that the resident's risks, problems, causes, and treatments are all interrelated. On a RAP Summary form the following note could be referenced for several triggered RAPs: Falls, Psychotropic Drug Use, Cognitive Loss, Mood State.

**PROBLEM: FALLS**

Mrs. T's severely depressed mood has improved with Trazodone and involvement in a twice-weekly expressive therapy group. She has been more attentive to her surroundings and has begun to socialize like her old self. She remains disoriented to time and continues to need many reminders for most tasks (her baseline). She has rejoined her baking group that meets every other day. Her appetite has picked up and she eats most meals that are offered. We are

now concerned about two falling episodes this past week. She usually walks alone but is very slow. On Monday night, she seemed to falter in the dining room, but grabbed onto some chairs to steady herself. On Tuesday, she was walking in the corridor with her daughter, faltered, and then her daughter caught her before she fell. Mrs. T insisted that she felt O.K. She denied feeling dizzy or unsteady and said she just tripped over a chair. Yesterday, she fell to the floor in the dining room while getting up from a chair. She sustained no injuries, but she was posturally hypotensive (See vital sign sheet). She was seen by Dr. R who cut back on her Trazodone dose. We will monitor postural vital signs twice daily, and supervise all transfers and walking, and observe for changes in mood. She has been referred to PT for gait evaluation.

**EXAMPLE #8:** The following example illustrates how to document a situation when the resident functions at a consistent level over a long period of time. The MDS assessment always triggers the same RAP for the same reason, but the resident has shown neither improvement nor decline in function. Note that a nursing diagnosis is used in the problem title rather than the triggered RAP title of ADL-Functional Rehabilitation Potential.

**PROBLEM: IMPAIRED PHYSICAL MOBILITY**

Mrs. X has impaired mobility related to Parkinson's disease. She transfers and ambulates with a walker and receives non-weight bearing physical assistance of one person to get in and out of bed and for all walking. Occasionally she "freezes" and her medications have been adjusted with success. Mrs. X requires coaxing from staff to take twice-daily walks as she would prefer to stay in her room. However, she enjoys and has been doing well in tri-weekly strength training and stretching classes on the unit. We will continue current care plan of walking, titrating weights per protocol (see strength training progress form) and individual progress note.

***OR, THE NOTE COULD LOOK LIKE THE FOLLOWING:***

**PROBLEM: IMPAIRED TRANSFER AND AMBULATION**

**S**. "I hate exercising even if it's good for me. It's a good thing I like you."

**O**. See MDS re: function. Occasionally Mrs. X "freezes" and her Sinemet dose has been adjusted by Dr. B with good results. Mrs. X requires coaxing from staff to take twice-daily walks around the unit. She would prefer to stay in her room. However, she seems to enjoy and has made progress in tri-weekly strength training and stretching classes on the unit.

**A**. Level of mobility is being maintained by walking and strength training programs.

**P**. Continue current plan, titrating weights as per strength training protocol (see strength training progress form) and progress.

**EXAMPLE #9:** This note illustrates a case where the resident's MDS assessment has not changed, and although it keeps triggering the same RAP, staff discover new ways of approaching the problem by using the RAP Guidelines.

**PROBLEM: IMPAIRED AMBULATION**

Mr. H is 25 lbs. overweight and has severe osteoarthritis of both knees. His MDS walking assessments have not changed. He uses a walker and continues to receive weight-bearing assistance of two persons for all transfers. Once he is standing he walks with one-person, non-weight bearing physical assistance. He has been involved in a tri-weekly strength training and daily walking program. During the last 3 months Mr. H's endurance has improved. He can now walk 20 feet without stopping to rest. He has lost 13 lbs. on a weight reduction program and is motivated to lose more. Plan: refer to PT for aerobic activities; refer to orthopedic surgeon to see if Mr. H. is a candidate for knee replacement surgery.

## 4.7 Development or Revision of the Care Plan (RAP Process)

Following the decision to address a "triggered" condition on the care plan, key staff or the interdisciplinary team should:

- Review the current care plan if the condition is already addressed and make changes, as needed, to reflect the new assessment; and
- Develop new care plan problems, goals and approaches as needed.
- Staff may choose to combine related "triggered" conditions into a single care plan problem that will address the initial set of causal problems and related outcomes identified in the RAP review.

## 4.8 RAP Clarifications

***Clarifications:*** ◆ It is not necessary to always review and document RAP findings on subsequent assessments the way you would on the initial assessment. Triggers identify areas warranting further assessment. The RAP guides this assessment. For example, if a resident always triggers the Nutritional Status RAP because 25% of the food is uneaten at most meals, further assessment may reveal a swallowing problem, chewing problem, delirium, activity endurance problem, or a healthy lifetime pattern. If the resident chooses to eat frequent snacks, and still is consuming a nutritionally adequate diet, then there is no reason to complete the RAP in its entirety at each full assessment. Clearly document the initial nutritional assessment including: preferences, information that confirms his/her diet is sufficient, any supporting weights or any lab values that give insight into nutrition. If he/she continues to trigger

this RAP for the same reasons, make a one-line entry referring to the original nutritional assessment and indicate that the resident's status has not changed. **On subsequent assessments, it is always necessary to assess the resident to validate that his or her status has not changed as compared to the original RAP assessment and documentation.**

- Statutory requirements dictate that the RAI be completed within 14 days after admission. As an integral part of the RAI, RAPs must be completed within 14 days, which means that the initial RAP Guideline review must be conducted and documented by the end of that time. However, the RAPs may point out the need for a more extensive evaluation, which cannot be completed entirely within the time period. A good example is the Urinary Incontinence RAP. It is generally difficult to perform a complete work-up in 14 days. Even getting initial tests ordered and scheduled can take several weeks. Rather what is intended by "14 days after admission" is when the initial RAP assessment process and documentation must be completed. Certainly you do not wait several weeks to initiate the assessment and make care planning decisions. These initial plans should be outlined in the care plan along with the plan for further assessment.

- The RN Coordinator for the RAP assessment process (VB1) does not need to be the same RN completing the MDS assessment (R2). The date entered in VB2 on the RAP Summary form is the date the RN oversaw completion of the RAPs, indicated the triggered RAPs and completed the location and date of the RAP assessment documentation section. For Admission assessments, the RAP assessment must be completed no later than 14 days after admission. See Chapter 2 for detailed instructions on the MDS completion schedule.

- The Signature of Person Completing Care Planning Decision (VB3) can be any person(s) who facilitates the care planning decision-making. It is an interdisciplinary process. For Admission assessments, the care plan must be completed no later than 21 days after admission or 7 days after the MDS and RAPs are completed. The care planning information on the RAP Summary form would be completed at that time, with the date entered in VB4 being the day that VB3 is signed.

- On the annual assessment, if a resident triggers the same RAP(s) that triggered on the last comprehensive assessment, it is a good idea to review the RAP again. Also keep in mind that even if the RAP triggers for the same reason (no difference in MDS responses), there may be a new or changed related event identified during RAP review, that might call for a revision to the resident's plan of care. The interdisciplinary team determines when a problem or potential problem needs to be addressed in the care plan.

## 4.9 When is the Resident Assessment Instrument Not Enough?

Federal requirements support a facility's ongoing responsibility to assess a resident. The Quality of Care regulation[2] requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Services provided or arranged by the facility must also meet professional standards of quality. Compliance with these regulations requires that the facility monitor the resident's condition and respond with appropriate care planning interventions.

The MDS is a screening instrument and does not include detailed descriptions of all factors necessary for care planning and evaluation. When completing the MDS, the assessor simply indicates whether or not a factor is present. For certain clinical situations, if the MDS indicates the presence of a potential resident problem, need, or strength, the assessor may need to investigate and document the resident's condition in more detail. For example, if a resident is noted as having a contracture on the MDS, additional documentation in the record may include the number of contractures present, sites, and degree of restriction in each affected joint. RAPs also assist in gathering additional information for some clinical conditions.

In addition, completion of the MDS/RAPs does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether or not the appropriate areas are included in the RAI. For example, the MDS includes a listing of those diagnoses that affect the resident's functioning or needs in the past 7 days. While the MDS may indicate the presence of medical problems, such as unstable diabetes or orthostatic hypotension, there should be evidence of additional assessment of these factors if relevant to the development of the care plan for an individual resident. The need for a physical examination detailing findings in pertinent body sub-systems is another example.

Some facilities have reacted to the Federal requirements for resident assessment by creating lengthy and cumbersome assessment tools, which are completed for each resident in addition to the State RAI. This is not a Federal requirement and often not a desirable use of facility staff resources. Additional assessment is necessary only for factors that are relevant for an individual resident. For example, an extensive cognitive status assessment is not necessary if no deficits were noted using the MDS. Likewise, using multiple assessment tools that basically measure the same thing is often a poor use of clinical resources. All members of the interdisciplinary team should be trained in assessment and capable of determining what is necessary and appropriate for a particular resident. Elaborate assessment systems should not necessarily replace the judgment of the team members.

## 4.10 Case Example - MDS, RAP and Care Planning

This case example is structured from the point of view of the nurse responsible for coordinating the RAI and care planning processes. It is organized in a series of stages, corresponding to how the care team acquired and used information in the MDS and RAPs.

[2] 42 CFR 483.25--(F 309)

**In this case example**:

- The processes of completing the MDS/RAP assessment [RAI] and developing an individualized care plan are illustrated.
- The goal is to show how MDS assessment information leads you to further assessment (by reviewing triggered RAPs) and to care planning.
- The RAP Summary forms are shown as part of this example to illustrate how this specific form can aid in coordinating and facilitating the flow of assessment data and decision-making.

**This example does NOT:**

- Represent a functionally complete MDS, RAP review and care planning process. Certain assessment areas and elements of care, although very appropriate, are not presented as part of this example.

## 1. THE ASSESSMENT PROCESS

We begin the MDS assessment process with examples of notes from the clinical record and conversations between caregivers displaying assessment points over the first few days of residency. These examples illustrate that MDS and RAP assessment information is being gathered from the point of admission, although the MDS form itself may be completed later.

**Day 1 (Initial Admission of Mr. S from the hospital)**

Following his admission, the following SOAP note was written on admission.

**S**: "Come sit with me, Joanne. I am so thirsty. Get me some water," says Mr. S talking to wife Marion. (Joanne is his sister who expired 12 years ago.) Wife stated that he never refers to her as his sister, but that since he was admitted to the hospital he has been more confused.

**O**: Mr. S admitted from the hospital, s/p left hip replacement. Mr. S has a five-year history of Alzheimer's disease, and has been attending the Cognitive Impairment Clinic at the hospital for three years.

According to hospital discharge summary, Mr. S was agitated in the ER, and was given Haldol IM several times during his stay in the hospital. His dehydration was treated successfully with IV fluids. He was "very confused, more so than what the wife previously indicated." Other new medications include ranitidine (Zantac), Morphine, Bactrim DS for a diagnosed urinary tract infection. He remained restrained throughout his stay.

Mr. S is oriented only to self and responds to his name only. He refers to his wife as his sister (new for him). He is not aware that he is in a nursing facility, or that he was in a hospital. He continuously picks at his bedclothes, and fidgets with the call light.

**A**: Acute confusion possibly related to hospitalization, medications, urinary tract infection, pain and isolation.

**P**: Monitor closely for safety. Do not use restraints. Begin 15 minute checks while awake. Encourage out of room activities. Resident continuing on Bactrim DS for six more days. Consult with physician about medication regimen. Ask daughter to bring in some of Mr. S.'s favorite articles to reorient him. Encourage frequent visits from family, explaining to them about Mr. S's change in cognitive status. Monitor closely for hip pain. Medicate with Tylenol for discomfort. Maintain pain flow sheet in the clinical record to assess effectiveness of pain regimen.

**Day 2 (Note by physician on her visit with Mr. S)**

I saw Mr. S today in the home where he was newly admitted. He has a five-year history of Alzheimer's disease, complicated by an acute confusional state. His hospitalization for hip repair was complicated by a urinary tract infection, dehydration, and acute confusional state. Whether the dehydration, infection, or medications was the cause of the cognitive changes is uncertain at this time. Wife reports that he was having difficulty urinating prior to admission, but thought that it was normal, considering his history of an enlarged prostate. I discontinued morphine and started Tylenol, 650 mg every six hours, since admission. Also, I changed his Haldol to p.o. and will slowly decrease the dosage. Continue with Bactrim DS until course completed. Discontinue Zantac. It is unclear why he was started on it and it may be contributing to his confusion. Monitor Intake and Output for next 7 days. I will do a further exam of Mr. S on Monday.

**Day 4 (The following is an example of a dialogue between the nurse and the social worker about what was learned in admission examinations. It does not represent documentation, but serves to illustrate the interdisciplinary assessment processes. Also included on this day are the follow-up nursing notes and a separate physical therapy note. Staff's awareness of the needs and treatments for the resident is expanding.)**

***SOCIAL WORKER (SW):***

"I spoke with Mr. S, his wife Marion and oldest daughter, Susan, the first two days of admission. Throughout the conversation, Mr. S was unable to answer simple questions. He was easily sidetracked and would become consumed with smoothing out his bedclothes. Marion and Susan said that normally he can't answer simple questions about his immediate needs, but he can talk endlessly about woodworking and opera."

***NURSE (N)*:**

"Mr. S is much clearer today. Although he didn't remember meeting me before, he responded to his name, and stated that he was not in his home, but in an old person's home. His wife was present and he called her by her proper name."

**SW:** "Mary (the nurse on evenings) told me that his cognition would probably continue to improve once his delirium clears. I have shared this with the family who seemed relieved."

**N:** "She is probably right. The UTI, dehydration, morphine, Zantac and Haldol probably contributed to his acute confusion, but because he has Alzheimer's disease, it makes it difficult to assess his baseline."

**SW:** "Well, his family described a gregarious man, who enjoyed attending the Alzheimer's Day Care Program at the community center. He was diagnosed with Alzheimer's disease five years ago, although the daughter stated she felt that he was having problems several years before the actual diagnosis. Also, Mr. S's wife told me that he was having increasing difficulties with his ADLs. She would have to break tasks down into sub-tasks. He required lots of cueing for dressing especially."

**N:** "He had his admission physical exam yesterday. Under the circumstances, everything seems O.K. His enlarged prostate probably causes some urinary retention, which would have put him at greater risk for the urinary tract infection, but his surgical incision line was clean. He appears well hydrated, and the nurse assistants from the day and evening shift indicate that he is taking in ample fluids. He continues to manipulate bedclothes, which according to his wife is a new activity, but it is tapering off. This could represent a resolution of his acute confusion. We will continue to monitor his intake and output, and cognition in light of his acute confusion. He is at risk for falling. He still has a few more days on his antibiotic for his UTI. The physical therapist will be seeing him today in fact. I'm going to write a brief note to document the areas we covered in these conversations."

***NURSING NOTE***

Discussed Mr. S's condition with Social Worker. Mr. S seems to be "clearer today." He is oriented to person, able to identify his wife by her correct name, and is aware that he is not in his home. He identifies his property that his wife brought in from home (picture and opera posters), and his fidgeting with the bedclothes has lessened. As his acute confusion improves we should see a returning to baseline. On exam Mr. S. appeared well hydrated, I/O adequate according to reports from nurse assistants. He appears in mild discomfort only when he ambulates, and is receiving Tylenol regularly. His dose of Haldol is being slowly tapered. He does not appear to have any negative effects from this.

K. Phillips, R.N.

***PHYSICAL THERAPY NOTE***

Mr. S sustained a fall and fractured his left hip. He underwent a successful replacement of the hip, and was cleared for light weight-bearing status. Because of his worsening cognition, and additional problems, he has not been ambulating except out of bed to the commode with nursing staff.

According to the daughter, who was involved with his care at home, his fall was an isolated event. Usually he ambulates around his home, Adult Day Care, and takes frequent walks without event. Orthostatic blood pressures and pulses from the end of his hospitalization and since admission here have been within normal limits, with orthostatic changes noted upon admission to the hospital.

His fall at home occurred at 2 am. The resident was very restless the entire day. He appeared to be having difficulty urinating. His wife was planning to take him into the doctor's office in the morning. Mr. S. got out of bed and was found wandering around the house. His wife tried to get him to return to bed, but he went into the bathroom, got into the shower - with his clothing on - and fell. Wife is not certain if he slipped or just fell.

Upon examination, he did not have orthostatic changes in his blood pressure or heart rate from a lying to upright position. He was able to get out of bed to a standing position with contact guard. Using his new walker, he was able to move to the hallways - safely. He did seem confused about the walker, but followed my commands appropriately.

This resident is ready to bear full weight. Staff should walk with him three times a day using contact guard and cueing for the walker. A sign that reads, "Mr. S remember your pusher" (his word for walker) was placed by his bed and by the inside of the door. According to notes from the Cognitive Impairment Clinic, he is able to read and follow simple written directions.

Assessment: Mr. S is at risk for future falls due to his recent fracture and hip replacement, cognitive impairments, new required use of walker (which he may get to a point that he doesn't need), and residual acute confusion. Plan: Monitor closely; contact guarding with all ambulation. Ambulate in hallway at least three times a day. Slowly increase distance, over the next two weeks, from room to dining room.

J. Smith, P.T.

**Day 5 (Example of documentation of additional information gathered that would be relevant to comprehensive resident assessment using the MDS and RAPs)**

***NURSING NOTE***

Resident incontinent of urine all three shifts since admission. His normal pattern at home was to toilet himself as needed, with additional reminders from his wife before leaving the house and at bedtime. Resident with a past history of enlarged prostate and urinary retention. Resident has daily bowel movements and passing moderate amounts of soft, formed stool. Digital exam is negative for feces in rectum. Mr. S is receiving tapering doses of Haldol. We expect the incontinence to resolve with diminishing Haldol doses, full treatment of UTI, and resolution of delirium. The decision was made to document bowel and bladder activity, I/O of fluids, assess for bladder distention, discuss with wife regarding past patterns for bathroom cueing, and to continue to review medications: Haldol, Bactrim DS.

K. Phillips, R.N.

## 2. DRAWING INFORMATION TOGETHER

This case example illustrates the types of activities and dialogue that occur as staff gathers information and structure care during the first few days of a resident's stay in the facility. Using this and other information, staff would complete the MDS. Each discipline would complete their assigned portion of the MDS, cross check the assessment across disciplines and shifts for accuracy, and then have it signed off by the RN.

## 3. FURTHER ASSESSMENT USING RAP GUIDELINES

The RAP review and assessment process provides a time for staff to think about and discuss key areas of concern related to the resident. There are many ways to structure this assessment process, e.g. who leads the discussion or assessment, who participates, and how the resident, family and physician are involved. But in each case, staff should:

Based on the case study presented above, staff should review the MDS to determine which RAPs should be triggered. Using delirium as an example, possible ways in which staff could proceed are indicated below.

- Discuss the triggered problems and any current treatment goals and related approaches to care.
- Identify the key causal factors (i.e., why the problem is present).
- Review the associated and confounding factors referenced in the RAP Guidelines (i.e., things that contribute to the problem or add to the complexity of the situation).
- Ensure that information regarding the resident's status and clinical decision-making is documented, and that the RAP Summary form identifies where this documentation can be found.
- Proceed to Care Planning.

1. The Delirium RAP was used throughout the initial assessment period. It was clear from admission that Mr. S had acute confusion. Predictably, the Delirium RAP was triggered. Staff documentation throughout the first weeks of residency captures the key elements of the Delirium RAP assessment. The location and date of this documentation is entered on the RAP Summary form. The decision to care plan is indicated. As key information is clearly documented in this example and readily accessible to all staff, there is no additional documentation <u>required</u> beyond the RAP Summary form and referenced notations and care plan.

2. In some cases, a staff person may want to write a summary of the RAP assessment. This could be for several reasons: e.g., while the assessment documentation is in the record it is incomplete, unclear, too scattered or not focused. It may also be useful to have the information summarized for quick reference by staff. If this is the case, the summary note for Delirium could look like this:

**Delirium: RAP Summary Example 1**

Mr. S admitted from hospital with diagnosis of acute confusion. Since admission his cognition has steadily cleared. Indicators of delirium, such as being easily distracted, having altered perception or

awareness of surroundings, and restlessness have lessened, but are not completely gone. Mr. S has a history of Alzheimer's disease, family have been very helpful in describing his baseline cognition. The team believes that delirium is related to his UTI, relocation, Haldol, Morphine, Zantac, and dehydration. Haldol is being tapered with the goal of elimination (he was not on this drug prior to hospitalization), Morphine and Zantac have been discontinued, UTI has been treated with Bactrim DS - a follow up U/A C+S will be sent upon completion, I/O is being monitored and fluids being encouraged, and the family has been helping us simulate a homelike environment with Mr. S's possessions and routine.

Another example could look like this:

**Delirium: RAP Summary Example 2**

Mr. S triggered for delirium. RAP was used as a guideline for assessment by team. (See nursing notes: 8/24/02, 8/28/02, MD note 8/25). Possible causal factors: UTI, Medication, Dehydration, Relocation have been identified and treatment plans are indicated. Refer to Delirium care plan.

## 4. CARE PLAN SPECIFICATION

The following is an example care plan for Delirium. It contains general points, rather than specific prescriptions. It is meant to show general culmination of the assessment process in the plan of care.

| Objective | Intervention | Evaluation |
|---|---|---|
| Mr. S will remain safe and have no injuries in next 30 days | • Keep night light on in room at night.<br>• Have family bring in familiar articles (bedspread, pictures).<br>• 15-minute checks while in room, encourage out of room activities. Involve in low stimulus activities.<br>• Keep pathways clear and free from clutter.<br>• Toilet q 2 hours while awake and q 4 hours during night. Offer frequent snacks including beverages. | • Resident remained safe in last 30 days, with no evidence of injury. |
| Mr. S's cognitive function will return to baseline[3] in 30 days | • Taper Haldol as ordered.<br>• Continue to review all medications with physician.<br>• Assess for adequate hydration by monitoring daily fluid intake.<br>• Review requested notes from Adult Day Care to gain further insight into baseline.<br>• Continue with Tylenol for pain, give PRN dose before physical therapy and if resident appears agitated or withdrawn. | • Resident's cognitive functioning appears similar to baseline[3] according to: family, documentation from Adult Day Care and cognitive clinic at hospital.<br>• Resident received Tylenol as ordered, and did not appear to be in pain. |
| Mr. S and family will be acclimated to the unit in 30 days as evidenced by recognizing his own room and participating in unit activities with minimal supervision | • Primary team to meet with family to work on care plans and tour unit.<br>• Involve family in all aspects of care.<br>• Assess family's level of knowledge about Alzheimer's disease and acute confusion.<br>• Reorient Mr. S to his room and surrounding unit. As acute confusion begins to clear, involve Mr. S in more of unit activities. | • Family met with primary care team and toured the unit. Mr. S is able to recognize his room and attend unit activities with a staff prompt. |
| Resident will maintain adequate nutrition and hydration over next 30 days as evidenced by eating at least 3/4 of his meals and drinking 2 liters of fluid each day | • See urinary incontinence care plan.<br>• Carefully assess fluid intake from meal trays. Offer supplemental fluids in between meals. Involve family in determining the best fluids; Mr. S likes chocolate milk and apple juice.<br>• Review monitored intake and output sheets from last 7 days.<br>• Monitor skin turgor and mucous membranes. | • Mr. S's intake was at least 2000.<br>• Resident received supplemental beverages in between meal.<br>• Skin turgor is intact and mucous membranes are moist. |

[3]Assumes description of baseline is documented elsewhere in the clinical record.

## 4.11 Overview of the RAI and Care Planning

**Assessment (MDS/other)** → **Decision-Making (RAPs/other)** → **Care Plan Development** → **Care Plan Implementation** → **Evaluation**

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This section provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review, which is carried out utilizing the Guidelines that have been developed for each RAP. Staff uses RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. Clinical judgment must be exercised in the identification of problems and potential problems in developing the plan of care. After using the RAP Guidelines to assess the resident, the staff may decide that a triggered condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan. Conversely, the staff may decide that items that were not triggered do affect the resident's functioning or well-being and therefore should be addressed on the care plan.

The care planning process in long-term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident

by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well-being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision-making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.

2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.

3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.

4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Documentation may be done by

individual staff members who have completed assessments using the RAP Guidelines or who participated in care planning, or as a joint note by members of the interdisciplinary team.

5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.

6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of well-being. The resident's wishes should be documented in the clinical record.

7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

**EXAMPLES**

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.

9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.

10. The parts of the goal statement should include:

    The **Subject** - the **Verb** - **Modifiers** - the **Time frame**. See following example.

**EXAMPLE**

| *Subject* | *Verb* | *Modifiers* | *Time frame* |
|---|---|---|---|
| Mr. Jones | will walk | up and down 5 stairs with the help of one nursing assistant | daily for the next 30 days. |

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.

12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.

13. The final care plan should be discussed with the resident or the resident's representative.

14. The goals and their accompanying approaches are to be communicated to all direct care staff who were not directly involved in the development of the care plan.

15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

## 4.12 The Care Planning Process

The care planning process is based on good clinical practice and specified in the interpretive guideline probes for the care planning requirements at 42 CFR 483.20(k)(1) and (2). The appropriate **F Tags** have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in **Appendix P** of the State Operations Manual (SOM). The SOM can be found at the following web site: **http://www.cms.gov/Manuals/IOMlist.asp**.

**The care plan must be oriented toward preventing avoidable declines in functioning or functional levels** - F 279

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

## Managing risk factors in the care plan - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

## Addressing resident strengths in the care planning process - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

## Utilizing current standards of practice in the care plan - F 281

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

## Evaluating treatment objectives and outcomes of care in the care planning process - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline-in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

## Respecting the resident's right to refuse treatment - F 279 and F280

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether or not they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how

a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

### Offering alternative treatments - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff that has regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

### Utilizing an interdisciplinary approach to care plan development to improve resident's functional abilities - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff is usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each member's contribution should be sought and valued.

### Family and other resident representatives involvement in care planning - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this

fact and that individual should be given the opportunity to participate in the assessment and care planning process.

## Assessment and care planning sufficient for meeting the care needs of new admissions - F 281

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20(a) Tag F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident were incontinent of urine at the first admission, or newly incontinent at re-admission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

## Involving the direct care staff with the care planning process relating to the resident's expected outcomes - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff has the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether or not specific program variations might be useful.

## Additional care planning areas that could be considered in the long-term care setting - F 280

The following are six general care planning areas that are useful in the long-term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

1. **Functional Status**

   Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

2. **Rehabilitation/Restorative Nursing**

   A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative-nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

3. **Health Maintenance**

   Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

   The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

   Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

4. **Discharge Potential**

   Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

5. **Medications**

The facility must conduct initially and periodically a comprehensive assessment of a resident's needs including medications **(See 483.20(b)(1)(xiv))**. This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facility staff on a monthly basis.

It is the interdisciplinary team's decision whether or not medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications that may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

Many medications have been identified that are judged to place a person over the age of 65 at greater risk of adverse drug outcomes. These were identified in a paper published in the *Archives of Internal Medicine*, Vol. 157, July 28, 1997 entitled "Explicit Criteria for Determining Inappropriate Medication Use by the Elderly" by Mark H. Beers, M.D., and are outlined in the State Operations Manual, Appendix PP, Guidance to Surveyors, Tag F329, 42 CFR 483.25(1)(1). The interdisciplinary team will want to carefully review the use of any of these medications and care plan for possible side effects.

6. **Daily Care Needs**

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

***Clarifications:***

- For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. In most nursing facilities, the timing of such routines is fairly standardized. If that is not the case, then specific times should be noted. Good clinical practice dictates that any care plan be periodically evaluated and revised as necessary, which would include documentation of the resident's response to the program.

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of

the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- The plan of care should present a true picture of the resident's status. It should therefore be revised with any major change of condition (decline or improvement), as well as completing a Significant Change in Status assessment. Refer to Chapter 2 for guidelines for Significant Change in Status assessment.

# CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Long-term care nursing facilities are required to submit MDS records for all residents in Medicare or Medicaid certified beds regardless of the pay source. Skilled nursing facilities are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF PPS.

## 5.1 Transmitting MDS Data

Every State agency is equipped with the standardized computer hardware and data management software system to electronically receive MDS data from all Medicare and Medicaid nursing facilities. After completion of the required assessments and/or tracking forms, each nursing facility must create an electronic transmission file that meets the requirements detailed in the current MDS Data Specifications available at **http://www.cms.hhs.gov/medicaid/mds20/mdssoftw.asp**.

In addition, nursing facilities must be certain they are submitting MDS assessments under the appropriate authority. There must be a Federal and/or State authority to submit MDS assessment data to the standard MDS system. The software used by nursing facilities should have a prompt for confirming the authority to submit that record.

The facility indicates the submission authority for a record in a field labeled SUB_REQ.

- **Value = 3** Indicates that the MDS record is for a resident on a Medicare and/or Medicaid certified unit. There is CMS authority to collect MDS information for residents on this unit.
- **Value = 2** Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, but the State has authority, under State licensure or Medicaid requirements, to collect MDS information for residents on this unit.
- **Value = 1** Indicates that the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for all residents on this unit. Note that if a record is submitted with SUB_REQ = 1, then that record will be rejected and all information concerning the record will be purged.

Nursing facilities must establish communication with the State MDS database in order to submit a file. This is accomplished by using specialized communications software and hardware and the Medicare Data Communication Network (MDCN). Details about these processes are available at the following web site: **http://www.qtso.com/mdsdownload.html**.

Once communication is established, the nursing facility can access the State's CMS MDS Welcome Page in the MDS system. This site allows nursing facilities to submit MDS assessment data, receive various reports, including the validation reports for the submitted MDS data, and access various

information sources such as Bulletins and Questions and Answers. The Minimum Data Set (MDS) Long-Term Care Facility User's Manual provides more detailed information about the MDS system. It is available at: **http://www.qtso.com/mdsdownload.html**.

When the transmission file is received by the State MDS database, the State system performs a series of validations or edits to evaluate whether or not the data submitted meets the required standards. MDS assessments are edited to verify that clinical responses are within valid ranges, dates are reasonable, and assessments are consistent with previous assessments completed for the same resident. The facility is notified of the results of this evaluation on the Initial Feedback Report or the Final Validation Report. All edit messages are detailed and explained in the Validation Report Messages and Descriptions Manual available at: **http://www.qtso.com/mdsdownload.html**.

## 5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR § 483.20 (f) (1), (2), and (3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
  - For the Admission assessment, the RAPs Completion Date (VB2) can be no more that 14 days from the date of admission or reentry, whichever is later.
  - For all other comprehensive MDS assessments, the RAPs Completion Date (VB2) may be no later than 14 days from the Assessment Reference Date (A3a).
  - For Quarterly or MPAF assessments, the MDS Completion Date (R2b) may be no later than 14 days from the Assessment Reference Date (A3a).
  - Discharge and Reentry records must be completed within 7 days of the Event Date (R4 for Discharge records; A4a for Reentry records).

- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)

- **Encoding Data:** Within 7 days after a facility completes a resident's MDS assessment or tracking form, a facility must encode the MDS data. The MDS data must be in a record format that conforms to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. When this process is completed, the facility is ready to transmit the MDS assessment to the State MDS database.

- **Transmitting Data:** Facilities must transmit all sections of the MDS 2.0 required for their State-specific instrument, including the Resident Assessment Protocol Summary (Section V) and all tracking or correction forms. Transmission requirements apply to all MDS 2.0 assessments or MPAF assessments when used to meet both OBRA and Medicare requirements. Care plans are not required to be transmitted.

- **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 31 days of the Care Plan Completion Date (VB4). All other MDS or MPAF assessments must be submitted within 31 days of the MDS Completion Date (R2b).
- **Tracking Form Transmission:** Tracking forms must be transmitted within 31 days of the Event Date (R4 for Discharge records; A4 for Reentry records).
- **Monthly Transmission Requirements:** A facility must, at least on a monthly basis, electronically transmit to the State MDS database encoded, accurate and complete MDS assessments conducted during the previous month.

## SUBMISSION TIME FRAME FOR MDS RECORDS

| Type of Record | Primary Reason (AA8a) | Secondary Reason (AA8b) | Final Completion or Event Date | Submit By |
|---|---|---|---|---|
| Admission Assmt. | 01 | All values | VB4 | VB4 + 31 |
| Annual Assmt. | 02 | All values | VB4 | VB4 + 31 |
| Sign. Change Assmt. | 03 | All values | VB4 | VB4 + 31 |
| Sign. Correction Full Assmt. | 04 | All values | VB4 | VB4 + 31 |
| Quarterly Assmt. | 05 | All values | R2b | R2b + 31 |
| Sign. Correction Quarterly Assmt. | 10 | All values | R2b | R2b + 31 |
| Assmt. for Medicare (with AA8a = 00) | 00 | 1, 2, 3, 4, 5, 7 or 8 | R2b | R2b + 31 |
| Discharge Tracking | 06, 07, 08 | Blank | R4 | R4 + 31 |
| Reentry Tracking | 09 | Blank | A4a | A4a + 31 |
| Correction Request | All values | All values | AT6 | AT6 + 31 |

**Table Legend:**

ITEM DESCRIPTION

VB4.....Date of the signature of the person completing the care planning decision on the RAP Summary sheet (Section V), indicating which RAPs are addressed in the care plan (Care Plan Completion Date).

R2b.....Date of the RN assessment coordinator's signature, indicating that the MDS is complete (MDS Completion Date).

R4.....Date of death or discharge

A4a .....Date of reentry

AT6.....Date of the RN coordinator's signature on the Correction Request form certifying completion of the correction request information and the corrected assessment or tracking form information.

## 5.3 Validation Edits

The MDS system has edits designed to monitor the timeliness and accuracy of MDS assessment record submissions. If transmitted MDS assessment records do not meet the edit requirements, the system will post error messages on the nursing facility's validation report.

**Validation and Editing Process:** Each time a facility accesses the State MDS system and transmits an assessment file, the State MDS system performs three types of validations:

1. **Fatal File Errors** - The first validation examines the basic structure and integrity of the submission file. The facility will be informed of the file submission status in the Initial Feedback Report indicating that the batch was "accepted," "received" (for a test file), or that it was "rejected." If there are fatal flaws in the file (batch of records), the entire file is rejected; the facility will not receive a Final Validation Report. Rejected files must be corrected and retransmitted.

2. **Fatal Record Errors** - If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include:

   - out of range responses, e.g., for G1aA Bed Mobility Self Performance, a 5 is submitted when the only allowable answers are 0 – 4;

   - selected inconsistent relationships between fields, e.g., dates submitted must be reasonable. As an example, it is not possible that the resident's Birthdate (Item AA3) would be later than the Date of Entry (Item AB1);

   - errors which may prevent accurate identification of the resident or record type.

   Fatal Record Errors result in rejection of individual records by the State MDS system. The facility is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.

3. **Non-Fatal Errors** - If there are no Fatal Record Errors, the record is loaded into the State MDS database and the record is further validated for Non-Fatal Errors. Non-Fatal Errors include missing or questionable data of a non-critical nature or field consistency errors of a non-critical nature. These might be timing errors, e.g., the date submitted at R2b is more than 14 days after the date at A3a, or record sequencing errors, e.g., a Reentry record (AA8a = 09) is submitted after a Quarterly record (AA8a = 05). Any Non-Fatal Errors are reported to the facility in the Final Validation Report as warnings. The facility must evaluate each error to identify necessary corrective actions.

The edits are structured to match the timeliness criteria outlined in Section 5.2. Detailed information on the timeliness edits may be found in the Validation Report Messages and Descriptions Manual available at: **http://www.qtso.com/mdsdownload.html**.

## 5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR § 413.343 (a) and (b), nursing facilities reimbursed under the SNF PPS "are required to submit the resident assessment data described at § 483.20…. in the manner necessary to administer the payment rate methodology described in § 413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in § 413.337 (c) related to the adjustment of the Federal rates for case-mix. SNFs must submit assessments according to an assessment schedule. This schedule must include performance of resident assessments on the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

**RUG-III Codes:** Every Medicare assessment (AA8b = 1, 2, 3, 4, 5, 7 or 8) submitted must include a RUG-III case mix code (T3a). The first three characters are the RUG-III group code and the last two characters are a valid RUG-III version code, e.g., RMC07. The RAVEN software calculates and inserts the correct RUG-III case mix code for each Medicare assessment. Every Medicare assessment that is submitted to the State MDS database must include a RUG-III case mix code. The version code is used solely for electronic submission purposes. The version code is included on all MDS files electronically submitted to the State MDS database. The version code is different from the HIPPS code, and is not used when filing Medicare Part A claims.

**HIPPS Codes:** Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting claims to the fiscal intermediary (FI). The HIPPS codes contain a three-position alpha code to represent the RUG-III case mix code of the SNF resident, plus a two-position assessment indicator to indicate which assessment was completed. SNFs are **not** currently required to transmit the HIPPS code as part of the MDS data record. The HIPPS code is calculated manually or by nursing facilities' proprietary software. Once the MDS record has been accepted into the State MDS database, clinical staff should give the HIPPS code to the billing office. The HIPPS code must appear on the claim and the claim cannot be filed until the MDS has been accepted into the State MDS database.

It is important to remember that the record will be accepted into the State MDS database, even if the calculated RUG-III code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG-III code. When such discrepancies occur, the RUG-III code reported on the Final Validation Report should always be used for billing.

## 5.5 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the State MDS Database

Facilities may not "change" a previously completed MDS assessment when the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is part of the facility's responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident's status is not required, unless a significant change in status has occurred.

A flow chart is provided at the end of this chapter to graphically present the decision processes necessary to identify the proper correction steps.

MDS assessments that have not yet been accepted in the State MDS database include records that have been submitted and rejected, production records that were inadvertently submitted as test records, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the State MDS database. The paper copy should be corrected according to standard procedures detailed below.

## ERRORS IDENTIFIED DURING THE ENCODING PERIOD

Facilities have up to 7 days to encode and edit an MDS assessment after the MDS has been completed. Amendments may be made to the electronic record for any item during the encoding period, provided the amended response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data is encoded into the facility's MDS system, the facility is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the facility is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 2.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a nursing facility may "correct" item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For "corrected" items, the facility must use the same "period of observation" as that used for the original item completion (i.e., the same Assessment Reference Date – A3a). Any corrections must be accurately reflected in both the electronic and paper copies of the MDS (i.e., the paper version of the MDS must be corrected.)

## ERRORS IDENTIFIED AFTER THE ENCODING PERIOD

The corrections process is more complex if errors are identified after the end of the encoding process but before the record has been accepted into the State database. After the 7-day editing period, the facility must correct and submit the record, using the process detailed above, but must also evaluate whether or not an additional Significant Change in Status or Significant Correction of a Prior assessment is required. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered "major" errors and require a new assessment. All other errors related to the coding of clinical items are considered "minor," and can be addressed through the correction process without performing another assessment.

In summary, the facility must then take the following actions:

1. Correct the original assessment,
2. Submit the corrected assessment, and
3. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment if the error was major, and update the care plan as necessary.

If the MDS (MPAF) is performed for Medicare purposes only (AA8a = 00, AA8b = 1, 2, 3, 4, 5, 7 or 8), no Significant Change in Status or Significant Correction of a Prior assessment is required. RAPs and care planning are not required with Medicare assessments.

## 5.6 Correcting Errors in MDS Records That Have Been Accepted Into The State MDS Database

Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. Two processes have been established to correct MDS records (assessments or tracking forms) that have been accepted into the State MDS database:

- **Modification**
- **Inactivation**

A Modification request moves the inaccurate record into the history file in the State MDS database and replaces it with the corrected record in the active database. An Inactivation request also moves the inaccurate record into the history file in the State MDS database, but does not replace it with a new record. Both the Modification and Inactivation processes require an MDS Correction Request form.

The MDS Correction Request form (Prior Record Section and Section AT) contains the minimum amount of information necessary to enable correction of the erroneous MDS data previously submitted and accepted into the State MDS database. A hard copy of the Correction Request form must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. A hard copy of the Correction Request form should also be kept with an inactivated record. (A copy of the Correction Request form can be found at the end of this chapter.)

Detailed instructions concerning completion of the Correction Request form and examples of the correction process are included in the final Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form (September, 2000), which may be accessed at **http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.**

## MODIFICATION REQUESTS

A Modification request should be used when a **valid** MDS record (assessment or tracking form) is in the State MDS database, but the information in the record contains errors. A record is considered to be valid if it meets all of the following conditions:

1. It is not a test record.
2. The record corresponds to an actual event.
3. The record identifies the correct resident.
4. The record identifies the correct reasons for assessment.
5. The facility has State or Federal authority to submit the record (i.e., the record meets the SUB_REQ submission requirements described in Section 5.1).

When an error is discovered in a tracking form, the facility must complete the following actions to correct the form:

1. Correct the original tracking form,
2. Complete a Correction Request form to modify the tracking form, and
3. Submit the correction record.

When an error is discovered in an assessment, the facility must decide whether or not it is a major error. If it is not a major error, or if this was an assessment completed only for Medicare purposes, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment, and
3. Submit the correction record.

When a major error is discovered in an assessment after the assessment has been accepted into the State MDS database, the facility must complete the following actions to correct the assessment:

1. Correct the original assessment,
2. Complete a Correction Request form to modify the assessment,
3. Submit the correction record, and
4. Perform a Significant Correction of a Prior assessment or Significant Change in Status assessment and update the care plan as necessary.

When errors identified in a prior assessment have been corrected in a more current assessment, the facility is not required to perform a new comprehensive assessment. In this situation, the facility has already incorporated the accurate data into the care planning process. However, the facility must use the Modification process to assure that the erroneous assessment residing in the State MDS database is corrected.

Generally, most errors may be corrected through the Modification or Inactivation request submitted with a correction record. Minor errors, such as the misspelling of an occupation in Item AB6, do not need to be corrected; they should be noted and corrected with the next assessment.

**INACTIVATION REQUESTS**

Records must be inactivated when an incorrect reason for assessment has been submitted in either the Primary Reason for Assessment (AA8a) or Medicare Reason for Assessment (AA8b). The record must then be resubmitted with the correct reason(s) for assessment.

An Inactivation should also be used when an **invalid** record has been accepted into the State MDS database, since it moves the inactive record into the history file in the database. Examples of invalid records include the following situations:

1. It was a test record inadvertently submitted as production.
2. The event did not occur; e.g., the record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident but there was no actual discharge. There was no event.
3. The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.
4. The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking form was submitted when the resident was discharged.
5. Inadvertent submission of an inappropriate, non-required record, such as a non-standard assessment performed for "in-house" quality improvement or quality assurance programs.

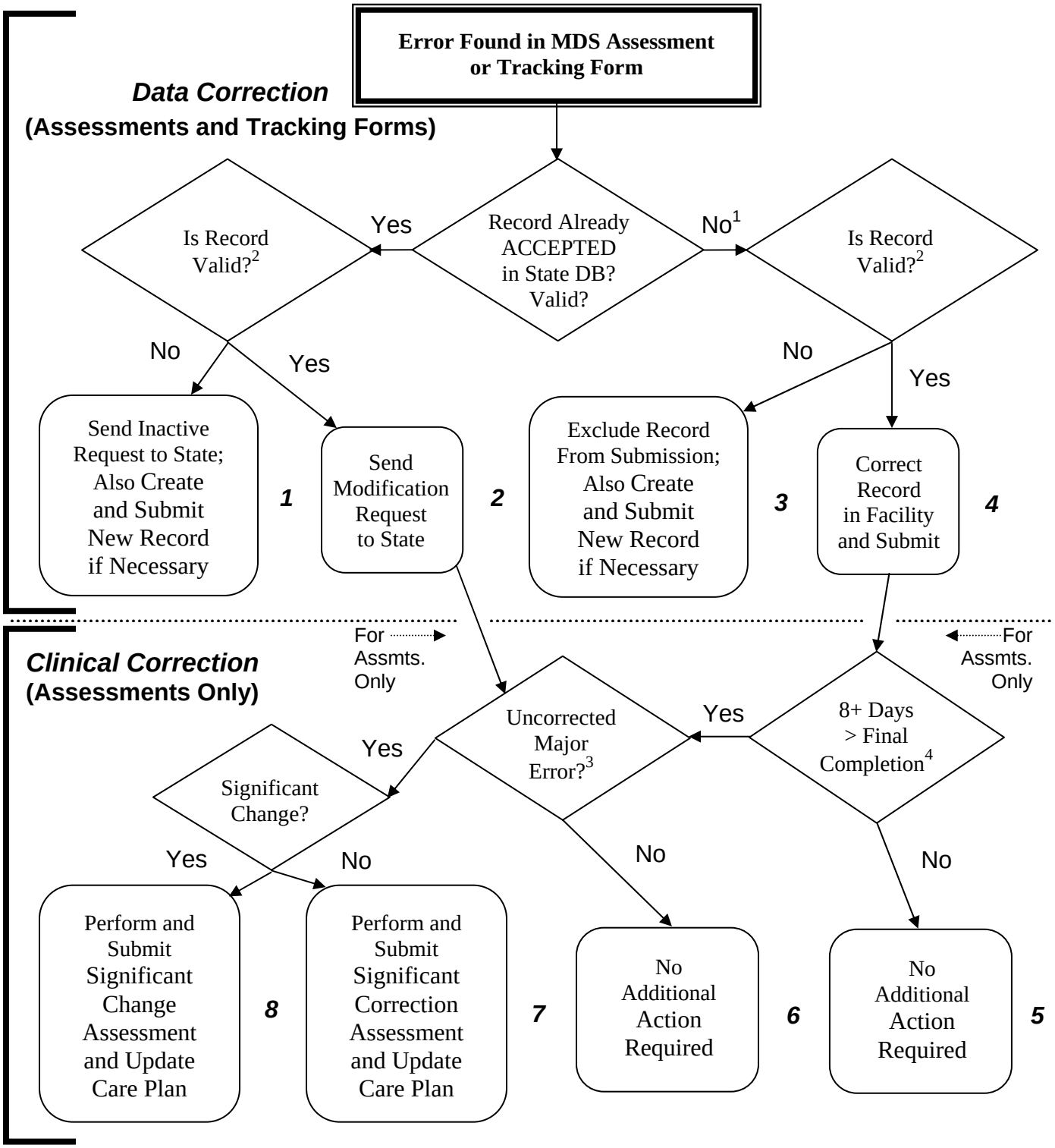
When inactivating a record, the facility is required to submit an electronic record.

## 5.7 Inactivation of Submitted Records Lacking State or Federal Authority

Submission of MDS assessment records to the MDS standard database constitutes a release of private information and must conform to privacy laws. The facility indicates the submission authority for a record in a field labeled SUB_REQ. (See Section 5.1)

SUB_REQ may not be modified with a normal MDS modification request. The formal Inactivation process is also insufficient, since the inappropriately submitted record would still remain in the database in the history file. If the SUB_REQ value is incorrect on a record already accepted into the standard MDS database, the facility must make a request to the State help desk to evaluate the problem and, if appropriate, the MDS database will be manually corrected.

# CORRECTION POLICY FLOWCHART




[1]Record has not been data entered, has not been submitted, or has been submitted and rejected.

[2]The record is ***valid*** if ***event occurred***, ***resident*** and ***reasons for assessment are correct***, and ***submission is required***.

[3]The assessment in error contains a Major error that has not been corrected by a subsequent assessment.

[4]Final completion is Item VB4 for a comprehensive and R2b for all other assessments.

**Example MDS SUB_REQ Correction Request Worksheet**

The nursing facility must submit the following information to the state MDS Coordinator in writing:

| | |
|---|---|
| **Facility information** | |
| Name | |
| ID (FAC_ID) | |
| **Requester information** | |
| Name | |
| Title | |
| Phone # | |
| **Resident information** | |
| First Name | |
| Last Name | |
| SSN | |
| Birthdate | |
| Gender | |
| **Record information** | |
| Item AA8a | |
| Item AA8b | |
| Target Date[1] | |
| **Submission information** | |
| Date and time | |
| Batch # | |
| **SUB_REQ values** | |
| Submitted (incorrect) | |
| Correct | |

[1]Target date is:
MDS Item A3a (reference date) for an assessment record.
MDS Item R4 (discharge date) for a discharge record.
MDS Item A4a (reentry date) for a reentry record.

Additional information may be found in the MDS Submission Authority instructions available at **http://www.qtso.com/download/mds/SubReqInstructQtso2.pdf**.

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# CHAPTER 6: MEDICARE SKILLED NURSING HOME PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

## 6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing homes, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for skilled nursing homes under Part A of the program. (Federal Register Vol. 63, No. 91, May 12, 1998, Final Rule.)

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970's, focusing on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of states that developed and implemented similar case mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of State and Federal payment systems for nursing home care is based on the recognition of the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs, but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels would be higher than for those residents with less intensive care needs. In a case mix adjusted payment system the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the MDS. Case mix reimbursement has become a widely adopted method for financing nursing home care. The case mix approach serves as the basis for the PPS for skilled nursing homes, swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

## 6.2 Utilizing the MDS in the Medicare Prospective Payment System

A key component of the Medicare skilled nursing home prospective payment system is the case mix reimbursement methodology used to determine resident care needs. A number of nursing home case mix systems have been developed over the last 20 years. Since the early 1990's, however, the most widely adopted approach to case mix has been the Resource Utilization Groups (RUG-III). This classification system uses information from the MDS assessment to classify SNF residents into a series of groups representing the residents' relative direct care resource requirements.

The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-III groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency or other conditions will be assigned to higher groups in the RUG-III hierarchy. Providing care to these residents is more costly, and is reimbursed on a higher level.

## 6.3 Resource Utilization Groups Version III (RUG-III)

The RUG-III classification system has eight major classification groups: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. The eight groups are further divided by the intensity of the resident's activities of daily living (ADL) needs, and in the Clinically Complex category, by the presence of depression.

One hundred and eight (108) MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the RUG-III Classification system for nursing homes can be found at the end of this section.

| EIGHT MAJOR RUG-III CLASSIFICATION GROUPS | |
|---|---|
| **MAJOR RUG-III GROUP** | **CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP** |
| Rehabilitation Plus Extensive Services | Residents receiving physical, speech or occupational therapy AND receiving IV feeding or medications, suctioning, tracheostomy care, or ventilator/respirator. |
| Rehabilitation | Residents receiving physical, speech or occupational therapy. |

| | |
|---|---|
| Extensive Services | Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications, suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the resident eligible for other RUG categories. |
| Special Care | Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding. |
| Clinically Complex | Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot infections or wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes. |
| Impaired Cognition | Residents having cognitive impairment in decision-making, recall and short-term memory. (Score on MDS 2.0 cognitive performance scale >=3). |
| Behavior Problems | Residents displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions |
| Reduced Physical Function | Residents whose needs are primarily for activities of daily living and general supervision. |

## 6.4 Relationship Between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

### 1. ASSESSMENT REFERENCE DATE (ARD)

The ARD must be reported on the Medicare claim. If an MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

### 2. THE RUG-III GROUP

The RUG-III group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted MDS assessments. Nursing homes cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process.

RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
SE1, SE2, SE3
SSA, SSB, SSC
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
BA1, BA2, BB1, BB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
AAA (the default code)

### 3. HEALTH INSURANCE PPS (HIPPS) CODES

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement.

The CMS HIPPS codes contain a three position code to represent the RUG-III of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was

completed. Together they make up the 5-position HIPPS code for the purpose of billing Part A covered days to the Fiscal Intermediary. The chart shown below list the HIPPS codes used by SNFs.

HIPPS modifier codes have been established for each type of assessment used to support Medicare payment. For example, the Medicare reason for assessment on a Medicare 5-Day assessment is "1", and the HIPPS code is "01".

Under the SNF PPS, there are situations when two assessments may be needed to fulfill Medicare requirements. Rather than requiring such duplication of effort, providers have the ability to combine assessments (see Chapter 2 for more detailed information). For example, if an OMRA is required during the assessment window for a Medicare 30-Day assessment (i.e., days 21-34), the SNF is required to perform only one assessment. There is no way to code two Medicare Reasons for Assessment. The combined OMRA/30-Day Medicare assessment is coded on the MDS as an OMRA and identified on the Part A billing by using a HIPPS modifier code of "28". The combined assessment can then be used when billing the Medicare claim. Similarly, if an assessment is a combined 30-Day and an SCSA, the SCSA is coded as the Primary Reason for Assessment. The 30-Day is shown as the Medicare Reason for Assessment, and the HIPPS modifier code used for billing is "32".

## SNF HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

| | |
|---|---|
| 01 | 5-Day Medicare-required assessment/not an Admission assessment. |
| 02 | 30-Day Medicare-required assessment. |
| 03 | 60-Day Medicare-required assessment. |
| 04 | 90-Day Medicare-required assessment. |
| 05 | Readmission/Return Medicare-required assessment. |
| 07 | 14-Day Medicare-required assessment/not an Admission assessment. |
| 08 | Off-cycle Other Medicare-required assessment (OMRA). |
| 11 | 5-Day (or readmission/return) Medicare-required assessment AND Admission assessment. |
| 17 | 14-Day Medicare-required assessment AND Admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-Day Medicare assessments, regardless of whether it is also an OBRA Admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process). |
| 18 | OMRA (Other Medicare Required Assessment) replacing 5-Day Medicare-required assessment |
| 19 | Special payment situation – 5-Day assessment |

| | |
|---|---|
| 28 | OMRA replacing 30-Day Medicare-required assessment |
| 29 | Special payment situation – 30-Day assessment |
| 30 | Off-cycle Significant Change assessment (outside assessment window). |
| 31 | Significant Change assessment REPLACES 5-Day Medicare-required assessment. |
| 32 | Significant Change assessment (SCSA) REPLACES 30-Day Medicare-required assessment |
| 33 | Significant Change assessment REPLACES 60-Day Medicare-required assessment |
| 34 | Significant Change assessment REPLACES 90-Day Medicare-required assessment |
| 35 | Significant Change assessment REPLACES a readmission/return Medicare-required assessment. |
| 37 | Significant Change assessment REPLACES 14-Day Medicare-required assessment |
| 38 | OMRA replacing 60-Day Medicare-required assessment. |
| 39 | Special payment situation – 60-Day assessment. |
| 40 | Off-cycle Significant Correction assessment of a prior assessment (outside assessment window) |
| 41 | Significant Correction of a Prior assessment (SCPA) REPLACES a 5-Day Medicare-required assessment |
| 42 | Significant Correction of a Prior assessment REPLACES 30-Day Medicare-required assessment |
| 43 | Significant Correction of a Prior assessment REPLACES 60-Day Medicare-required assessment |
| 44 | Significant Correction of a Prior assessment REPLACES 90-Day Medicare-required assessment |
| 45 | Significant Correction of a Prior assessment REPLACES a readmission/return assessment. |
| 47 | Significant Correction of a Prior assessment REPLACES 14-Day Medicare-required assessment |
| 48 | OMRA replacing 90-Day Medicare required assessment. |
| 49 | Special payment situation – 90-Day assessment. |
| 54 | 90-Day Medicare assessment that is also a Quarterly assessment |
| 78 | OMRA replacing 14-Day Medicare-required assessment. |
| 79 | Special payment situation – 14-Day assessment |
| 00 | Default code |

## 6.5 SNF PPS Eligibility Criteria for SNFs

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized below.

### TECHNICAL ELIGIBILITY REQUIREMENTS

Technical eligibility remains the same, as outlined below, per the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1 (Pub. 100-1) and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2). The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay.
- Admission for SNF-level services is within thirty days of discharge from an acute care stay.

### CLINICAL ELIGIBILITY REQUIREMENTS

A beneficiary is eligible for SNF extended care if all the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition for which the resident:
  - -- was treated during the qualifying hospital stay, or
  - -- arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

### PHYSICIAN CERTIFICATION

The attending physician or a physician on the staff of the skilled nursing home who has knowledge of the case, or a nurse practitioner (NP) or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician, must certify and then periodically re-certify the need for extended care services in the skilled nursing home.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable. (42 CFR 424.20)
  - -- The initial certification certifies, per the existing context found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, **or**
  - -- Validates that the beneficiary's assignment to one of the upper RUG-III (Top 35) groups is correct through a statement indicating the assignment is correct.
- **Re-certifications** are used to document the continued need for skilled extended care services.
  - -- The first re-certification is required no later than the **14th** day.
  - -- Subsequent re-certifications are required no later than **30 days** after the prior re-certification.

## 6.6 RUG-III 53 Group Model Calculation Worksheet for SNFs

This RUG-III Version 5.20 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 53-group RUG-III Version 5.20 model. In the 53-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups representing 10 different levels of rehabilitation services. In the 53-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 53-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Function groups.

There are two basic approaches to RUG-III Classification: (1) hierarchical classification and (2) index maximizing classification. CMS has not developed an index maximization worksheet. The worksheet included at the end of this chapter was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below.

**Hierarchical Classification.** The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top and work down through the RUG-III model, and the classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-III model. Then you work your way down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. When you find the first of the 53 individual RUG-III groups for which the resident qualifies, then assign that group as the RUG-III Classification and you are finished.

If the resident qualifies in the Extensive Services group and a Special Care group, always choose the Extensive Services classification, since it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearest the top of the model.

**Index Maximizing Classification.** Index maximizing classification is used in Medicare PPS and most Medicaid payment systems. There is a designated Case Mix Index (CMI) for each RUG-III category. The first step in index maximizing is to determine all of the RUG-III groups for which the resident qualifies. Then from the qualifying groups you choose the RUG-III group that has the highest case mix index. The index maximizing method uses the case mix indices effective with RUG-III changes on January 1, 2006.

While the present worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. To index maximize, you would evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, you again start at the beginning of the worksheet. You then work down through all of the 53 RUG-III Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When you finish, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

# *CALCULATION OF TOTAL "ADL" SCORE*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

The ADL score is used in all determinations of a resident's placement in a RUG-III category. It is a very important component of the classification process.

### ► *STEP # 1*

To calculate the ADL score use the following chart for G1a (bed mobility), G1b (transfer), and G1i (toilet use). **Enter the ADL scores to the right.**

| ***Column A =*** | | ***Column B =*** | ***ADL score =*** | ***SCORE*** |
|---|---|---|---|---|
| -, 0 or 1 | **and** | (any number) | = 1 | G1a=____ |
| 2 | **and** | (any number) | = 3 | G1b=____ |
| 3, 4, or 8 | **and** | -, 0, 1 or 2 | = 4 | G1i= ____ |
| 3, 4, or 8 | **and** | 3 or 8 | = 5 | |

### ► *STEP # 2*

If K5a (parenteral/IV) is checked, the eating ADL score is 3. If K5b (feeding tube) is checked and EITHER (1) K6a is 51% or more calories OR (2) K6a is 26% to 50% calories and K6b is 501cc or more per day fluid enteral intake, then the eating ADL score is 3**. Enter the ADL eating score (G1h) below and total the ADL score. If not*, go to Step #3.***

### ► *STEP # 3*

If neither K5a nor K5b (with appropriate intake) are checked, evaluate the chart below for G1hA (eating self-performance). *Enter the score to the right* and total the ADL score. This is the RUG-III **TOTAL ADL SCORE.** (The total ADL score range possibilities are 4 through 18.)

| ***Column A (G1h) =*** | ***ADL score =*** | ***SCORE*** |
|---|---|---|
| -, 0 or 1 | = 1 | G1h =____ |
| 2 | = 2 | |
| 3, 4, or 8 | = 3 | |

**TOTAL RUG-III ADL SCORE** _____

*Other ADLs are also very important, but the researchers have determined that the late loss ADLs were more predictive of resource use. They determined that allowing for the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.*

# *CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES*

## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

You start the classification process beginning at the Rehabilitation Plus Extensive Services level. In order for a resident to qualify for this category, he/she must meet 3 requirements, which are 1) have an ADL score of 7 or more, 2) meet one of the criteria for the Extensive Services category, and 3) meet the criteria for one of the Rehabilitation categories.

### ► *STEP # 1*

Determine the resident's ADL score. **If the resident's ADL score is 7 or higher go to step 2.**

**If the ADL score is less than 7, *skip to Category II* now.**

### ► *STEP # 2*

Is the resident coded for receiving **one** or more of the following extensive services?

| | |
|---|---|
| K5a | Parenteral / IV |
| P1ac | IV Medication |
| P1ai | Suctioning |
| P1aj | Tracheostomy care |
| P1al | Ventilator or respirator |

**If the resident does not receive one of the above, *skip to Category II* now.**

### ► *STEP # 3*

Determine if the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the resident does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria**

In the last 7 days (section P1b [a,b,c]):

720 minutes or more (total) of therapy per week **AND**
At least two disciplines, 1 for at least 5 days, **AND**
2nd for at least 3 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RUX |
| 7 - 15 | RUL |

B. **Very High Intensity Criteria**

In the last 7 days (section P1b [a, b, c,]):

500 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RVX |
| 7 - 15 | RVL |

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days (section P1b [a, b, c]):

325 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section T1b, T1c, T1d and section P1b [a, b, c]):

Ordered Therapies, T1b is checked **AND**
In the last 7 days:
Received 65 or more minutes, P1b [a,b,c] **AND**
In the first 15 days from admission:
520 or more minutes expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 13 - 18 | RHX |
| 7 - 12 | RHL |

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days: (section P1b [a,b,c] )

150 minutes or more (total) of therapy per week **AND**
At least 5 days of any combination of the 3 disciplines

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply:** (section T1b, T1c, T1d):

Ordered Therapies, T1b is checked **AND**
In the first 15 days from admission:
240 or more minutes are expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 15 - 18 | RMX |
| 7 - 14 | RML |

E. **Low Intensity Criteria** (either (1) or (2) below may qualify):

(1) In the last 7 days (section P1b [a,b,c] and P3):

45 minutes or more (total) of therapy per week **AND**
At least 3 days of any combination of the 3 disciplines **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section P3 and section T1b, T1c, T1d):

Ordered therapies T1b is checked **AND**
In the first 15 days from admission:

75 or more minutes are expected, T1d **AND**
rehabilitation services expected on 5 or more days, T1c **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, P3.

***Nursing Rehabilitation Services***

| | |
|---|---|
| ***H3a,b*** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b*** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f*** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

***Count as one service even if both provided***

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 7 - 18 | RLX |

**RUG-III Classification** _____

**If the resident does not classify in the Rehabilitation Plus Extensive Services Category*, proceed to Category II*.**

# *CATEGORY II: REHABILITATION*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

Rehabilitation therapy is any combination of the disciplines of physical therapy, occupational therapy, or speech language pathology. This information is found in Section P1b. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in Section P3 and H3a,b of the MDS Version 2.0.

### ► *STEP # 1*

Determine if the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the resident does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria**

In the last 7 days (section P1b [a,b,c]):

720 minutes or more (total) of therapy per week **AND**
At least two disciplines, 1 for at least 5 days, **AND**
2nd for at least 3 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RUC |
| 9 - 15 | RUB |
| 4 - 8 | RUA |

B. **Very High Intensity Criteria**

In the last 7 days (section P1b [a, b, c,]):

500 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RVC |
| 9 - 15 | RVB |
| 4 - 8 | RVA |

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days (section P1b [a, b, c]):

325 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section T1b, T1c, T1d and section P1b [a, b, c]):

Ordered Therapies, T1b is checked **AND**
In the last 7 days:
Received 65 or more minutes, P1b [a,b,c] **AND**
In the first 15 days from admission:
520 or more minutes expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 13 - 18 | RHC |
| 8 - 12 | RHB |
| 4 - 7 | RHA |

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days: (section P1b [a,b,c] )

150 minutes or more (total) of therapy per week **AND**
At least 5 days of any combination of the 3 disciplines

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply:** (section T1b, T1c, T1d):

Ordered Therapies, T1b is checked **AND**
In the first 15 days from admission:
240 or more minutes are expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 15 - 18 | RMC |
| 8 - 14 | RMB |
| 4 - 7 | RMA |

E. **Low Intensity Criteria** (either (1) or (2) below may qualify):

(1) In the last 7 days (section P1b [a,b,c] and P3):

45 minutes or more (total) of therapy per week **AND**
At least 3 days of any combination of the 3 disciplines **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section P3 and section T1b, T1c, T1d):

Ordered therapies T1b is checked **AND**
In the first 15 days from admission:
75 or more minutes are expected, T1d **AND**
rehabilitation services expected on 5 or more days, T1c **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, P3.

***Nursing Rehabilitation Services***

| | |
|---|---|
| ***H3a,b*** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b*** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f*** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

***Count as one service even if both provided***

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 14 - 18 | RLB |
| 4 - 13 | RLA |

**RUG-III Classification** _____

**If the resident does not classify in the Rehabilitation Category, *proceed to Category III*.**

# *CATEGORY III: EXTENSIVE SERVICES*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

The classification groups in this hierarchy are based on various services provided. Use the following instructions to begin the calculation:

### ► *STEP # 1*
Is the resident coded for receiving **one** or more of the following extensive services?

| | |
|---|---|
| K5a | Parenteral / IV |
| P1ac | IV Medication |
| P1ai | Suctioning |
| P1aj | Tracheostomy care |
| P1al | Ventilator or respirator |

**If the resident does not receive one of the above, *skip to Category IV* now.**

### ► *STEP # 2*
If at least **one** of the above treatments is coded and the resident has a total RUG-III ADL score of 7 or more, he/she classifies as Extensive Services. ***Move to Step #3*. If the resident's ADL score is 6 or less, he/she classifies as Special Care (SSA*). Skip to Category IV, Step #5* now and record the classification as SSA.**

### ► *STEP # 3*
The resident classifies in the Extensive Services category. To complete the scoring, however, an extensive count will need to be determined. If K5a (Parenteral IV) is checked, add 1 to the extensive count below. If P1ac (IV Medication) is checked, add 1 to the extensive count below. To complete the extensive count, determine if the resident also meets the criteria for Special Care, Clinically Complex, and Impaired Cognition. The final split into either SE1, SE2, or SE3 will be completed after these criteria have been scored. ***Go to Category IV, Step #1* now.**

| | |
|---|---|
| K5a | Parenteral / IV |
| P1ac | IV Medication |

**Extensive Count** _____
***(Enter this count in Step #4 on Page 6-25.)***

# *CATEGORY IV: SPECIAL CARE*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

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

### ► *STEP # 1*

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

| | |
|---|---|
| I1s | Cerebral palsy, with ADL sum >=10 |
| I1w | Multiple sclerosis, with ADL sum >=10 |
| I1z | Quadriplegia, with ADL sum >=10 |
| J1h | Fever and **one** of the following; |
| | I2e Pneumonia |
| | J1c Dehydration |
| | J1o Vomiting |
| | K3a Weight loss |
| | K5b Tube feeding* |
| K5b, I1r | Tube feeding* and aphasia |
| M1a,b,c,d | Ulcers 2+ sites over all stages with 2 or more skin treatments** |
| M2a | Any stage 3 or 4 pressure ulcer with 2 or more skin treatments** |
| M4g,M4c | Surgical wounds or open lesions with 1 or more skin treatments*** |
| P1ah | Radiation treatment |
| P1bdA | Respiratory therapy =7 days |

****Tube feeding classification requirements:***

***(1) K6a is 51% or more calories OR***

***(2) K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake in the last 7 days.***

*****Skin treatments:***

| | |
|---|---|
| ***M5a, b#*** | ***Pressure relieving chair and/or bed*** |
| ***M5c*** | ***Turning/repositioning*** |
| ***M5d*** | ***Nutrition or hydration intervention*** |
| ***M5e*** | ***Ulcer care*** |
| ***M5g*** | ***Application of dressings (not to feet)*** |
| ***M5h*** | ***Application of ointments (not to feet)*** |

***#Count as one treatment even if both provided***

******Skin Treatments***

| | |
|---|---|
| ***M5f*** | ***Surgical wound care*** |
| ***M5g*** | ***Application of dressing (not to feet)*** |
| ***M5h*** | ***Application of ointments (not to feet)*** |

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

### ► *STEP # 2*

If at least one of the special care conditions above is met:

a. If the resident previously qualified for Extensive Services, proceed to Extensive Count Determination. ***Go to Step #3.*** **OR**
b. If the RUG-III ADL score is 7 or more, the resident classifies as Special Care. ***Go to Step #4.*** **OR**
c. If the RUG-III ADL score is 6 or less, the resident classifies as Clinically Complex. ***Skip to Category V, Step #4.***

### ► *STEP # 3 (Extensive Count Determination)*

If the resident previously met the criteria for the Extensive Services category and the evaluation of the Special Care category is done only to determine if the resident is an SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Category V, Step #1.***

**Extensive Count** _____
***(Enter this count in Step #4 on Page 6-25.)***

### ► *STEP # 4*

If at least one of the special care conditions above is coded and the RUG-III ADL score is 7 or more, **the resident classifies in the Special Care category. Select the Special Care classification below based on the ADL score and *record this classification in Step #5:***

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 17 - 18 | SSC |
| 15 - 16 | SSB |
| 7 - 14 | SSA |

### ► *STEP #5*

Record the appropriate Special Care classification:

**RUG-III CLASSIFICATION** _____

# *CATEGORY V: CLINICALLY COMPLEX*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

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

### ► *STEP # 1*

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

| | |
|---|---|
| B1 | Coma (B1=1) and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA= 4 or 8) |
| I1a,O3, P8 | Diabetes mellitus and injection 7 days and Physician order changes >= 2 days |
| I1v | Hemiplegia with ADL sum >=10 |
| I2e | Pneumonia |
| I2g | Septicemia |
| J1c | Dehydration |
| J1j | Internal bleeding |
| K5b | Tube feeding* |
| M4b | Burns |
| M6b,c,f | Infection of foot (M6b or M6c) with treatment in M6f |
| P1aa | Chemotherapy |
| P1ab | Dialysis |
| P1ag | Oxygen therapy |
| P1ak | Transfusions |
| P7, P8 | Number of Days in last 14, Physician Visit/order changes: Visits >= 1 day and changes >= 4 days **OR** Visits >= 2 days and changes >= 2 days |

***Tube feeding classification requirements***

***(1) K6a is 51% or more calories OR***

***(2) K6a is 26% to 50% calories and K6b is 501 cc or more per day fluid enteral intake in the last 7 days.***

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

### ► *STEP # 2*

If at least one of the clinically complex conditions above is met:

a. Extensive Count Determination. ***Go to Step #3*** **OR**

b. Clinically Complex classification. The resident classifies as Clinically Complex. ***Go to Step #4.***

### ► *STEP # 3 (Extensive Count Determination)*

If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Clinically Complex category is done only to determine if the resident is an SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Category VI Step #1***.

**Extensive Count** _____
***(Enter this count in Step #4 on Page 6-25.)***

### ► *STEP # 4*

Evaluate for Depression. Signs and symptoms of a depressed or sad mood are used as a third level split for the Clinically Complex category. Residents with a depressed or sad mood are identified by the presence of a combination of symptoms, as follows:

Count the number of indicators of depression. The resident is considered depressed if he/she has at least 3 of the following:

(Indicator exhibited in last 30 days and coded "1" or "2")

| | |
|---|---|
| E1a | Negative statements |
| E1b | Repetitive questions |
| E1c | Repetitive verbalization |
| E1d | Persistent anger with self and others |
| E1e | Self deprecation |
| E1f | Expressions of what appear to be unrealistic fears |
| E1g | Recurrent statements that something terrible is going to happen |
| E1h | Repetitive health complaints |
| E1i | Repetitive anxious complaints/concerns (Non-health related) |
| E1j | Unpleasant mood in morning |
| E1k | Insomnia/changes in usual sleep pattern |
| E1l | Sad, pained, worried facial expression |
| E1m | Crying, tearfulness |
| E1n | Repetitive physical movements |
| E1o | Withdrawal from activities of interest |
| E1p | Reduced social interaction |

Does the resident have 3 or more indicators of depression? **YES**_____ **NO**_____

### ► *STEP # 5*

Assign the Clinically Complex category based on both the ADL score and the presence or absence of depression.

| ***RUG-III ADL Score*** | ***Depressed*** | ***RUG-III Class*** |
|---|---|---|
| 17 - 18 | YES | CC2 |
| 17 - 18 | NO | CC1 |
| 12 - 16 | YES | CB2 |
| 12 - 16 | NO | CB1 |
| 4 - 11 | YES | CA2 |
| 4 - 11 | NO | CA1 |

**RUG-III CLASSIFICATION** _____

# *CATEGORY VI: IMPAIRED COGNITION*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

### ► *STEP # 1*

Determine if the resident is cognitively impaired according to the RUG-III Cognitive Performance Scale (CPS). The resident is cognitively impaired if **one** of the three following conditions exists:

| | | |
|---|---|---|
| (1) | B1 | Coma (B1=1) and not awake (N1a, b, c = 0) and completely ADL dependent (G1aA, G1bA, G1hA, G1iA = 4 or 8) |
| (2) | B4 | Severely impaired cognitive skills (B4 = 3) |
| (3) | B2a, B4, C4 | These three items (B2a, B4, and C4) are all assessed with none being blank or unknown (value N/A or "-") |

**AND**

Two or more of the following impairment indicators are present

| | |
|---|---|
| B2a = 1 | Short-term memory problem |
| B4 > 0 | Cognitive skills problem |
| C4 > 0 | Problem being understood |

**AND**

One or more of the following severe impairment indicators are present:

| | |
|---|---|
| B4 >= 2 | Severe cognitive skills problem |
| C4 >= 2 | Severe problem being understood |

**If the resident does not meet the criteria for cognitively impaired:**

a. and the evaluation is being done to determine if the resident is in SE1, SE2, or SE3, ***skip to Step #4*** **on Page 6-25 "Category III: Extensive Services (cont.)."**
**OR**

b. ***Skip to Category VII*** **now.**

### ► *STEP # 2*

If the resident meets the criteria for cognitive impairment:

a. Extensive Count Determination. ***Go to Step #3.*** **OR**

b. Impaired Cognition classification. The resident may classify as Impaired Cognition. ***Go to Step #4.***

### ► *STEP # 3 (Extensive Count Determination)*

If the resident previously met the criteria for the Extensive Services category, and the evaluation of the Impaired Cognition category is done to determine if the resident is in SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Step #4* on Page 6-25 "Category III: Extensive Services (cont.)."**

**Extensive Count** _____
***(Enter this count in Step #4 on Page 6-25.)***

### ► *STEP # 4*

The resident's total RUG-III ADL score must be 10 or less to be classified in the RUG-III Impaired Cognition category. **If the ADL score is greater than 10, *skip to Category VIII* now. If the ADL score is 10 or less and one of the impaired cognition conditions above is present, then the resident classifies as Impaired Cognition. *Proceed with Step #5.***

### ► *STEP # 5*

**Determine Nursing Rehabilitation Count**

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

***Enter the nursing rehabilitation count to the right.***

| | |
|---|---|
| ***H3a,b**** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b**** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f**** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

****Count as one service even if both provided***

**Nursing Rehabilitation Count** _____

### ► *STEP # 6*

Select the final RUG-III Classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

| ***RUG-III ADL Score*** | ***Nursing Rehabilitation*** | ***RUG-III Class*** |
|---|---|---|
| 6 - 10 | 2 or more | IB2 |
| 6 - 10 | 0 or 1 | IB1 |
| 4 - 5 | 2 or more | IA2 |
| 4 - 5 | 0 or 1 | IA1 |

**RUG-III CLASSIFICATION** _____

# *CATEGORY III: EXTENSIVE SERVICES (cont.)*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

If the resident previously met the criteria for the Extensive Services category with an ADL score of 7 or more, complete the Extensive Services classification here.

### ► *STEP # 4 (Extensive Count Determination)*

Complete the scoring of the Extensive Services by summing the extensive count items:

| | | |
|---|---|---|
| Page 6-17 | Extensive Count - Extensive Services | _____ |
| Page 6-19 | Extensive Count - Special Care | _____ |
| Page 6-21 | Extensive Count - Clinically Complex | _____ |
| Page 6-24 | Extensive Count - Impaired Cognition | _____ |
| | **Total Extensive Count** | _____ |

Select the final Extensive Service classification using the Total Extensive Count.

| ***Extensive Count*** | ***RUG-III Class*** |
|---|---|
| 4 or 5 | SE3 |
| 2 or 3 | SE2 |
| 0 or 1 | SE1 |

**RUG-III CLASSIFICATION** _____

# *CATEGORY VII: BEHAVIOR PROBLEMS*
## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

### ► *STEP # 1*
The resident's total RUG-III ADL score must be 10 or less. **If the score is greater than 10*, skip to Category VIII* now.**

### ► *STEP # 2*
**One** of the following must be met:

| | |
|---|---|
| E4aA | Wandering (2 or 3) |
| E4bA | Verbal abuse (2 or 3) |
| E4cA | Physical abuse (2 or 3) |
| E4dA | Inappropriate behavior (2 or 3) |
| E4eA | Resisted care (2 or 3) |
| J1e | Delusions |
| J1i | Hallucinations |

**If the resident does not meet one of the above, *skip to Category VIII* now.**

### ► *STEP # 3*
**Determine Nursing Rehabilitation**
Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

***Enter the nursing rehabilitation count to the right.***

| | |
|---|---|
| ***H3a,b**** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b**** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f**** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

****Count as one service even if both provided.***

**Nursing Rehabilitation Count _____**

### ► *STEP # 4*

Select the final RUG-III Classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

| ***RUG-III ADL Score*** | ***Nursing Rehabilitation*** | ***RUG-III Class*** |
|---|---|---|
| 6 - 10 | 2 or more | BB2 |
| 6 - 10 | 0 or 1 | BB1 |
| 4 - 5 | 2 or more | BA2 |
| 4 - 5 | 0 or 1 | BA1 |

**RUG-III CLASSIFICATION** _____

# *CATEGORY VIII: REDUCED PHYSICAL FUNCTION*

## *RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION*

### ► *STEP # 1*

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Impaired Cognition or Behavior Problems categories but have a RUG-III ADL score greater than 10, are placed in this category.

### ► *STEP # 2*

**Determine Nursing Rehabilitation**

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

***Enter the nursing rehabilitation count to the right.***

| | |
|---|---|
| ***H3a,b**** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b**** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f**** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

****Count as one service even if both provided***

**Nursing Rehabilitation Count** _____

### ► *STEP # 3*

Select the RUG-III Classification by using the RUG-III ADL score and the Nursing Rehabilitation Count.

| ***RUG-III ADL Score*** | ***Nursing Rehabilitation*** | ***RUG-III Class*** |
|---|---|---|
| 16 - 18 | 2 or more | PE2 |
| 16 - 18 | 0 or 1 | PE1 |
| 11 - 15 | 2 or more | PD2 |
| 11 - 15 | 0 or 1 | PD1 |
| 9 - 10 | 2 or more | PC2 |
| 9 - 10 | 0 or 1 | PC1 |
| 6 - 8 | 2 or more | PB2 |
| 6 - 8 | 0 or 1 | PB1 |
| 4 - 5 | 2 or more | PA2 |
| 4 - 5 | 0 or 1 | PA1 |

**RUG-III CLASSIFICATION** _____