Track Changes
from Chapter 3 Section J v1.13
to Chapter 3 Section J v1.14

Chapter	Section	Page	Change
3	J1800	J-30	**Steps for Assessment** 1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD. 2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3	J1900	J-31	**Planning for Care** • A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment. • It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.
3	J1900	J-31–J-34	Page length changed due to revised content.
3	J1900	J-32	**Steps for Assessment** 5. Ask the resident, staff, and family about falls during the look-back period. Resident and family reports of falls should be captured here, whether or not these incidents are documented in the medical record. 6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.
3	J1900	J-33	**Coding Tip** • If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

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Chapter	Section	Page	Change
3	J1900	J-34	4. A resident fell, lacerated his head, and head CT scan indicated a subdural hematoma. Coding: J1900C would be coded 1, one. Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall. 5. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment. Original Coding: J1900B, Injury (except major) was coded 1, one. Rationale: Mr. R. had a fall-related injury that caused him to complain of pain. Modification of Quarterly assessment: J1900B, Injury (except major) is coded 0, none and J1900C, Major Injury, is coded 1, one. Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.