Track Changes
from Chapter 3 Section J v1.15
to Chapter 3 Section J v1.16

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3	J0200	J-4–J-5	**Steps for Assessment** 1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item J1100, Shortness of Breath~~at least sometimes~~. ~~1~~3.Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter. • If the resident needs or wants an interpreter, complete the interview with an interpreter. • ~~If an interpreter is needed or requested, every effort should be made to have an interpreter present for the MDS clinical interview.~~
3	J0200	J-5	**Coding Tips and Special Populations** • Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. • If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300–J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No. • Do not complete the Staff Assessment for Pain items (J0800–J0850) if the resident interview should have been conducted, but was not done. • If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete **Staff Assessment of Pain** item (J0800), instead of the **Pain Interview** items (J0300-J0600). • There is one exception to completing the Staff Assessment for Pain items (J0800–J0850) in place of

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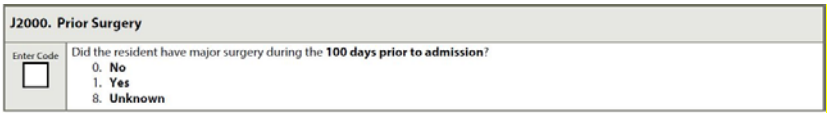
<tr><td></td><td></td><td></td><td>the resident interview. This exception is specific to a stand-alone, unscheduled Prospective Payment System (PPS) assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.
• When coding a stand-alone Change of Therapy OMRA (COT), a stand-alone End of Therapy OMRA (EOT), or a stand-alone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment only if the DATE of the interview responses from the previous assessment (as documented in item Z0400) was obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.</td></tr>
<tr><td>3</td><td>J0200–J2000</td><td>J-4–J-37</td><td>Page length changed due to revised content.</td></tr>
<tr><td>3</td><td>J2000</td><td>J-35–J-37</td><td>
<h2>J2000: Prior Surgery</h2>

J2000. Prior Surgery
Enter Code ☐ Did the resident have major surgery during the 100 days prior to admission?
0. No
1. Yes
8. Unknown
<h3>Item Rationale</h3>
<h4>Health-related Quality of Life</h4>
• A recent history of major surgery during the 100 days prior to admission can affect a resident’s recovery.
<h4>Planning for Care</h4>
• This item identifies whether the resident has had major surgery during the 100 days prior to admission. A recent history of major surgery can affect a resident’s recovery.
<h3>Steps for Assessment</h3>
1. Ask the resident and his or her family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the resident’s medical record to determine whether the resident had major surgery during the 100 days prior to admission.
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			Medical record sources include medical records received from facilities where the resident received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available. **Coding Instructions** • Code 0, No, if the resident did not have major surgery during the 100 days prior to admission. • Code 1, Yes, if the resident had major surgery during the 100 days prior to admission. • Code 8, Unknown, if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission. **Coding Tips** • Generally, major surgery for item J2000 refers to a procedure that meets *all* the following criteria: 1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), 2. the resident had general anesthesia during the procedure, *and* 3. the surgery carried some degree of risk to the resident's life or the potential for severe disability. **Examples** 1. Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure as an outpatient. Mrs. T reports no other surgeries in the last 100 days. Coding: J2000 would be coded 0, No. Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay, and general anesthesia was not administered; therefore, the skin tag removal does not meet all three required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days. 2. Mr. A's wife informs his nurse that six months ago he was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife

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			reports Mr. A has had no other surgeries since the time of his bowel resection. Coding: J2000 would be coded 0, No. Rationale: Bowel resection is a major surgery requiring general anesthesia and has some degree of risk for death or severe disability. Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time. 3. Mrs. G. was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy for which she received general anesthesia. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. She was transferred to the facility immediately following a 4-day acute care hospital stay. Coding: J2000 would be coded 1, Yes. Rationale: Mrs. G underwent a complicated cholecystectomy for which she required general anesthesia. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability. Mrs. G required a four-day hospitalization that occurred in the last 100 days.