The Long-Term Care Facility Resident Assessment Instrument User’s Manual for Version 3.0 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.

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 System SNF and Swing Bed information collection is 0938-1140 and forms have been approved through January 30, 2020. The times required to complete the information collection for the item sets are as follows:

<table>
<thead>
<tr>
<th>Item Set</th>
<th>Estimated response time</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP</td>
<td>51 minutes</td>
</tr>
<tr>
<td>NOD</td>
<td>39 minutes</td>
</tr>
<tr>
<td>NO/SO</td>
<td>26.52 minutes</td>
</tr>
<tr>
<td>NSD</td>
<td>34.17 minutes</td>
</tr>
<tr>
<td>NS/SS</td>
<td>14.03 minutes</td>
</tr>
</tbody>
</table>

These times are estimated per response, including completion, encoding, and transmission of the information collection.

If you have comments concerning the accuracy of the time estimates or suggestions for improving these forms, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.
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*Special Recognition for the development of the RAI Manual goes to Ellen Berry, PT and Stella Mandl, BSW, BSN, PHN, RN. Without their dedication, drive, and endless hours of work this manual would not have come to fruition.*

Application of the Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631). An adapted version of this LTCH measure was finalized for skilled nursing facilities in the Fiscal Year (FY) 2016 SNF PPS final rule for FY 2018 payment determination. Data collected for the SNF QRP is submitted through the QIES ASAP system as it currently is for other MDS assessments.

It is important to note that data collection for Section GG does not substitute for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for both Section GG and Section G.


The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.*
  - Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into QIES ASAP. Therefore, these assessments cannot be submitted to the QIES ASAP system.
  - Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to QIES ASAP.
    - For OBRA assessments, the assessment schedule is determined from the resident’s actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date.
B0700: Makes Self Understood (cont.)

Steps for Assessment

1. Assess using the resident’s preferred language or method of communication.
2. Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.
3. Observe his or her interactions with others in different settings and circumstances.
4. Consult with the primary nurse assistants (over all shifts) and the resident’s family and speech-language pathologist.

Coding Instructions

- **Code 0, understood**: if the resident expresses requests and ideas clearly.
- **Code 1, usually understood**: if the resident has difficulty communicating some words or finishing thoughts but is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood.
- **Code 2, sometimes understood**: if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
- **Code 3, rarely or never understood**: if, at best, the resident’s 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).

Coding Tips and Special Populations

- *This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents’ ability to make self understood during the entire 7-day look-back period.*

- *While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.*

B0800: Ability to Understand Others

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Understands verbal content, however able (with hearing aid or device if used)</td>
</tr>
<tr>
<td>1</td>
<td>Understands - clear comprehension</td>
</tr>
<tr>
<td>2</td>
<td>Sometimes understands - responds adequately to simple, direct communication only</td>
</tr>
<tr>
<td>3</td>
<td>Rarely/never understands</td>
</tr>
</tbody>
</table>
**B0800: Ability to Understand Others (cont.)**

**Item Rationale**

**Health-related Quality of Life**

- Inability to understand direct person-to-person communication
  - Can severely limit association with others.
  - Can inhibit the individual’s ability to follow instructions that can affect health and safety.

**Planning for Care**

- Thorough assessment to determine underlying cause or causes is critical in order to develop a care plan to address the individual’s specific deficits and needs.
- Every effort should be made by the facility to provide information to the resident in a consistent manner that he or she understands based on an individualized assessment.

**Steps for Assessment**

1. **Assess in the resident’s preferred language or preferred method of communication.**
2. **If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident’s understanding of person-to-person communication.**
3. **Interact with the resident and observe his or her understanding of other’s communication.**
4. **Consult with direct care staff over all shifts, if possible, the resident’s family, and speech-language pathologist (if involved in care).**
5. **Review the medical record for indications of how well the resident understands others.**

**Coding Instructions**

- **Code 0, understands:** if the resident clearly comprehends the message(s) and demonstrates comprehension by words or actions/behaviors.
- **Code 1, usually understands:** if the resident misses 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.
- **Code 2, sometimes understands:** if the resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or
B0800: Ability to Understand Others (cont.)

instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident’s comprehension is enhanced.

- **Code 3, rarely/never understands**: if the resident demonstrates very limited ability to understand communication. Or, if staff have 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.

B1000: Vision

<table>
<thead>
<tr>
<th>B1000. Vision</th>
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</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- A person’s reading vision often diminishes over time.
- If uncorrected, vision impairment can limit the enjoyment of everyday activities such as reading newspapers, books or correspondence, and maintaining and enjoying hobbies and other activities. It also limits the ability to manage personal business, such as reading and signing consent forms.
- Moderate, high or severe impairment can contribute to sensory deprivation, social isolation, and depressed mood.

**Planning for Care**

- Reversible causes of vision impairment should be sought.
- Consider whether simple environmental changes such as better lighting or magnifiers would improve ability to see.
- Consider large print reading materials for persons with impaired vision.
- For residents with moderate, high, or severe impairment, consider alternative ways of providing access to content of desired reading materials or hobbies.

**Steps for Assessment**

1. Ask direct care staff over all shifts if possible about the resident’s usual vision patterns during the 7-day look-back period (e.g., is the resident able to see newsprint, menus, greeting cards?).
2. Then ask the resident about his or her visual abilities.
3. Test the accuracy of your findings:
B1000: Vision (cont.)

- Ensure that the resident’s customary visual appliance for close vision is in place (e.g., eyeglasses, magnifying glass).
- Ensure adequate lighting.
- Ask the resident to look at regular-size print in a book or newspaper. 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.
- When the resident is unable to read out loud (e.g. due to aphasia, illiteracy), you should test this by another means such as, but not limited to:
  — Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper).

Coding Instructions

- **Code 0, adequate**: if the resident sees fine detail, including regular print in newspapers/books.
- **Code 1, impaired**: if the resident sees large print, but not regular print in newspapers/books.
- **Code 2, moderately impaired**: if the resident has limited vision and is not able to see newspaper headlines but can identify objects in his or her environment.
- **Code 3, highly impaired**: if 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).
- **Code 4, severely impaired**: if the resident has no vision, sees only light, colors or shapes, or does not appear to follow objects with eyes.

Coding Tips and Special Populations

- Some residents have never learned to read or are unable to read English. In such cases, ask the resident to read 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 of objects or people. These gross measures of visual acuity may assist you in assessing whether or not the resident has any visual ability. For residents who appear to do this, code 3, highly impaired.
B1200: Corrective Lenses

**Item Rationale**

**Health-related Quality of Life**
- Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.
- Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.
- Many persons who benefit from and own visual aids do not have them on arrival at the nursing home.

**Planning for Care**
- Knowing if corrective lenses were used when determining ability to see allows better identification of evaluation and management needs.
- Residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning.
- Residents who do not have adequate vision without eyeglasses or other visual appliances should be asked about history of corrective lens use.
- Residents who do not have adequate vision, despite using a visual appliance, might benefit from a re-evaluation of the appliance or assessment for new causes of vision impairment.

**Steps for Assessment**
1. Prior to beginning the assessment, ask the resident whether he or she uses eyeglasses or other vision aids and whether the eyeglasses or vision aids are at the nursing home. Visual aids do not include surgical lens implants.
2. If the resident cannot respond, check with family and care staff about the resident’s use of vision aids during the 7-day look-back period.
3. Observe whether the resident used eyeglasses or other vision aids during reading vision test (B1000).
4. Check the medical record for evidence that the resident used corrective lenses when ability to see was recorded.
5. Ask staff and significant others whether the resident was using corrective lenses when they observed the resident’s ability to see.
B1200: Corrective Lenses (cont.)

**Coding Instructions**

- **Code 0, no:** if the resident did not use eyeglasses or other vision aid during the B1000, Vision assessment.
- **Code 1, yes:** if corrective lenses or other visual aids were used when visual ability was assessed in completing B1000, Vision.
SECTION C: COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the resident’s attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

C0100: Should Brief Interview for Mental Status Be Conducted?

Item Rationale

Health-related Quality of Life

- Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis.
  - Structured interviews will efficiently provide insight into the resident’s current condition that will enhance good care.

Planning for Care

- Structured cognitive interviews assist in identifying needed supports.
- The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).

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 if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
C0100: Should Brief Interview for Mental Status Be Conducted? (cont.)

- **Code 1, yes**: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

**Coding Tips**

- **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 needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status.

- Includes residents who use American Sign Language (ASL).

- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.

- Do not complete the Staff Assessment for Mental Status items (C0700–C1000) if the resident interview should have been conducted, but was not done.

- There is one exception to completing the Staff Assessment for Mental Status items (C0700–C1000) in place of the resident interview. This exception is specific to a stand-alone, unscheduled 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) were 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.
### Brief Interview for Mental Status (BIMS)

#### C0200. Repetition of Three Words

| Enter Code |  |  |
|------------|-------------------------------|
|  | **Ask resident:** “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words.”  |
|  | **Number of words repeated after first attempt:**  |
|  | 0. None  |
|  | 1. One  |
|  | 2. Two  |
|  | 3. Three  |
|  | **After the resident’s first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.**  |

#### C0300. Temporal Orientation (orientation to year, month, and day)

| Enter Code |  |  |
|------------|-------------------------------|
|  | **Ask resident:** “Please tell me what year it is right now.”  |
| A. | **Able to report correct year:**  |
|  | 0. Missed by > 5 years or no answer  |
|  | 1. Missed by 2-5 years  |
|  | 2. Missed by 1 year  |
|  | 3. Correct  |
|  | **Ask resident:** “What month are we in right now?”  |
| B. | **Able to report correct month:**  |
|  | 0. Missed by > 1 month or no answer  |
|  | 1. Missed by 6 days to 1 month  |
|  | 2. Accurate within 5 days  |
|  | **Ask resident:** “What day of the week is today?”  |
| C. | **Able to report correct day of the week:**  |
|  | 0. Incorrect or no answer  |
|  | 1. Correct  |

#### C0400. Recall

| Enter Code |  |  |
|------------|-------------------------------|
|  | **Ask resident:** “Let’s go back to an earlier question. What were those three words that I asked you to repeat?” If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.  |
| A. | **Able to recall “sock”:**  |
|  | 0. No - could not recall  |
|  | 1. Yes, after cueing (“something to wear”)  |
|  | 2. Yes, no cue required  |
| B. | **Able to recall “blue”:**  |
|  | 0. No - could not recall  |
|  | 1. Yes, after cueing (“a color”)  |
|  | 2. Yes, no cue required  |
| C. | **Able to recall “bed”:**  |
|  | 0. No - could not recall  |
|  | 1. Yes, after cueing (“a piece of furniture”)  |
|  | 2. Yes, no cue required  |

#### C0500. BIMS Summary Score

| Enter Score |  |  |
|-------------|-------------------------------|
|  | **Add scores for questions C0200-C0400 and fill in total score (00-15)**  |
|  | **Enter 99 if the resident was unable to complete the interview**  |
C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

Item Rationale

**Health-related Quality of Life**

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact residents may appear to be cognitively impaired because of extreme frailty, hearing impairment or lack of interaction.
- Some residents may appear to be more cognitively intact than they actually are.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.
- A resident’s performance on cognitive tests can be compared over time.
  — If performance worsens, then an assessment for delirium and or depression should be considered.
- The BIMS is an opportunity to observe residents for signs and symptoms of delirium (C1310).

**Planning for Care**

- Assessment of a resident’s mental state provides a direct understanding of resident function that may:
  — enhance future communication and assistance and
  — direct nursing interventions to facilitate greater independence such as posting or providing reminders for self-care activities.
- A resident’s performance on cognitive tests can be compared over time.
  — An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life threatening illness.
  — A decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning.

**Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)**

1. Refer to Appendix D for a review of basic approaches to effective interviewing techniques.
2. Interview any resident not screened out by Should Brief Interview for Mental Status Be Conducted? (Item C0100).
3. Conduct the interview in a private setting.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

- Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
- Minimize background noise.

5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident’s face.

6. Give an introduction before starting the interview.

   Suggested language: “I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult.”

7. If the resident expresses concern that you are testing his or her memory, he or she may be more comfortable if you reply: “We ask these questions of everyone so we can make sure that our care will meet your needs.”

8. Directly ask the resident each item in C0200 through C0400 at one sitting and in the order provided.

9. If the resident chooses not to answer a particular item, accept his or her refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect.

Coding Instructions

See coding instructions for individual items.

Coding Tips

- On occasion, the interviewer may not be able to state the items clearly because of an accent or slurred speech. If the interviewer is unable to pronounce any cognitive items clearly, have a different staff member complete the BIMS.
- Nonsensical responses should be coded as zero.
- Rules for stopping the interview before it is complete:
  — Stop the interview after completing (C0300C) “Day of the Week” if:
    1. all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR
    2. there has been no verbal or written response to any of the questions up to this point, OR
    3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.
- If the interview is stopped, do the following:
  1. Code -, dash in C0400A, C0400B, and C0400C.
  2. Code 99 in the summary score in C0500.
  3. Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?
  4. Complete the Staff Assessment for Mental Status.
C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)

- When staff identify that the resident’s primary method of communication is in written format, the BIMS can be administered in writing. **The administration of the BIMS in writing should be limited to this circumstance.**
- See Appendix E for details regarding how to administer the BIMS in writing.

**Examples of Incorrect and Nonsensical Responses**

1. Interviewer asks resident to state the year. The resident replies that it is 1935. This answer is incorrect but related to the question.
   
   **Coding:** This answer is coded 0, incorrect but would NOT be considered a nonsensical response.
   
   **Rationale:** The answer is wrong, but it is logical and relates to the question.

2. Interviewer asks resident to state the year. The resident says, “Oh what difference does the year make when you’re as old as I am?” The interviewer asks the resident to try to name the year, and the resident shrugs.
   
   **Coding:** This answer is coded 0, incorrect but would NOT be considered a nonsensical response.
   
   **Rationale:** The answer is wrong because refusal is considered a wrong answer, but the resident’s comment is logical and clearly relates to the question.

3. Interviewer asks the resident to name the day of the week. Resident answers, “Sylvia, she’s my daughter.”
   
   **Coding:** The answer is coded 0, incorrect; the response is illogical and nonsensical.
   
   **Rationale:** The answer is wrong, and the resident’s comment clearly does not relate to the question; it is nonsensical.

**C0200: Repetition of Three Words**

### REPEAT THE THREE WORDS AFTER I HAVE SAID THEM. THE WORDS ARE: Sock, Blue, Bed.

After the resident’s first attempt, repeat the words using cues (“Sock, something to wear; blue, a color; bed, a piece of furniture”). You may repeat the words up to two more times.
C0200: Repetition of Three Words (cont.)

Item Rationale

Health-related Quality of Life

• Inability to repeat three words on first attempt may indicate:
  — a hearing impairment,
  — a language barrier, or
  — inattention that may be a sign of delirium.

Planning for Care

• A cue can assist learning.

• Cues may help residents with memory impairment who can store new information in their memory but who have trouble retrieving something that was stored (e.g., not able to remember someone’s name but can recall if given part of the first name).

• Staff can use cues when assisting residents with learning and recall in therapy, and in daily and restorative activities.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-3 and C-4. In addition, for repetition of three words:

1. Say to the resident: “I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed.” Interviewers need to use the words and related category cues as indicated. If the interview is being conducted with an interpreter present, the interpreter should use the equivalent words and similar, relevant prompts for category cues.

2. Immediately after presenting the three words, say to theresident: “Now please tell me the three words.”

3. After the resident’s first attempt to repeat the items:
   • If the resident correctly stated all three words, say, “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture” [category cues].
   
   Category cues serve as a hint that helps prompt residents’ recall ability. Putting words in context stimulates learning and fosters memory of the words that residents will be asked to recall in item C0400, even among residents able to repeat the words immediately.

   • If the resident recalled two or fewer words, say to the resident: “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.” If the resident still does not recall all three words correctly, you may repeat the words and category cues one more time.
C0200: Repetition of Three Words (cont.)

- If the resident does not repeat all three words after three attempts, re-assess ability to hear. If the resident can hear, move on to the next question. If he or she is unable to hear, attempt to maximize hearing (alter environment, use hearing amplifier) before proceeding.

**Coding Instructions**

*Record the maximum number of words that the resident correctly repeated on the first attempt. This will be any number between 0 and 3.*

- The words may be recalled in any order and in any context. For example, if the words are repeated back in a sentence, they would be counted as repeating the words.
- Do not score the number of repeated words on the second or third attempt. These attempts help with learning the item, but only the number correct on the first attempt go into the total score. Do not record the number of attempts that the resident needed to complete.
- **Code 0, none:** if the resident did not repeat any of the 3 words on the first attempt.
- **Code 1, one:** if the resident repeated only 1 of the 3 words on the first attempt.
- **Code 2, two:** if the resident repeated only 2 of the 3 words on the first attempt.
- **Code 3, three:** if the resident repeated all 3 words on the first attempt.

**Coding Tips**

- On occasion, the interviewer may not be able to state the words clearly because of an accent or slurred speech. If the interviewer is unable to pronounce any of the 3 words clearly, have a different staff member conduct the interview.

**Examples**

1. The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.” The resident replies, “Bed, sock, and blue.” The interviewer repeats the three words with category cues, by saying, “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture.”

   **Coding:** C0200 would be *coded 3, three* words correct.
   **Rationale:** The resident repeated all three items on the first attempt. The order of repetition does not affect the score.

2. The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.” The resident replies, “Sock, bed, black.” The interviewer repeats the three words plus the category cues, saying, “Let me say the three words again. They are sock, something to wear; blue, a color; and bed, a piece of furniture. Now tell me the three words.” The resident says, “Oh yes, that’s right, sock, blue, bed.”

   **Coding:** C0200 would be *coded 2, two* of three words correct.
   **Rationale:** The resident repeated two of the three items on the first attempt. Residents are scored based on the first attempt.
C0200: Repetition of Three Words (cont.)

3. The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.” The resident says, “Blue socks belong in the dresser.” The interviewer repeats the three words plus the category cues.

   **Coding:** C0200 would be coded 2, two of the three words correct.
   **Rationale:** The resident repeated two of the three items—blue and sock. The resident put the words into a sentence, resulting in the resident repeating two of the three words.

4. The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.” The resident replies, “What were those three words?” The interviewer repeats the three words plus the category cues.

   **Coding:** C0200 would be coded 0, none of the words correct.
   **Rationale:** The resident did not repeat any of the three words after the first time the interviewer said them.

C0300: Temporal Orientation (Orientation to Year, Month, and Day)

**Item Rationale**

**Health-related Quality of Life**

- A lack of temporal orientation may lead to decreased communication or participation in activities.
- Not being oriented may be frustrating or frightening.

**Planning for Care**

- If staff know that a resident has a problem with orientation, they can provide reorientation aids and verbal reminders that may reduce anxiety.

**DEFINITION**

**TEMPORAL ORIENTATION**

In general, the ability to place oneself in correct time. For the BIMS, it is the ability to indicate the correct date in current surroundings.
C0300: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

- Reorienting those who are disoriented or at risk of disorientation may be useful in treating symptoms of delirium.
- Residents who are not oriented may need further assessment for delirium, especially if this fluctuates or is recent in onset.

Steps for Assessment

Basic BIMS interview instructions are shown on pages C-3 and C-4.

1. Ask the resident each of the 3 questions in Item C0300 separately.
2. Allow the resident up to 30 seconds for each answer and do not provide clues.
3. If the resident specifically asks for clues (e.g., “is it bingo day?”) respond by saying, “I need to know if you can answer this question without any help from me.”

Coding Instructions for C0300A, Able to Report Correct Year

- **Code 0, missed by >5 years or no answer:** if the resident’s answer is incorrect and is greater than 5 years from the current year or the resident chooses not to answer the item.
- **Code 1, missed by 2-5 years:** if the resident’s answer is incorrect and is within 2 to 5 years from the current year.
- **Code 2, missed by 1 year:** if the resident’s answer is incorrect and is within one year from the current year.
- **Code 3, correct:** if the resident states the correct year.

Examples

1. The date of interview is May 5, 2011. The resident, responding to the statement, “Please tell me what year it is right now,” states that it is 2011.
   - **Coding:** C0300A would be coded 3, correct.
   - **Rationale:** 2011 is the current year.

2. The date of interview is June 16, 2011. The resident, responding to the statement, “Please tell me what year it is right now,” states that it is 2007.
   - **Coding:** C0300A would be coded 1, missed by 2-5 years.
   - **Rationale:** 2007 is within 2 to 5 years of 2011.

3. The date of interview is January 10, 2011. The resident, responding to the statement, “Please tell me what year it is right now,” states that it is 1911.
   - **Coding:** C0300A would be coded 0, missed by more than 5 years.
   - **Rationale:** Even though the ’11 part of the year would be correct, 1911 is more than 5 years from 2011.
C03000: Temporal Orientation (Orientation to Year, Month, and Day) (cont.)

4. The date of interview is April 1, 2011. The resident, responding to the statement, “Please tell me what year it is right now,” states that it is “’11”. The interviewer asks, “Can you tell me the full year?” The resident still responds “’11,” and the interviewer asks again, “Can you tell me the full year, for example, nineteen-eighty-two.” The resident states, “2011.”

**Coding:** C0300A would be **coded 3, correct.**

**Rationale:** Even though ’11 is partially correct, the only correct answer is the exact year. The resident must state “2011,” not “’11” or “1811” or “1911.”

**Coding Instructions for C0300B, Able to Report Correct Month**

*Count the current day as day 1 when determining whether the response was accurate within 5 days or missed by 6 days to 1 month.*

- **Code 0, missed by >1 month or no answer:** if the resident’s answer is incorrect by more than 1 month or if the resident chooses not to answer the item.

- **Code 1, missed by 6 days to 1 month:** if the resident’s answer is accurate within 6 days to 1 month.

- **Code 2, accurate within 5 days:** if the resident’s answer is accurate within 5 days, count current date as day 1.

**Coding Tips**

- In most instances, it will be immediately obvious which code to select. In some cases, you may need to write the resident’s response in the margin and go back later to count days if you are unsure whether the date given is within 5 days.

**Examples**

1. The date of interview is June 25, 2011. The resident, responding to the question, “What month are we in right now?” states that it is June.

   **Coding:** C0300B would be **coded 2, accurate within 5 days.**

   **Rationale:** The resident correctly stated the month.

2. The date of interview is June 28, 2011. The resident, responding to the question, “What month are we in right now?” states that it is July.

   **Coding:** C0300B would be **coded 2, accurate within 5 days.**

   **Rationale:** The resident correctly stated the month within 5 days, even though the correct month is June. June 28th (day 1) + 4 more days is July 2nd, so July is within 5 days of the interview.
3. The date of interview is June 25, 2011. The resident, responding to the question, “What month are we in right now?” states that it is July.
   
   **Coding:** C0300B would be **coded 1, missed by 6 days to 1 month.**
   
   **Rationale:** The resident missed the correct month by six days. June 25th (day 1) + 5 more days = June 30th. Therefore, the resident’s answer is incorrect within 6 days to 1 month.

4. The date of interview is June 30, 2011. The resident, responding to the question, “What month are we in right now?” states that it is August.

   **Coding:** C0300B would be **coded 0, missed by more than 1 month.**
   
   **Rationale:** The resident missed the month by more than 1 month.

5. The date of interview is June 2, 2011. The resident, responding to the question, “What month are we in right now?” states that it is May.

   **Coding:** C0300B would be **coded 2, accurate within 5 days.**
   
   **Rationale:** June 2 minus 5 days = May 29th. The resident correctly stated the month within 5 days even though the current month is June.

**Coding Instructions for C0300C. Able to Report Correct Day of the Week**

- **Code 0, incorrect, or no answer:** if the answer is incorrect or the resident chooses not to answer the item.
- **Code 1, correct:** if the answer is correct.

**Examples**

1. The day of interview is Monday, June 25, 2011. The interviewer asks: “What day of the week is it today?” The resident responds, “It’s Monday.”

   **Coding:** C0300C would be **coded 1, correct.**
   
   **Rationale:** The resident correctly stated the day of the week.

2. The day of interview is Monday, June 25, 2011. The resident, responding to the question, “What day of the week is it today?” states, “Tuesday.”

   **Coding:** C0300C would be **coded 0, incorrect.**
   
   **Rationale:** The resident incorrectly stated the day of the week.

3. The day of interview is Monday, June 25, 2011. The resident, responding to the question, “What day of the week is it today?” states, “Today is a good day.”

   **Coding:** C0300C would be **coded 0, incorrect.**
   
   **Rationale:** The resident did not answer the question correctly.
C0400: Recall

**Item Rationale**

**Health-related Quality of Life**

- Many persons with cognitive impairment can be helped to recall if provided cues.
- Providing memory cues can help maximize individual function and decrease frustration for those residents who respond.

**Planning for Care**

- Care plans should maximize use of cueing for resident who respond to recall cues. This will enhance independence.

**Steps for Assessment**

*Basic BIMS interview instructions are shown on pages C-3 and C-4.*

1. Ask the resident the following: “Let’s go back to an earlier question. What were those three words that I asked you to repeat?”
2. Allow up to 5 seconds for spontaneous recall of each word.
3. For any word that is not correctly recalled after 5 seconds, provide a category cue (refer to “Steps for Assessment,” pages C-6–C-7 for the definition of category cue). Category cues should be used only after the resident is unable to recall one or more of the three words.
4. Allow up to 5 seconds after category cueing for each missed word to be recalled.

**Coding Instructions**

*For each of the three words the resident is asked to remember:*

- **Code 0, no—could not recall:** if the resident cannot recall the word even after being given the category cue or if the resident responds with a nonsensical answer or chooses not to answer the item.
- **Code 1, yes, after cueing:** if the resident requires the category cue to remember the word.
- **Code 2, yes, no cue required:** if the resident correctly remembers the word spontaneously without cueing.
C0400: Recall (cont.)

Coding Tips

• If on the first try (without cueing), the resident names multiple items in a category, one of which is correct, they should be coded as correct for that item.
• If, however, the interviewer gives the resident the cue and the resident then names multiple items in that category, the item is coded as could not recall, even if the correct item was in the list.

Examples

1. The resident is asked to recall the three words that were initially presented. The resident chooses not to answer the question and states, “I’m tired, and I don’t want to do this anymore.”

   Coding: C0400A-C0400C would be **coded 0, no—could not recall**, could not recall for each of the three words.

   Rationale: Choosing not to answer a question often indicates an inability to answer the question, so refusals are **coded 0, no—could not recall**. This is the most accurate way to score cognitive function, even though, on occasion, residents might choose not to answer for other reasons.

2. The resident is asked to recall the three words. The resident replies, “Socks, shoes, and bed.” The examiner then cues, “One word was a color.” The resident says, “Oh, the shoes were blue.”

   Coding: C0400A, sock, would be **coded 2, yes, no cue required**.

   Rationale: The resident’s initial response to the question included “sock.” He is given credit for this response, even though he also listed another item in that category (shoes), because he was answering the initial question, without cueing.

   Coding: C0400B, blue, would be **coded 1, yes, after cueing**.

   Rationale: The resident did not recall spontaneously, but did recall after the category cue was given. Responses that include the word in a sentence are acceptable.

   Coding: C0400C, bed, would be **coded 2, yes, no cue required**.

   Rationale: The resident independently recalled the item on the first attempt.

3. The resident is asked to recall the three words. The resident answers, “I don’t remember.” The assessor then says, “One word was something to wear.” The resident says, “Clothes.” The assessor then says, “OK, one word was a color.” The resident says, “Blue.” The assessor then says, “OK, the last word was a piece of furniture.” The resident says, “Couch.”

   Coding: C0400A, sock, would be **coded 0, no—could not recall**.

   Rationale: The resident did not recall the item, even with a cue.

   Coding: C0400B, blue, would be **coded 1, yes, after cueing**.

   Rationale: The resident did recall after being given the cue.

   Coding: C0400C, bed, would be **coded 0, no—could not recall**.

   Rationale: The resident did not recall the item, even with a cue.
C0400: Recall (cont.)

4. The resident is asked to recall the three words. The resident says, “I don’t remember.” The assessor then says, “One word was something to wear.” The resident says, “Hat, shirt, pants, socks, shoe, belt.”

**Coding:** C0400A, sock, would be coded 0, no—could not recall.

**Rationale:** After getting the category cue, the resident named more than one item (i.e., a laundry list of items) in the category. The resident’s response is coded as incorrect, even though one of the items was correct, because the resident did not demonstrate recall and likely named the item by chance.

C0500: BIMS Summary Score

**Item Rationale**

**Health-related Quality of Life**

- The total score:
  - Allows comparison with future and past performance.
  - Decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
  - Provides staff with a more reliable estimate of resident function and allows staff interactions with residents that are based on more accurate impressions about resident ability.

**Planning for Care**

- The BIMS is a brief screener that aids in detecting cognitive impairment. It does not assess all possible aspects of cognitive impairment. A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance. The final determination of the level of impairment should be made by the resident’s physician or mental health care specialist; however, these practitioners can be provided specific BIMS results and the following guidance:

  The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:

  - 13-15: cognitively intact
  - 8-12: moderately impaired
  - 0-7: severe impairment
C0500: BIMS Summary Score (cont.)

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life threatening illness and a change in cognition may be the only indication of an underlying problem.

- Care plans can be more individualized based upon reliable knowledge of resident function.

Steps for Assessment

*After completing C0200-C0400:*

1. Add up the values for all questions from C0200 through C0400.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.

Coding Instructions

*Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.*

- If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed.

- To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-4 for residents who choose not to participate at all.

  - **Code 99, unable to complete interview:** if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash.

    — Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

Coding Tips

- Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, BIMS Summary Score, and complete the staff assessment of mental status.
C0500: BIMS Summary Score (cont.)

Example

1. The resident’s scores on items C0200-C0400 were as follows:
   - C0200 (repetition) 3
   - C0300A (year) 2
   - C0300B (month) 2
   - C0300C (day) 1
   - C0400A (recall “sock”) 2
   - C0400B (recall “blue”) 2
   - C0400C (recall “bed”) 0

   **Coding:** C0500 would be coded 12.

C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted?

### Item Rationale

**Health-related Quality of Life**

- Direct or performance-based testing of cognitive function using the BIMS is preferred as it decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium. However, a minority of residents are unable or unwilling to participate in the BIMS.
- Mental status can vary among persons unable to communicate or who do not complete the interview.
  - Therefore, report of observed behavior is needed for persons unable to complete the BIMS interview.
  - When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, activities, and therapies may not be offered.

**Planning for Care**

- Abrupt changes in cognitive status (as indicative of delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
  - This remains true for persons who are unable to communicate or to complete the BIMS.
- Specific aspects of cognitive impairment, when identified, can direct nursing interventions to facilitate greater independence and function.
C0600: Should the Staff Assessment for Mental Status (C0700-C1000) Be Conducted? (cont.)

Steps for Assessment

1. Review whether BIMS Summary Score item (C0500), is coded 99, unable to complete interview.

Coding Instructions

- **Code 0, no:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.
- **Code 1, yes:** if the resident chooses not to participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be coded 99.

Coding Tips

- If a resident is scored 00 on C0500, C0700-C1000, Staff Assessment, should not be completed. 00 is a legitimate value for C0500 and indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items.

C0700-C1000: Staff Assessment of Mental Status Item

<table>
<thead>
<tr>
<th>Staff Assessment for Mental Status</th>
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<tbody>
<tr>
<td>Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed</td>
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<table>
<thead>
<tr>
<th>C0700. Short-term Memory OK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Seeks or appears to recall after 5 minutes</td>
</tr>
<tr>
<td>0. Memory OK</td>
</tr>
<tr>
<td>1. Memory problem</td>
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</tbody>
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<tr>
<th>C0800. Long-term Memory OK</th>
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<tbody>
<tr>
<td>Enter Code</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Seeks or appears to recall long past</td>
</tr>
<tr>
<td>0. Memory OK</td>
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<tr>
<td>1. Memory problem</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C0900. Memory/Recall Ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that the resident was normally able to recall</td>
</tr>
<tr>
<td>A. Current season</td>
</tr>
<tr>
<td>B. Location of own room</td>
</tr>
<tr>
<td>C. Staff names and faces</td>
</tr>
<tr>
<td>D. That he or she is in a nursing home/hospital swing bed</td>
</tr>
<tr>
<td>Z. None of the above were recalled</td>
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<tr>
<th>C1000. Cognitive Skills for Daily Decision Making</th>
</tr>
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<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Made decisions regarding tasks of daily life</td>
</tr>
<tr>
<td>0. Independent - decisions consistent/reasonable</td>
</tr>
<tr>
<td>1. Modified independence - some difficulty in new situations only</td>
</tr>
<tr>
<td>2. Moderately impaired - decisions poor; cues/ supervision required</td>
</tr>
<tr>
<td>3. Severely impaired - never/rarely made decisions</td>
</tr>
</tbody>
</table>
C0700-C1000: Staff Assessment of Mental Status Item (cont.)

**Item Rationale**

**Health-related Quality of Life**

- Cognitive impairment is prevalent among some groups of residents, but not all residents are cognitively impaired.
- Many persons with memory problems can function successfully in a structured, routine environment.
- Residents may appear to be cognitively impaired because of communication challenges or lack of interaction but may be cognitively intact.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities, and therapies may not be offered.

**Planning for Care**

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life-threatening illness and a change in cognition may be the only indication of an underlying problem.
- The level and specific areas of impairment affect daily function and care needs. By identifying specific aspects of cognitive impairment, nursing interventions can be directed toward facilitating greater function.
- Probing beyond first, perhaps mistaken, impressions is critical to accurate assessment and appropriate care planning.

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**C0700: Short-term Memory OK**

**Item Rationale**

**Health-related Quality of Life**

- To assess the mental state of residents who cannot be interviewed, an intact 5-minute recall (“short-term memory OK”) indicates greater likelihood of normal cognition.
- An observed “memory problem” should be taken into consideration in Planning for Care.

**Planning for Care**

- Identified memory problems typically indicate the need for:
C0700: Short-term Memory OK (cont.)

— Assessment and treatment of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect, or
— possible evaluation for other problems with thinking
— additional nursing support
— at times frequent prompting during daily activities
— additional support during recreational activities.

Steps for Assessment

1. Determine the resident’s short-term memory status by asking him or her:
   - to describe an event 5 minutes after it occurred if you can validate the resident’s response, or
   - to follow through on a direction given 5 minutes earlier.

2. Observe how often the resident has to be re-oriented to an activity or instructions.
3. Staff members also should observe the resident’s cognitive function in varied daily activities.
4. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
5. Ask direct care staff across all shifts and family or significant others about the resident’s short-term memory status.
6. Review the medical record for clues to the resident’s short-term memory during the look-back period.

Coding Instructions

Based on all information collected regarding the resident’s short-term memory during the 7-day look-back period, identify and code according to the most representative level of function.

- Code 0, memory OK: if the resident recalled information after 5 minutes.
- Code 1, memory problem: if the most representative level of function shows the absence of recall after 5 minutes.

Coding Tips

- If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff members were unable to make a determination based on observing the resident, use the standard “no information” code (a dash, “-”) to indicate that the information is not available because it could not be assessed.
C0700: Short-term Memory OK (cont.)

Example

1. A resident has just returned from the activities room where she and other residents were playing bingo. You ask her if she enjoyed herself playing bingo, but she returns a blank stare. When you ask her if she was just playing bingo, she says, “no.” **Code 1, memory problem.**

   **Coding:** C0700, would be coded 1, memory problem.
   
   **Rationale:** The resident could not recall an event that took place within the past 5 minutes.

C0800: Long-term Memory OK

**Item Rationale**

**Health-related Quality of Life**

- An observed “long-term memory problem” may indicate the need for emotional support, reminders, and reassurance. It may also indicate delirium if this represents a change from the resident’s baseline.

- An observed “long-term memory problem” should be taken into consideration in Planning for Care.

**Planning for Care**

- Long-term memory problems indicate the need for:
  - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect, or
  - possible evaluation for other problems with thinking
  - additional nursing support
  - at times frequent prompting during daily activities
  - additional support during recreational activities.

**Steps for Assessment**

1. Determine resident’s long-term memory status by engaging in conversation, reviewing memorabilia (photographs, memory books, keepsakes, videos, or other recordings that are meaningful to the resident) with the resident or observing response to family who visit.

2. Ask questions for which you can validate the answers from review of the medical record, general knowledge, the resident’s family, etc.

   - Ask the resident, “Are you married?” “What is your spouse’s name?” “Do you have any children?” “How many?” “When is your birthday?”
C0800: Long-term Memory OK (cont.)

3. Observe if the resident responds to memorabilia or family members who visit.
4. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
5. Ask direct care staff across all shifts and family or significant others about the resident’s memory status.
6. Review the medical record for clues to the resident’s long-term memory during the look-back period.

Coding Instructions

- **Code 0, memory OK:** if the resident accurately recalled long past information.
- **Code 1, memory problem:** if the resident did not recall long past information or did not recall it correctly.

Coding Tips

- If the test cannot be conducted (resident will not cooperate, is non-responsive, etc.) and staff were unable to make a determination based on observation of the resident, use the standard “no information” code (a dash, “-”), to indicate that the information is not available because it could not be assessed.

C0900: Memory/Recall Ability

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Item Rationale

**Health-related Quality of Life**

- An observed “memory/recall problem” with these items may indicate:
  - cognitive impairment and the need for additional support with reminders to support increased independence; or
  - delirium, if this represents a change from the resident’s baseline.

**Planning for Care**

- An observed “memory/recall problem” with these items may indicate the need for:
  - Exclusion of an underlying related medical problem (particularly if this is a new observation) or adverse medication effect; or
  - possible evaluation for other problems with thinking;
  - additional signs, directions, pictures, verbal reminders to support the resident’s independence;
C0900: Memory/Recall Ability (cont.)

— an evaluation for acute delirium if this represents a change over the past few days to weeks;
— an evaluation for chronic delirium if this represents a change over the past several weeks to months; or
— additional nursing support;
— the need for emotional support, reminders and reassurance to reduce anxiety and agitation.

Steps for Assessment

1. Ask the resident about each item. For example, “What is the current season? Is it fall, winter, spring, or summer?” “What is the name of this 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.
2. For residents with limited communication skills, in order to determine the most representative level of function, ask direct care staff across all shifts and family or significant other about recall ability.
   • Ask whether the resident gave indications of recalling these subjects or recognizing them during the look-back period.
3. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
4. Review the medical record for indications of the resident’s recall of these subjects during the look-back period.

Coding Instructions

For each item that the resident recalls, check the corresponding answer box. If the resident recalls none, check none of above.

- **Check C0900A, current season:** if resident is able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
- **Check C0900B, location of own room:** if resident is 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.
- **Check C0900C, staff names and faces:** if resident is 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.
- **Check C0900D, that he or she is in a nursing home/hospital swing bed:** if resident is able to determine that he or she is currently living in a nursing home. To check this item, it is not necessary that the resident be able to state the name of the nursing home, but he or she should be able to refer to the nursing home by a term such as a “home for older people,” a “hospital for the elderly,” “a place where people who need extra help live,” etc.
- **Check C0900Z, none of above was recalled.**
C1000: Cognitive Skills for Daily Decision Making

Item Rationale

**Health-related Quality of Life**

- An observed “difficulty with daily decision making” may indicate:
  - underlying cognitive impairment and the need for additional coaching and support or
  - possible anxiety or depression.

**Planning for Care**

- An observed “difficulty with daily decision making” may indicate the need for:
  - a more structured plan for daily activities and support in decisions about daily activities,
  - encouragement to participate in structured activities, or
  - an assessment for underlying delirium and medical evaluation.

**Steps for Assessment**

1. Review the medical record. Consult family and direct care staff across all shifts. Observe the resident.
2. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
3. The intent of this item is to record what the resident is doing (performance). 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.
4. Focus on the resident’s actual 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 coded as impaired performance in decision making.

**DEFINITION**

**DAILY DECISION MAKING**

Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); 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 to regulate the day’s events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.
C1000: Cognitive Skills for Daily Decision Making (cont.)

Coding Instructions

Record the resident’s actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.

- **Code 0, independent:** if the resident’s decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values.
- **Code 1, modified independence:** if 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.
- **Code 2, moderately impaired:** if the resident’s decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- **Code 3, severely impaired:** if the resident’s decision making was severely impaired; the resident never (or rarely) made decisions.

Coding Tips

- If the resident “rarely or never” made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be **coded 3, severely impaired.** If the resident makes decisions, although poorly, **code 2, moderately impaired**.
- A resident’s considered decision to exercise his or her right to decline treatment or recommendations by interdisciplinary team members should **not** be captured as impaired decision making in Item C1000, **Cognitive Skills for Daily Decision Making**.

Examples

1. Mr. B. seems to have severe cognitive impairment and is non-verbal. He usually clamps his mouth shut when offered a bite of food.
2. Mrs. C. does not generally make conversation or make her needs known, but replies “yes” when asked if she would like to take a nap.

**Coding:** For the above examples, Item C1000 would be **coded 3, severe impairment.**

**Rationale:** In both examples, the residents are primarily non-verbal and do not make their needs known, but they do give basic verbal or non-verbal responses to simple gestures or questions regarding care routines. More information about how the residents function in the environment is needed to definitively answer the questions. From the limited information provided it appears that their communication of choices is limited to very particular circumstances, which would be regarded as “rarely/never” in the relative number of decisions a person could make during the course of a week on the MDS. If such decisions are more frequent or involved more activities, the resident may be only moderately impaired or better.
C1000: Cognitive Skills for Daily Decision Making (cont.)

3. A resident makes her own decisions throughout the day and is consistent and reasonable in her decision-making except that she constantly walks away from the walker she has been using for nearly 2 years. Asked why she doesn’t use her walker, she replies, “I don’t like it. It gets in my way, and I don’t want to use it even though I know all of you think I should.”

   **Coding:** C1000 would be **coded 0, independent.**
   **Rationale:** This resident is making and expressing understanding of her own decisions, and her decision is to decline the recommended course of action – using the walker. Other decisions she made throughout the look-back period were consistent and reasonable.

4. A resident routinely participates in coffee hour on Wednesday mornings, and often does not need a reminder. Due to renovations, however, the meeting place was moved to another location in the facility. The resident was informed of this change and was accompanied to the new location by the activities director. Staff noticed that the resident was uncharacteristically agitated and unwilling to engage with other residents or the staff. She eventually left and was found sitting in the original coffee hour room. Asked why she came back to this location, she responded, “the aide brought me to the wrong room, I’ll wait here until they serve the coffee.”

   **Coding:** C1000 would be **coded 1, modified independent.**
   **Rationale:** The resident is independent under routine circumstances. However, when the situation was new or different, she had difficulty adjusting.

5. Mr. G. enjoys congregate meals in the dining and is friendly with the other residents at his table. Recently, he has started to lose weight. He appears to have little appetite, rarely eats without reminders and willingly gives his food to other residents at the table. Mr. G. requires frequent cueing from staff to eat and supervision to prevent him from sharing his food.

   **Coding:** C1000 would be **coded 2, moderately impaired.**
   **Rationale:** The resident is making poor decisions by giving his food away. He requires cueing to eat and supervision to be sure that he is eating the food on his plate.
C1310: Signs and Symptoms of Delirium

Item Rationale

**Health-related Quality of Life**

- Delirium is associated with:
  - increased mortality,
  - functional decline,
  - development or worsening of incontinence,
  - behavior problems,
  - withdrawal from activities
  - rehospitalizations and increased length of nursing home stay.
- Delirium can be misdiagnosed as dementia.
- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.

**Planning for Care**

- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection is essential in order to identify and treat or eliminate the cause.
C1310: Signs and Symptoms of Delirium (cont.)

Steps for Assessment

1. Observe resident behavior during the BIMS items (C0200-C0400) for the signs and symptoms of delirium. Some experts suggest that increasing the frequency of assessment (as often as daily for new admissions) will improve the level of detection.

2. If the Staff Assessment for Mental Status items (C0700-C1000) was completed instead of the BIMS, ask staff members who conducted the interview about their observations of signs and symptoms of delirium.

3. Review medical record documentation during the 7-day look-back period to determine the resident’s baseline status, fluctuations in behavior, and behaviors that might have occurred during the 7-day look-back period that were not observed during the BIMS.

4. Interview staff, family members and others in a position to observe the resident’s behavior during the 7-day look-back period.

For additional guidance on the signs and symptoms of delirium can be found in Appendix C.

Coding Instructions for C1310A, Acute Mental Status Change

- **Code 0, no:** if there is no evidence of acute mental status change from the resident’s baseline.

- **Code 1, yes:** if resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline.

Coding Tips

- Interview resident’s family or significant others.

- Review medical record prior to 7-day look-back to determine the resident’s usual mental status.

Examples

1. Resident was admitted to the nursing home 4 days ago. Her family reports that she was alert and oriented prior to admission. During the BIMS interview, she is lethargic and incoherent.

   **Coding:** Item C1310A would be **coded 1, yes.**

   **Rationale:** There is an acute change of the resident’s behavior from alert and oriented (family report) to lethargic and incoherent during interview.

2. Nurse reports that a resident with poor short-term memory and disorientation to time suddenly becomes agitated, calling out to her dead husband, tearing off her clothes, and being completely disoriented to time, person, and place.

   **Coding:** Item C1310A would be **coded 1, yes.**

   **Rationale:** The new behaviors represent an acute change in mental status.

**DEFINITION**

**DELIRIUM**

A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.
C1310: Signs and Symptoms of Delirium (cont.)

Other Examples of Acute Mental Status Changes

- A resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
- A resident who is normally quiet and content suddenly becomes restless or noisy.
- A resident who is usually able to find his or her way around the unit begins to get lost.

Steps for Assessment for C1310B, Inattention

1. Assess attention separately from level of consciousness. Evidence of inattention may be found during the resident interview, in the medical record, or from family or staff reports of inattention during the 7-day look-back period.
2. An additional step to identify difficulty with attention is to ask the resident to count backwards from 20.

Coding Instructions for C1310B, Inattention

- **Code 0, behavior not present:** if the resident remains focused during the interview and all other sources agree that the resident was attentive during other activities.
- **Code 1, behavior continuously present, did not fluctuate:** if the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention did not vary during the look-back period. All sources must agree that inattention was consistently present to select this code.
- **Code 2, behavior present, fluctuates:** if inattention is noted during the interview or any source reports that the resident had difficulty focusing attention, was easily distracted, or had difficulty keeping track of what was said AND the inattention varied during interview or during the look-back period or if information sources disagree in assessing level of attention.

**DEFINITIONS**

**INATTENTION**
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

**FLUCTUATION**
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look-back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.
C1310: Signs and Symptoms of Delirium (cont.)

Examples

1. The resident tries to answer all questions during the BIMS. Although she answers several items incorrectly and responds “I don’t know” to others, she pays attention to the interviewer. Medical record and staff indicate that this is her consistent behavior.

   **Coding:** Item C1310B would be **coded 0, behavior not present.**
   **Rationale:** The resident remained focused throughout the interview and this was constant during the look-back period.

2. Questions during the BIMS must be frequently repeated because resident’s attention wanders. This behavior occurs throughout the interview and medical records and staff agree that this behavior is consistently present. The resident has a diagnosis of dementia.

   **Coding:** Item C1310B would be **coded 1, behavior continuously present, does not fluctuate.**
   **Rationale:** The resident’s attention consistently wandered throughout the 7-day look-back period. The resident’s dementia diagnosis does not affect the coding.

3. During the BIMS interview, the resident was not able to focus on all questions asked and his gaze wandered. However, several notes in the resident’s medical record indicate that the resident was attentive when staff communicated with him.

   **Coding:** Item C1310B would be **coded 2, behavior present, fluctuates.**
   **Rationale:** Evidence of inattention was found during the BIMS but was noted to be absent in the medical record. This disagreement shows possible fluctuation in the behavior. If any information source reports the symptom as present, C1310B **cannot be coded as 0, Behavior not present.**

4. Resident is dazedly staring at the television for the first several questions. When you ask a question, she looks at you momentarily but does not answer. Midway through questioning, she seems to pay more attention and tries to answer.

   **Coding:** Item C1310B would be **coded 2, behavior present, fluctuates.**
   **Rationale:** Resident’s attention fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2.**
C1310: Signs and Symptoms of Delirium (cont.)

Coding Instructions for C1310C, Disorganized Thinking

- **Code 0, behavior not present:** if all sources agree that the resident’s thinking was organized and coherent, even if answers were inaccurate or wrong.

- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident’s responses were consistently disorganized or incoherent, conversation was rambling or irrelevant, ideas were unclear or flowed illogically, or the resident unpredictably switched from subject to subject.

- **Code 2, behavior present, fluctuates:** if, during the interview or according to other data sources, the resident’s responses fluctuated between disorganized/incoherent and organized/clear. Also code as fluctuating if information sources disagree.

Examples

1. The interviewer asks the resident, who is often confused, to give the date, and the response is: “Let’s go get the sailor suits!” The resident continues to provide irrelevant or nonsensical responses throughout the interview, and medical record and staff indicate this is constant.

   **Coding:** C1310C would be **coded 1, behavior continuously present, does not fluctuate.**
   
   **Rationale:** All sources agree that the disorganized thinking is constant.

2. The resident responds that the year is 1837 when asked to give the date. The medical record and staff indicate that the resident is never oriented to time but has coherent conversations. For example, staff reports he often discusses his passion for baseball.

   **Coding:** C1310C would be **coded 0, behavior not present.**
   
   **Rationale:** The resident’s answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.

3. The resident was able to tell the interviewer her name, the year and where she was. She was able to talk about the activity she just attended and the residents and staff that also attended. Then the resident suddenly asked the interviewer, “Who are you? What are you doing in my daughter’s home?”

   **Coding:** C1310C would be **coded 2, behavior present, fluctuates.**
   
   **Rationale:** The resident’s thinking fluctuated between coherent and incoherent at least once. If as few as one source notes fluctuation, then the behavior should be **coded 2.**
C1310: Signs and Symptoms of Delirium (cont.)

Coding Instructions for C1310D, Altered Level of Consciousness

- **Code 0, behavior not present:** if all sources agree that the resident was alert and maintained wakefulness during conversation, interview(s), and activities.

- **Code 1, behavior continuously present, did not fluctuate:** if, during the interview and according to other sources, the resident was consistently lethargic (difficult to keep awake), stuporous (very difficult to arouse and keep aroused), vigilant (startles easily to any sound or touch), or comatose.

- **Code 2, behavior present, fluctuates:** if, during the interview or according to other sources, the resident varied in levels of consciousness. For example, was at times alert and responsive, while at other times resident was lethargic, stuporous, or vigilant. Also code as fluctuating if information sources disagree.

**Coding Tips**

- A diagnosis of coma or stupor does not have to be present for staff to note the behavior in this section.

**Examples**

1. Resident is alert and conversational and answers all questions during the BIMS interview, although not all answers are correct. Medical record documentation and staff report during the 7-day look-back period consistently noted that the resident was alert.

   **Coding:** C1310D would be **coded 0, behavior not present.**
   
   **Rationale:** All evidence indicates that the resident is alert during conversation, interview(s) and activities.

2. The resident is lying in bed. He arouses to soft touch but is only able to converse for a short time before his eyes close, and he appears to be sleeping. Again, he arouses to voice or touch but only for short periods during the interview. Information from other sources indicates that this was his condition throughout the look-back period.

   **Coding:** C1310D would be **coded 1, behavior continuously present, does not fluctuate.**
   
   **Rationale:** The resident’s lethargy was consistent throughout the interview, and there is consistent documentation of lethargy in the medical record during the look-back period.
C1310: Signs and Symptoms of Delirium (cont.)

3. Resident is usually alert, oriented to time, place, and person. Today, at the time of the BIMS interview, resident is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.

**Coding:** C1310D would be **coded 2, behavior present, fluctuates.**

**Rationale:** The level of consciousness fluctuated during the interview. If as few as one source notes fluctuation, then the behavior should be **coded 2, fluctuating.**

```
CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1  OR  Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2  OR  Item D = 1 OR 2
```
SECTION D: MOOD

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident’s individualized care plan.

- Depression can be associated with:
  - psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain),
  - decreased participation in therapy and activities (e.g., caused by isolation),
  - decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and
  - poorer outcomes (e.g., decreased appetite, decreased cognitive status).

- Findings suggesting mood distress should lead to:
  - identifying causes and contributing factors for symptoms,
  - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
  - ensuring resident safety.

D0100: Should Resident Mood Interview Be Conducted?

Item Rationale

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about mood directly from the resident, sometimes called “hearing the resident’s voice,” is more reliable and accurate than observation alone for identifying a mood disorder.
D0100: Should Resident Mood Interview Be Conducted? (cont.)

Planning for Care

- Symptom-specific information from direct resident interviews will allow for the incorporation of the resident’s voice in the individualized care plan.
- If a resident cannot communicate, then **Staff Mood Interview** (D0500 A-J) should be conducted.

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** the resident is rarely/never understood **verbally, in writing, or using another method.** If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

3. **Review Language item (A1100)** to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

- **Code 1, yes:** if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Continue to item D0200, Resident Mood Interview (PHQ-9©).

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 needs an interpreter, every effort should be made to have an interpreter present for the PHQ-9© interview. If it is not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0650.

- **Includes residents who use American Sign Language (ASL).**
D0100: Should Resident Mood Interview Be Conducted? (cont.)

- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.

- Do not complete the Staff Assessment of Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

- There is one exception to completing the Staff Assessment of Resident Mood items (D0500) in place of the resident interview. This exception is specific to a stand-alone, unscheduled 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 standalone End of Therapy OMRA (EOT), or a standalone 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) were 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.
D0200: Resident Mood Interview (PHQ-9©)

Item Rationale

**Health-related Quality of Life**

- Depression can be associated with:
  - psychological and physical distress,
  - decreased participation in therapy and activities,
  - decreased functional status, and
  - poorer outcomes.

- Mood disorders are common in nursing homes and are often underdiagnosed and undertreated.

**Planning for Care**

- Findings suggesting mood distress could lead to:
  - identifying causes and contributing factors for symptoms and
  - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.

**DEFINITION**

**9-ITEM PATIENT HEALTH QUESTIONNAIRE (PHQ-9©)**

A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.
D0200: Resident Mood Interview (PHQ-9©) (cont.)

Steps for Assessment

Look-back period for this item is 14 days.

1. Conduct the interview preferably the day before or day of the ARD.
2. Interview any resident when D0100 = 1.
3. Conduct the interview in a private setting.
4. If an interpreter is used during resident interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the resident’s responses. Interpreters are people who translate oral or written language from one language to another.
5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident’s face.
6. Be sure the resident can hear you.
   - Residents with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
7. If you are administering the PHQ-9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.
8. Explain the reason for the interview before beginning.
   Suggested language: “I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care.”
9. Explain and/or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident comprehend the response choices.
   Suggested language: “I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card.” (Say while pointing to cue card): “0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day.”
10. Interview the resident.
   Suggested language: “Over the last 2 weeks, have you been bothered by any of the following problems?”

Then, for each question in Resident Mood Interview (D0200):

- Read the item as it is written.
- Do not provide definitions because the meaning must be based on the resident’s interpretation. For example, the resident defines for himself what “tired” means; the item should be scored based on the resident’s interpretation.
- Each question must be asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the resident’s response is not informative with respect to the item being rated; this is considered a nonsensical response (e.g., when asked the question about “poor appetite or overeating,” the resident answers, “I always win at poker.”).
D0200: Resident Mood Interview (PHQ-9©) (cont.)

- For a **yes** response, ask the resident to tell you how often he or she was bothered by the symptom over the last 14 days. Use the response choices in D0200 Column 2, **Symptom Frequency**. Start by asking the resident the number of days that he or she was bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

**Coding Instructions for Column 1. Symptom Presence**

- **Code 0, no:** if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1, yes:** if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

**Coding Instructions for Column 2. Symptom Frequency**

*Record the resident’s responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.*

- **Code 0, never or 1 day:** if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that he or she has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates that he or she has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates that he or she has experienced the symptom for 12-14 days.

**Coding Tips and Special Populations**

- For question D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc). Follow facility protocol for evaluating possible self-harm.
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,
    - Experienced interviewers have found that most residents who are having this feeling appreciate the opportunity to express it.
D0200: Resident Mood Interview (PHQ-9©) (cont.)

- Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the resident is already feeling.
- The best interviewing approach is to ask the question openly and without hesitation.

- If the resident uses his or her own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using his or her own words, ask him to tell you how often he or she was bothered by that symptom.
- Select only one frequency response per item.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Residents may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers.

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
  - **Example:** Say, “That’s interesting, now I need to know…”; “Let’s get back to…”; “I understand, can you tell me about….?”
    - Validate your understanding of what the resident is saying by asking for clarification.
      - **Example:** Say, “I think I hear you saying that…”; “Let’s see if I understood you correctly.”; “You said…. Is that right?”
- If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
  - **Example:** Say, “Would you say [name symptom] bothered you more than half the days in the past 2 weeks?”
    - If the resident says “yes,” show the cue card and ask whether it bothered him or her nearly every day (12-14 days) or on half or more of the days (7-11 days).
    - If the resident says “no,” show the cue card and ask whether it bothered him or her several days (2-6 days) or never or 1 day (0-1 day).
D0200: Resident Mood Interview (PHQ-9©) (cont.)

• Noncommittal responses such as “not really” should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
  — “What do you mean?”
  — “Tell me what you have in mind.”
  — “Tell me more about that.”
  — “Please be more specific.”
  — “Give me an example.”

• Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
  — **Example:** Item D0200E, Poor Appetite or Overeating. The resident responds “the food is always cold and it just doesn’t taste like it does at home. The doctor won’t let me have any salt.”
    ○ Possible interviewer response: “You’re telling me the food isn’t what you eat at home and you can’t add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?”

  — **Example:** Item D0200A, Little Interest or Pleasure in Doing Things. The resident, when asked how often he or she has been bothered by little interest or pleasure in doing things, responds, “There’s nothing to do here, all you do is eat, bathe, and sleep. They don’t do anything I like to do.”
    ○ Possible interview response: “You’re saying there isn’t much to do here and I want to come back later to talk about some things you like to do. Thinking about how you’ve been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?”

  — **Example:** Item D0200B, Feeling Down, Depressed, or Hopeless. The resident, when asked how often he or she has been bothered by feeling down, depressed, or hopeless, responds: “How would you feel if you were here?”
    ○ Possible interview response: “You asked how I would feel, but it is important that I understand your feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?”

• If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a resident has moderate cognitive impairment but can respond to simple, direct questions.
  — **Example:** Item D0200E, Poor Appetite or Overeating.
    ○ You can simplify this item by asking: “In the last 2 weeks, how often have you been bothered by poor appetite?” (pause for a response) “Or overeating?”
D0200: Resident Mood Interview (PHQ-9©) (cont.)

— **Example:** Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
  ○ You can break the item down as follows: “How often are you having problems falling asleep?” (pause for response) “How often are you having problems staying asleep?” (pause for response) “How often do you feel you are sleeping too much?”

— **Example:** Item D0200H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual.
  ○ You can simplify this item by asking: “How often are you having problems with moving or speaking so slowly that other people could have noticed?” (pause for response) “How often have you felt so fidgety or restless that you move around a lot more than usual?”

D0300: Total Severity Score

### Item Rationale

**Health-related Quality of Life**

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident’s physician, other clinicians and mental health specialists for appropriate follow up.

- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists.

**Planning for Care**

- The PHQ-9© **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.
D0300: Total Severity Score (cont.)

Steps for Assessment

After completing D0200 A-I:

1. Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
3. The maximum resident score is 27 (3 x 9).

Coding Instructions

- The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9©.
- If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as “99” and the Staff Assessment of Mood should be conducted.
- Enter the total score as a two-digit number. The Total Severity Score will be between 00 and 27 (or “99” if symptom frequency is blank for 3 or more items).
- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9© Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:
  - Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
  - Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
  - In addition, PHQ-9© Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows:
    - 1-4: minimal depression
    - 5-9: mild depression
    - 10-14: moderate depression
    - 15-19: moderately severe depression
    - 20-27: severe depression
D0350: Follow-up to D0200I

Item Rationale

**Health-related Quality of Life**

- This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that he or she had thoughts of being better off dead, or hurting him or herself in some way.
- It is well-known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life threatening behaviors, including poor nutrition and treatment refusal are common.
- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.

**Planning for Care**

- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at [https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm](https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm)).

**Steps for Assessment**

1. Complete item D0350 **only** if item D0200I1 **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1 indicating the possibility of resident self-harm.

**Coding Instructions**

- **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.
- **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

Item Rationale

Health-related Quality of Life

- PHQ-9© Resident Mood Interview is preferred as it improves the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the PHQ-9© Resident Mood Interview. Therefore, staff should complete the PHQ-9-OV© Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified.

- Persons unable to complete the PHQ-9© Resident Mood Interview may still have a mood disorder.

- Even if a resident was unable to complete the Resident Mood Interview, important insights may be gained from the responses that were obtained during the interview, as well as observations of the resident’s behaviors and affect during the interview.

- The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.

- It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators.
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

- Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© Resident Mood Interview. This ensures that information about their mood is not overlooked.

Planning for Care

- When the resident is not able to complete the PHQ-9©, scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

Steps for Assessment

Look-back period for this item is 14 days.

1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
2. The same administration techniques outlined above for the PHQ-9© Resident Mood Interview (pages D-4–D-6) and Interviewing Tips & Techniques (pages D-6–D-8) should also be followed when staff are interviewed.
3. Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.
4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation.
5. If frequency cannot be coded because the resident has been in the facility for less than 14 days, talk to family or significant other and review transfer records to inform the selection of a frequency code.

Examples of Staff Responses That Indicate Need for Follow-up Questioning with the Staff Member

1. **D0500A, Little Interest or Pleasure in Doing Things**
   - The resident doesn’t really do much here.
   - The resident spends most of the time in his or her room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
   - She’s 95—what can you expect?
   - How would you feel if you were here?
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
   - Her back hurts when she lies down.
   - He urinates a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
   - She’s 95—she’s always saying she’s tired.
   - He’s having a bad spell with his COPD right now.
D0500: Staff Assessment of Resident Mood (PHQ-9-OV®) (cont.)

5. **D0500E, Poor Appetite or Overeating**
   - She has not wanted to eat much of anything lately.
   - He has a voracious appetite, more so than last week.

6. **D0500F, Indicating That S/he Feels Bad about Self, Is a Failure, or Has Let Self or Family Down**
   - She does get upset when there’s something she can’t do now because of her stroke.
   - He gets embarrassed when he can’t remember something he thinks he should be able to.

7. **D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television**
   - She says there’s nothing good on TV.
   - She never watches TV.
   - He can’t see to read a newspaper.

8. **D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite—Being So Fidgety or Restless That S/he Has Been Moving Around a Lot More than Usual**
   - His arthritis slows him down.
   - He’s bored and always looking for something to do.

9. **D0500I, States That Life Isn’t Worth Living, Wishes for Death, or Attempts to Harm Self**
   - She says God should take her already.
   - He complains that man was not meant to live like this.

10. **D0500J, Being Short-Tempered, Easily Annoyed**
    - She’s OK if you know how to approach her.
    - He can snap but usually when his pain is bad.
    - Not with me.
    - He’s irritable.

**Coding Instructions for Column 1. Symptom Presence**

- **Code 0, no:** if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.
- **Code 1, yes:** if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency**.
D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

Coding Instructions for Column 2. Symptom Frequency

- **Code 0, never or 1 day**: if staff indicate that the resident has never or has experienced the symptom on only 1 day.
- **Code 1, 2-6 days (several days)**: if staff indicate that the resident has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days)**: if staff indicate that the resident has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day)**: if staff indicate that the resident has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- Ask the staff member being interviewed to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., “nearly every day” or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the highest frequency rating that is reported.
- If the staff member has difficulty selecting between two frequency responses, code for the higher frequency.
- If the resident has been in the facility for less than 14 days, also talk to the family or significant other and review transfer records to inform selection of the frequency code.

D0600: Total Severity Score

Item Rationale

**Health-related Quality of Life**

- Review Item Rationale for D0300, Total Severity Score (page D-8).
- The PHQ-9© Observational Version (PHQ-9-OV©) is adapted to allow the assessor to interview staff and identify a Total Severity Score for potential depressive symptoms.

**Planning for Care**

- The score can be communicated among health care providers and used to track symptoms and how they are changing over time.
- The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression.
D0600: Total Severity Score (cont.)

Steps for Assessment

After completing items D0500 A-J:

1. Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2.
2. Maximum score is 30 (3 × 10).

Coding Instructions

*The interview is successfully completed if the staff members were able to answer the frequency responses of at least 8 out of 10 items on the PHQ-9-OV©.*

- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9-OV© Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9-OV© can indicate possible depression. Responses can be interpreted as follows:
  - Major Depressive Syndrome is suggested if—of the 10 items, 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
  - Minor Depressive Syndrome is suggested if—of the 10 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
  - In addition, PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
    - 1-4: minimal depression
    - 5-9: mild depression
    - 10-14: moderate depression
    - 15-19: moderately severe depression
    - 20-30: severe depression
D0650: Follow-up to D0500I

<table>
<thead>
<tr>
<th>Item Rationale</th>
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</tr>
<tr>
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### Planning for Care

• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at [https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm](https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm)).

### Steps for Assessment

1. Complete item D0650 only if item D0500I, States That Life Isn’t Worth Living, Wishes for Death, or Attempts to Harm Self = 1 indicating the possibility of resident self-harm.

### Coding Instructions

• **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.

• **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.
SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES

**Intent:** The intent of items in this section is to obtain information regarding the resident’s preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident’s preferences, and is not meant to be all-inclusive.

**F0300: Should Interview for Daily and Activity Preferences Be Conducted?**

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<th>Enter Code</th>
<th>Rationale</th>
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<tr>
<td>0</td>
<td>No (residents are rarely/never understood and family/significant other not available) - Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences</td>
</tr>
<tr>
<td>1</td>
<td>Yes - Continue to F0400, Interview for Daily Preferences</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Most residents capable of communicating can answer questions about what they like.
- Obtaining information about preferences directly from the resident, sometimes called “hearing the resident’s voice,” is the most reliable and accurate way of identifying preferences.
- If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences.

**Planning for Care**

- Quality of life can be greatly enhanced when care respects the resident’s choice regarding anything that is important to the resident.
- Interviews allow the resident’s voice to be reflected in the care plan.
- Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning.

**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 resident is rarely/never understood verbally, in writing, or using another method.** If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.

3. **If resident is rarely/never understood and a family member or significant other is not available,** skip to item F0800, Staff Assessment of Daily and Activity Preferences.

4. **Conduct the interview during the observation period.**
F0300: Should Interview for Daily and Activity Preferences Be Conducted? (cont.)

5. 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.

Coding Instructions

• **Code 0, no:** if the interview should not be *conducted* with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences).

• **Code 1, yes:** if the resident interview should be *conducted*. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences).

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 needs an interpreter, every effort should be made to have an interpreter present for the MDS clinical interview. If it is not possible for a needed interpreter to be present on the day of the interview, and a family member or significant other is not available for interview, **code F0300 = 0** to indicate interview not attempted, and complete the Staff Assessment of Daily and Activity Preferences (F0800) instead of the interview with the resident (F0400 and F0500).

• *If the resident interview was not conducted within the look-back period of the ARD, item F0300 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.*

• *Do not complete the Staff Assessment of Daily and Activity Preferences items (F0700–F0800) if the resident interview should have been conducted, but was not done.*
F0400: Interview for Daily Preferences

Item Rationale

Health-related Quality of Life

- Individuals who live in nursing homes continue to have distinct lifestyle preferences.
- A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms.
- Resident responses that something is important but that they can’t do it or have no choice can provide clues for understanding pain, perceived functional limitations, and perceived environmental barriers.

Planning for Care

- Care planning should be individualized and based on the resident’s preferences.
- Care planning and care practices that are based on resident preferences can lead to
  — improved mood,
  — enhanced dignity, and
  — increased involvement in daily routines and activities.
- Incorporating resident preferences into care planning is a dynamic, collaborative process. Because residents may adjust their preferences in response to events and changes in status, the preference assessment tool is intended as a first step in an ongoing dialogue between care providers and the residents. Care plans should be updated as residents’ preferences change, paying special attention to preferences that residents state are important.

Steps for Assessment: Interview Instructions

1. Interview any resident not screened out by the **Should Interview for Daily and Activity Preferences Be Conducted?** item (F0300).
2. Conduct the interview in a private setting.
F0400: Interview for Daily Preferences (cont.)

3. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident’s face.
4. Be sure the resident can hear you.
   - Residents with hearing impairment should be interviewed using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
5. Explain the reason for the interview before beginning.
   **Suggested language:** “I’d like to ask you a few questions about your daily routines. The reason I’m asking you these questions is that the staff here would like to know what’s important to you. This helps us plan your care around your preferences so that you can have a comfortable stay with us. Even if you’re only going to be here for a few days, we want to make your stay as personal as possible.”
6. Explain the interview response choices. While explaining, also show the resident a clearly written list of the response options, for example a cue card.
   **Suggested language:** “I am going to ask you how important various activities and routines are to you **while you are in this home**. I will ask you to answer using the choices you see on this card [read the answers while pointing to cue card]: ‘Very Important,’ ‘Somewhat important,’ ‘Not very important,’ ‘Not important at all,’ or ‘Important, but can’t do or no choice.’”
   Explain the “Important, but can’t do or no choice” response option.
   **Suggested language:** “Let me explain the ‘Important, but can’t do or no choice’ answer. You can select this answer if something would be important to you, but because of your health or because of what’s available in this nursing home, you might not be able to do it. So, if I ask you about something that is important to you, but you don’t think you’re able to do it now, answer ‘Important, but can’t do or no choice.’ If you choose this option, it will help us to think about ways we might be able to help you do those things.”
7. Residents may respond to questions
   - verbally,
   - by pointing to their answers on the cue card, **OR**
   - by writing out their answers.
8. If resident cannot report preferences, then interview family or significant others.
F0400: Interview for Daily Preferences (cont.)

Coding Instructions

- **Code 1, very important:** if resident, family, or significant other indicates that the topic is “very important.”

- **Code 2, somewhat important:** if resident, family, or significant other indicates that the topic is “somewhat important.”

- **Code 3, not very important:** if resident, family, or significant other indicates that the topic is “not very important.”

- **Code 4, not important at all:** if resident, family, or significant other indicates that the topic is “not important at all.”

- **Code 5, important, but can’t do or no choice:** if resident, family, or significant other indicates that the topic is “important,” but that he or she is physically unable to participate, or has no choice about participating while staying in nursing home because of nursing home resources or scheduling.

- **Code 9, no response or non-responsive:**
  - If resident, family, or significant other refuses to answer or says he or she does not know.
  - If resident does not give an answer to the question for several seconds and does not appear to be formulating an answer.
  - If resident provides an incoherent or nonsensical answer that does not correspond to the question.

Coding Tips and Special Populations

- The interview is considered incomplete if the resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500. If the interview is stopped because it is considered incomplete, fill the remaining F0400 and F0500 items with a 9 and proceed to F0600, Daily Activity Preferences Primary Respondent.

- No look-back is provided for resident. He or she is being asked about current preferences while in the nursing home but is not limited to a 7-day look-back period to convey what his/her preferences are.

- The facility is still obligated to complete the interview within the 7-day look-back period.
F0400: Interview for Daily Preferences (cont.)

Interviewing Tips and Techniques

- Sometimes respondents give long or indirect answers to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
- For these questions, it is appropriate to explore residents’ answers and try to understand the reason.

Examples for F0400A, How Important Is It to You to Choose What Clothes to Wear (including hospital gowns or other garments provided by the facility)?

1. Resident answers, “It’s very important. I’ve always paid attention to my appearance.”

   **Coding:** F0400A would be **coded 1, very important.**

2. Resident replies, “I leave that up to the nurse. You have to wear what you can handle if you have a stiff leg.”

   Interviewer echoes, “You leave it up to the nurses. Would you say that, while you are here, choosing what clothes to wear is [pointing to cue card] very important, somewhat important, not very important, not important at all, or that it’s important, but you can’t do it because of your leg?”

   Resident responds, “Well, it would be important to me, but I just can’t do it.”

   **Coding:** F0400A would be **coded 5, important, but can’t do or no choice.**

Examples for F0400B, How Important Is It to You to Take Care of Your Personal Belongings or Things?

1. Resident answers, “It’s somewhat important. I’m not a perfectionist, but I don’t want to have to look for things.”

   **Coding:** F0400B would be **coded 2, somewhat important.**

2. Resident answers, “All my important things are at home.”

   Interviewer clarifies, “Your most important things are at home. Do you have any other things while you’re here that you think are important to take care of yourself?”

   Resident responds, “Well, my son brought me this CD player so that I can listen to music. It is very important to me to take care of that.”

   **Coding:** F0400B would be **coded 1, very important.**
F0400: Interview for Daily Preferences (cont.)

Examples for F0400C, How Important Is It to You to Choose between a Tub Bath, Shower, Bed Bath, or Sponge Bath?

1. Resident answers, “I like showers.”
   
   Interviewer clarifies, “You like showers. Would you say that choosing a shower instead of other types of bathing is very important, somewhat important, not very important, not important at all, or that it’s important, but you can’t do it or have no choice?”

   The resident responds, “It’s very important.”

   **Coding:** F0400C would be coded 1, very important.

2. Resident answers, “I don’t have a choice. I like only sponge baths, but I have to take shower two times a week.”

   The interviewer says, “So how important is it to you to be able to choose to have a sponge bath while you’re here?”

   The resident responds, “Well, it is very important, but I don’t always have a choice because that’s the rule.”

   **Coding:** F0400C would be coded 5, important, but can’t do or no choice.

Example for F0400D, How Important Is It to You to Have Snacks Available between Meals?

1. Resident answers, “I’m a diabetic, so it’s very important that I get snacks.”

   **Coding:** F0400D would be coded 1, very important.

---

**DEFINITIONS**

**BED BATH**
Bath taken in bed using washcloths and water basin or other method in bed.

**SHOWER**
Bath taken standing or using gurney or shower chair in a shower room or stall.

**SPONGE BATH**
Bath taken sitting or standing at sink.

**TUB BATH**
Bath taken in bathtub.

**SNACK**
Food available between meals, including between dinner and breakfast.
F0400: Interview for Daily Preferences (cont.)

Example for F0400E, How Important Is It to You to Choose Your Own Bedtime?
1. Resident answers, “At home I used to stay up and watch TV. But here I’m usually in bed by 8. That’s because they get me up so early.”

Interviewer echoes and clarifies, “You used to stay up later, but now you go to bed before 8 because you get up so early. Would you say it’s [pointing to cue card] very important, somewhat important, not very important, not important at all, or that it’s important, but you don’t have a choice about your bedtime?”

Resident responds, “I guess it would be important, but I can’t do it because they wake me up so early in the morning for therapy and by 8 o’clock at night, I’m tired."

**Coding:** F0400E would be **coded 5, important, but can’t do or no choice.**

Example for F0400F, How Important Is It to You to Have Your Family or a Close Friend Involved in Discussions about Your Care?
1. Resident responds, “They’re not involved. They live in the city. They’ve got to take care of their own families.”

Interviewer replies, “You said that your family and close friends aren’t involved right now. When you think about what you would prefer, would you say that it’s very important, somewhat important, not very important, not important at all, or that it is important but you have no choice or can’t have them involved in decisions about your care?”

Resident responds, “It’s somewhat important.”

**Coding:** F0400F would be **coded 2, somewhat important.**

Example for F0400G, How Important Is It to You to Be Able to Use the Phone in Private?
1. Resident answers “That’s not a problem for me, because I have my own room. If I want to make a phone call, I just shut the door.”

Interviewer echoes and clarifies, “So, you can shut your door to make a phone call. If you had to rate how important it is to be able to use the phone in private, would you say it’s very important, somewhat important, not very important, or not important at all?”

Resident responds, “Oh, it’s very important.”

**Coding:** F0400G would be **coded 1, very important.**
F0400: Interview for Daily Preferences (cont.)

Example for F0400H, How Important Is It to You to Have a Place to Lock Your Things to Keep Them Safe?

1. Resident answers, “I have a safe deposit box at my bank, and that’s where I keep family heirlooms and personal documents.”
   Interviewer says, “That sounds like a good service. While you are staying here, how important is it to you to have a drawer or locker here?”
   Resident responds, “It’s not very important. I’m fine with keeping all my valuables at the bank.”

   **Coding:** F0400H would be **coded 3, not very important.**

F0500: Interview for Activity Preferences

<table>
<thead>
<tr>
<th>F0500. Interview for Activity Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Show resident the response options and say: <em>“While you are in this facility...”</em></td>
</tr>
</tbody>
</table>

**Coding:**
1. Very important
2. Somewhat important
3. Not very important
4. Not important at all
5. Important, but can't do or no choice
9. No response or non-responsive

- **Enter Codes in Boxes**
  - A. how important is it to you to have books, newspapers, and magazines to read?
  - B. how important is it to you to listen to music you like?
  - C. how important is it to you to be around animals such as pets?
  - D. how important is it to you to keep up with the news?
  - E. how important is it to you to do things with groups of people?
  - F. how important is it to you to do your favorite activities?
  - G. how important is it to you to go outside to get fresh air when the weather is good?
  - H. how important is it to you to participate in religious services or practices?

**Item Rationale**

**Health-related Quality of Life**

- Activities are a way for individuals to establish meaning in their lives, and the need for enjoyable activities and pastimes does not change on admission to a nursing home.
- A lack of opportunity to engage in meaningful and enjoyable activities can result in boredom, depression, and behavior disturbances.
- Individuals vary in the activities they prefer, reflecting unique personalities, past interests, perceived environmental constraints, religious and cultural background, and changing physical and mental abilities.
F0500: Interview for Activity Preferences (cont.)

Planning for Care

• These questions will be useful for designing individualized care plans that facilitate residents’ participation in activities they find meaningful.

• Preferences may change over time and extend beyond those included here. Therefore, the assessment of activity preferences is intended as a first step in an ongoing informal dialogue between the care provider and resident.

• As with daily routines, responses may provide insights into perceived functional, emotional, and sensory support needs.

Coding Instructions

• See Coding Instructions on page F-4. Coding approach is identical to that for daily preferences.

Coding Tips and Special Populations

• See Coding Tips on page F-5. Coding tips include those for daily preferences.

• Include Braille and or audio recorded material when coding items in F0500A.

Interviewing Tips and Techniques

• See Interview Tips and Techniques on page F-5. Coding tips and techniques are identical to those for daily preferences.

**DEFINITIONS**

<table>
<thead>
<tr>
<th>READ</th>
<th>Script, Braille, or audio recorded written material.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEWS</td>
<td>News about local, state, national, or international current events.</td>
</tr>
<tr>
<td>KEEP UP WITH THE NEWS</td>
<td>Stay informed by reading, watching, or listening.</td>
</tr>
<tr>
<td>NEWSPAPERS AND MAGAZINES</td>
<td>Any type, such as journalistic, professional, and trade publications in script, Braille, or audio recorded format.</td>
</tr>
</tbody>
</table>
F0500: Interview for Activity Preferences (cont.)

Examples for F0500A, How Important Is It to You to Have Books (Including Braille and Audio-recorded Format), Newspapers, and Magazines to Read?

1. Resident answers, “Reading is very important to me.”
   
   **Coding:** F0500A would be **coded 1, very important.**

2. Resident answers, “They make the print so small these days. I guess they are just trying to save money.”
   
   Interviewer replies, “The print is small. Would you say that having books, newspapers, and magazines to read is very important, somewhat important, not very important, not important at all, or that it is important but you can’t do it because the print is so small?”
   
   Resident answers: “It would be important, but I can’t do it because of the print.”
   
   **Coding:** F0500A would be **coded 5, important, but can’t do or no choice.**

Example for F0500B, How Important Is It to You to Listen to Music You Like?

1. Resident answers, “It’s not important, because all we have in here is TV. They keep it blaring all day long.”
   
   Interviewer echoes, “You’ve told me it’s not important because all you have is a TV. Would you say it’s not very important or not important at all to you to listen to music you like while you are here? Or are you saying that it’s important, but you can’t do it because you don’t have a radio or CD player?”
   
   Resident responds, “Yeah. I’d enjoy listening to some jazz if I could get a radio.”
   
   **Coding:** F0500B would be **coded 5, important, but can’t do or no choice.**

Examples for F0500C, How Important Is It to You to Be Around Animals Such as Pets?

1. Resident answers, “It’s very important for me NOT to be around animals. You get hair all around and I might inhale it.”
   
   **Coding:** F0500C would be **coded 4, not important at all.**

2. Resident answers, “I’d love to go home and be around my own animals. I’ve taken care of them for years and they really need me.”
   
   Interviewer probes, “You said you’d love to be at home with your own animals. How important is it to you to be around pets while you’re staying here? Would you say it is [points to card] very important, somewhat important, not very important, not important at all, or is it important, but you can’t do it or don’t have a choice about it?”
   
   Resident responds, “Well, it’s important to me to be around my own dogs, but I can’t be around them. I’d say important but can’t do.”
   
   **Coding:** F0500C would be **coded 5, Important, but can't do or no choice.**

**Rationale:** Although the resident has access to therapeutic dogs brought to the nursing home, he does not have access to the type of pet that is important to him.
F0500: Interview for Activity Preferences (cont.)

Example for F0500D, How Important Is It to You to Keep Up with the News?

1. Resident answers, “Well, they are all so liberal these days, but it’s important to hear what they are up to.”

   Interviewer clarifies, “You think it is important to hear the news. Would you say it is [points to card] very important, somewhat important, or it’s important but you can’t do it or have no choice?”

   Resident responds, “I guess you can mark me somewhat important on that one.”

   **Coding:** F0500D would be **coded 2, somewhat important.**

Example for F0500E, How Important Is It to You to Do Things with Groups of People?

1. Resident answers, “I’ve never really liked groups of people. They make me nervous.”

   Interviewer echoes and clarifies, “You’ve never liked groups. To help us plan your activities, would you say that while you’re here, doing things with groups of people is very important, somewhat important, not very important, not important at all, or would it be important to you but you can’t do it because you feel nervous about it?”

   Resident responds, “At this point I’d say it’s not very important.”

   **Coding:** F0500E would be **coded 3, not very important.**

Examples for F0500F, How Important Is It to You to Do Your Favorite Activities?

1. Resident answers, “Well, it’s very important, but I can’t really do my favorite activities while I’m here. At home, I used to like to play board games, but you need people to play and make it interesting. I also like to sketch, but I don’t have the supplies I need to do that here. I’d say important but no choice.”

   **Coding:** F0500F would be **coded 5, important, but can’t do or no choice.**

2. Resident answers, “I like to play bridge with my bridge club.”

   Interviewer probes, “Oh, you like to play bridge with your bridge club. How important is it to you to play bridge while you are here in the nursing home?”

   Resident responds, “Well, I’m just here for a few weeks to finish my rehabilitation. It’s not very important.”

   **Coding:** F0500F would be **coded 3, not very important.**
F0500: Interview for Activity Preferences (cont.)

Example for F0500G, How Important Is It to You to Go Outside to Get Fresh Air When the Weather Is Good (Includes Less Temperate Weather if Resident Has Appropriate Clothing)?

1. Resident answers, “They have such a nice garden here. It’s very important to me to go out there.”

   **Coding:** F0500G would be **coded 1, very important.**

Examples for F0500H, How Important Is It to You to Participate in Religious Services or Practices?

1. Resident answers, “I’m Jewish. I’m Orthodox, but they have Reform services here. So I guess it’s not important.”

   Interviewer clarifies, “You’re Orthodox, but the services offered here are Reform. While you are here, how important would it be to you to be able to participate in religious services? Would you say it is very important, somewhat important, not very important, not important at all, or would it be important to you but you can’t or have no choice because they don’t offer Orthodox services.”

   Resident responds, “It’s important for me to go to Orthodox services if they were offered, but they aren’t. So, can’t do or no choice.”

   **Coding:** F0500I would be **coded 5, important, but can’t do or no choice.**

2. Resident answers “My pastor sends taped services to me that I listen to in my room on Sundays. I don’t participate in the services here.”

   Interviewer probes, “You said your pastor sends you taped services. Would you say that it is very important, somewhat important, not very important, or not important at all, to you that you are able to listen to those tapes from your pastor?”

   Resident responds, “Oh, that’s very important.”

   **Coding:** F0500I would be **coded 1, very important.**
F0600: Daily and Activity Preferences Primary Respondent

**Item Rationale**
- This item establishes the source of the information regarding the resident’s preferences.

**Coding Instructions**
- **Code 1, resident**: if resident was the primary source for the preference questions in F0400 and F0500.
- **Code 2, family or significant other**: if a family member or significant other was the primary source of information for F0400 and F0500.
- **Code 9, interview could not be completed**: if F0400 and F0500 could not be completed by the resident, a family member, or a representative of the resident.

F0700: Should the Staff Assessment of Daily and Activity Preferences Be Conducted?

**Item Rationale**

**Health-related Quality of Life**
- Resident interview is preferred as it most accurately reflects what the resident views as important. However, a small percentage of residents are unable or unwilling to complete the interview for Daily and Activity Preferences.
- Persons unable to complete the preference interview should still have preferences evaluated and considered.

**Planning for Care**
- Even though the resident was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors, and observing the resident’s affect during the interview.

**Steps for Assessment**
1. Review resident, family, or significant other responses to F0400A-H and F0500A-H.
F0700: Should the Staff Assessment of Daily and Activity Preferences Be Conducted? (cont.)

Coding Instructions

- **Code 0, no:** if Interview for Daily and Activity Preferences items (F0400 and F0500) was completed by resident, family or significant other. Skip to Section G, Functional Status.

- **Code 1, yes:** if Interview for Daily and Activity Preferences items (F0400 through F0500) were not completed because the resident, family, or significant other was unable to answer 3 or more items (i.e. 3 or more items in F0400 through F0500 were coded as 9 or “-“).

Coding Tips and Special Populations

- If the total number of unanswered questions in F0400 through F0500 is equal to 3 or more, the interview is considered incomplete.

F0800: Staff Assessment of Daily and Activity Preferences

<table>
<thead>
<tr>
<th>Resident Preferences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>A. Choosing clothes to wear</td>
</tr>
<tr>
<td>B. Caring for personal belongings</td>
</tr>
<tr>
<td>C. Receiving tub bath</td>
</tr>
<tr>
<td>D. Receiving shower</td>
</tr>
<tr>
<td>E. Receiving bed bath</td>
</tr>
<tr>
<td>F. Receiving sponge bath</td>
</tr>
<tr>
<td>G. Snacks between meals</td>
</tr>
<tr>
<td>H. Staying up past 8:00 p.m.</td>
</tr>
<tr>
<td>I. Family or significant other involvement in care discussions</td>
</tr>
<tr>
<td>J. Use of phone in private</td>
</tr>
<tr>
<td>K. Place to lock personal belongings</td>
</tr>
<tr>
<td>L. Reading books, newspapers, or magazines</td>
</tr>
<tr>
<td>M. Listening to music</td>
</tr>
<tr>
<td>N. Being around animals such as pets</td>
</tr>
<tr>
<td>O. Keeping up with the news</td>
</tr>
<tr>
<td>P. Doing things with groups of people</td>
</tr>
<tr>
<td>Q. Participating in favorite activities</td>
</tr>
<tr>
<td>R. Spending time away from the nursing home</td>
</tr>
<tr>
<td>S. Spending time outdoors</td>
</tr>
<tr>
<td>T. Participating in religious activities or practices</td>
</tr>
<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>
F0800: Staff Assessment of Daily and Activity Preferences (cont.)

**Item Rationale**

**Health-related Quality of Life**

- Alternate means of assessing daily preferences must be used for residents who cannot communicate. This ensures that information about their preferences is not overlooked.
- Activities allow residents to establish meaning in their lives. A lack of meaningful and enjoyable activities can result in boredom, depression, and behavioral symptoms.

**Planning for Care**

- Caregiving staff should use observations of resident behaviors to understand resident likes and dislikes in cases where the resident, family, or significant other cannot report the resident’s preferences. This allows care plans to be individualized to each resident.

**Steps for Assessment**

1. Observe the resident when the care, routines, and activities specified in these items are made available to the resident.
2. Observations should be made by staff across all shifts and departments and others with close contact with the resident.
3. If the resident appears happy or content (e.g., is involved, pays attention, smiles) during an activity listed in **Staff Assessment of Daily and Activity Preferences** item (F0800), then that item should be checked.
   
   If the resident seems to resist or withdraw when these are made available, then do not check that item.

**Coding Instructions**

*Check all that apply in the last 7 days based on staff observation of resident preferences.*

- **F0800A.** Choosing clothes to wear
- **F0800B.** Caring for personal belongings
- **F0800C.** Receiving tub bath
- **F0800D.** Receiving shower
- **F0800E.** Receiving bed bath
- **F0800F.** Receiving sponge bath
- **F0800G.** Snacks between meals
- **F0800H.** Staying up past 8:00 p.m.
- **F0800I.** Family or significant other involvement in care discussions
- **F0800J.** Use of phone in private
- **F0800K.** Place to lock personal belongings
F0800: Staff Assessment of Daily and Activity Preferences (cont.)

- **F0800L.** Reading books, newspapers, or magazines
- **F0800M.** Listening to music
- **F0800N.** Being around animals such as pets
- **F0800O.** Keeping up with the news
- **F0800P.** Doing things with groups of people
- **F0800Q.** Participating in favorite activities
- **F0800R.** Spending time away from the nursing home
- **F0800S.** Spending time outdoors
- **F0800T.** Participating in religious activities or practices
- **F0800Z.** None of the above
**ADL Self-Performance Rule of 3 Algorithm**

**START HERE** - Review these instructions for Rule of 3 before using the algorithm. Follow steps in sequence and stop at first level that applies.

*Exceptions to Rule of 3:*
- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not occur at least 3 times.

**Rule of 3:**
1. When an activity occurs 3 or more times at any one level, code that level – *note exceptions for Independent (0) and Total Dependence (4).
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – *note exceptions for Independent (0) and Total Dependence (4).
3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule only applies if there are NOT ANY LEVELS that are 3 or more episodes at any one level. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.)
   a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).
   b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3).
   c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).

If none of the above are met, code Supervision (1).

---

### Start algorithm here - STOP at the First Code That Applies

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the activity occur at least 1 time?</td>
<td>Code 8: Activity Did Not Occur</td>
<td>Code 7: Activity Occurred Once or Twice</td>
</tr>
<tr>
<td>Did the activity occur 3 or more times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 0: Independent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 1: Supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 4: Total Dependence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did resident require Total Dependence EVERY time? (Item 1 Rule of 3, Total Dependence* exception)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 3: Extensive Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident require Total Dependence 3 or more times, but not every time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 2: Limited Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident require Limited Assistance 3 or more times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 1: Supervision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident require oversight, encouragement or cueing 3 or more times?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 3: Extensive Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident require a combination of Total Dependence and Extensive Assist 3 or more times but not 3 times at any one level? (Items 3a and 3b Rule of 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code 2: Limited Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3c Rule of 3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

<table>
<thead>
<tr>
<th>Coding</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Independent: if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.</td>
</tr>
<tr>
<td>2</td>
<td>Needed Some Help: if the resident needed partial assistance from another person to complete the activities.</td>
</tr>
<tr>
<td>1</td>
<td>Dependent: if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.</td>
</tr>
<tr>
<td>8</td>
<td>Unknown: if the resident’s usual ability prior to the current illness, exacerbation, or injury is unknown.</td>
</tr>
<tr>
<td>9</td>
<td>Not Applicable: if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.</td>
</tr>
</tbody>
</table>

Item Rationale

Knowledge of the resident’s functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or his or her family about, or review the resident’s medical records describing, the resident’s prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent:** if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.
- **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- **Code 8, Unknown:** if the resident’s usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable:** if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.
GG0100. Prior Functioning: Everyday Activities (cont.)

Coding Tips

- Record the resident’s usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the resident’s ability is available after attempts to interview the resident or his or her family and after reviewing the resident’s medical record, code as 8, Unknown.

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** Ms. R was admitted to an acute care facility after sustaining a right hip fracture and subsequently admitted to the SNF for rehabilitation. Prior to the hip fracture, Ms. R was independent in eating, bathing, dressing, and using the toilet. Ms. R used a raised toilet seat because of arthritis in both knee joints. Both she and her family indicated that there were no safety concerns when she performed these everyday activities in her home.

   **Coding:** GG0100A would be coded 3, Independent.

   **Rationale:** Prior to her hip fracture, the resident completed the self-care tasks of eating, bathing, dressing, and using the toilet safely without any assistance from a helper. The resident may use an assistive device, such as a raised toilet seat, and still be coded as independent.

2. **Self-Care:** Mr. T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, Mr. T was independent in eating and using the toilet; however, Mr. T required assistance for bathing and putting on and taking off his shoes and socks. The assistance needed was due to severe arthritic lumbar pain upon bending, which limited his ability to access his feet.

   **Coding:** GG0100A would be coded 2, Needed Some Help.

   **Rationale:** Mr. T needed partial assistance from a helper to complete the activities of bathing and dressing. While Mr. T did not need help for all self-care activities, he did need some help. Code 2 is used to indicate that Mr. T needed some help for self-care.

3. **Self-Care:** Mr. R was diagnosed with a progressive neurologic condition five years ago. He lives in a long-term nursing facility and was recently hospitalized for surgery and has now been admitted to the SNF for skilled services. According to Mr. R’s wife, prior to the surgery, Mr. R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

   **Coding:** GG0100A would be coded 1, Dependent.

   **Rationale:** Mr. R’s wife has reported that Mr. R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.
GG0100. Prior Functioning: Everyday Activities (cont.)

4. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder and is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission. The staff has not been successful in contacting either Mr. F’s family or his friends. Mr. F’s prior self-care abilities are unknown.

   **Coding:** GG0100A would be coded 8, Unknown.
   **Rationale:** Attempts to seek information regarding Mr. F’s prior functioning were made; however, no information was available. This item is coded 8, Unknown.

5. **Indoor Mobility (Ambulation):** Mr. C was admitted to an acute care hospital after experiencing a stroke. Prior to admission, he used a cane to walk from room to room. In the morning, Mr. C’s wife would provide steadying assistance to Mr. C when he walked from room to room because of joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day when walking from room to room.

   **Coding:** GG0100B would be coded 2, Needed Some Help.
   **Rationale:** The resident needed some assistance (steadying assistance) from his wife to complete the activity of walking in the home.

6. **Indoor Mobility (Ambulation):** Approximately three months ago, Mr. K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Mr. K has been living at home with his wife and developed aspiration pneumonia. After this most recent hospitalization, he was admitted to the SNF for aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking.

   **Coding:** GG0100B would be coded 2, Needed Some Help.
   **Rationale:** While the resident experienced a cardiac event three months ago, he recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident’s prior functioning is based on the time immediately before his most recent condition exacerbation that required acute care.

7. **Indoor Mobility (Ambulation):** Mrs. L had a stroke one year ago that resulted in her using a wheelchair to self-mobilize, as she was unable to walk. Mrs. L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

   **Coding:** GG0100B would be coded 9, Not Applicable.
   **Rationale:** The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).
GG0100. Prior Functioning: Everyday Activities (cont.)

8. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by his recent admission to the SNF for rehabilitation, Mr. V experienced severe knee pain upon ascending and particularly descending his internal and external stairs at home. Mr. V required assistance from his wife when using the stairs to steady him in the event his left knee would buckle. Mr. V’s wife was interviewed about her husband’s functioning prior to admission, and the therapist noted Mr. V’s prior functional level information in his medical record.

   **Coding:** GG0100C would be coded 2, Needed Some Help.
   **Rationale:** Prior to admission, Mr. V required some help in order to manage internal and external stairs.

9. **Stairs:** Mrs. E lived alone prior to her hospitalization for sepsis and has early stage multiple sclerosis. She has now been admitted to a SNF for rehabilitation as a result of deconditioning. Mrs. E reports that she used a straight cane to ascend and descend her indoor stairs at home and small staircases within her community. Mrs. E reports that she did not require any human assistance with the activity of using stairs prior to her admission.

   **Coding:** GG0100C would be coded 3, Independent.
   **Rationale:** Mrs. E reported that prior to admission, she was independent in using her internal stairs and the use of small staircases in her community.

10. **Stairs:** Mr. P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to Mr. P’s family members requesting a return call. Mr. P has not received any visitors since his admission. The medical record from his prior facility does not indicate Mr. P’s prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

   **Coding:** GG0100C would be coded 8, Unknown.
   **Rationale:** Attempts were made to seek information regarding Mr. P’s prior functioning; however, no information was available.

11. **Functional Cognition:** Mr. K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Mr. K has been admitted to the SNF for rehabilitation. Mr. K’s caregiver reports that when living at home, Mr. K needed reminders to take his medications on time, manage his money, and plan tasks, especially when he was fatigued.

   **Coding:** GG0100D would be coded 2, Needed Some Help.
   **Rationale:** Mr. K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.
GG0100. Prior Functioning: Everyday Activities (cont.)

12. **Functional Cognition:** Ms. L recently sustained a brain injury from a fall at home. Prior to her recent hospitalization, she had been living in an apartment by herself. Ms. L’s cognition is currently impaired. Ms. L’s cousin, who had visited her frequently prior to her recent hospitalization, indicated that Ms. L did not require any help with taking her prescribed medications, planning her daily activities, and managing money when shopping.

   **Coding:** GG0100D would be coded 3, Independent.
   **Rationale:** Ms. L’s cousin, who frequently visited Ms. L prior to her sustaining a brain injury, reported that Ms. L was independent in taking her prescribed medications, planning her daily activities, and managing money when shopping, indicating her independence in using memory and problem-solving skills.

13. **Functional Cognition:** Mrs. R had a stroke, resulting in a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R’s prior functional status, and her medical records do not include information about her functional cognition prior to the stroke.

   **Coding:** GG0100D would be coded 8, Unknown.
   **Rationale:** Attempts to seek information regarding Mrs. R’s prior functioning were made; however, no information was available.

GG0110. Prior Device Use

<table>
<thead>
<tr>
<th>GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury</th>
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<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>A. Manual wheelchair</td>
</tr>
<tr>
<td>B. Motorized wheelchair and/or scooter</td>
</tr>
<tr>
<td>C. Mechanical lift</td>
</tr>
<tr>
<td>D. Walker</td>
</tr>
<tr>
<td>E. Orthotics/Prosthetics</td>
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<tr>
<td>Z. None of the above</td>
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**Item Rationale**

- Knowledge of the resident’s routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

**Steps for Assessment**

1. Ask the resident or his or her family or review the resident’s medical records to determine the resident’s use of prior devices and aids.
GG0110. Prior Device Use (cont.)

Coding Instructions

• Check all devices that apply.

• **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

• For GG0110D, Prior Device Use - Walker: “Walker” refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

• GG0110C, Mechanical lift, includes sit-to-stand, stand assist, and full-body-style lifts.

Example for Coding Prior Device Use

Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. She is unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. She uses a motorized wheelchair to mobilize.

**Coding:** GG0110B would be checked.

**Rationale:** Mrs. M used a motorized wheelchair prior to the current illness/injury.
GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)

<table>
<thead>
<tr>
<th>1. Admission Performance</th>
<th>2. Discharge Goal</th>
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<td>Enter Codes in Boxes</td>
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**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

**D. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

**E. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.

**F. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

**G. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
GG0130: Self-Care (3-day assessment period) 
Discharge (End of Medicare Part A Stay)

**Item Rationale**

- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Steps for Assessment

1. Assess the resident’s self-care performance based on direct observation, as well as the resident’s self-report and reports from qualified clinicians, care staff, or family documented in the resident’s medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

3. For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, “helper” does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.

4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

5. The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

**DEFINITION**

**USUAL PERFORMANCE**
A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status. If the resident’s functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worst performance, but rather record the resident’s usual performance.

**QUALIFIED CLINICIAN**
Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Admission or Discharge Performance Coding Instructions

- When coding the resident’s usual performance and discharge goal(s), use the six-point scale, or use one of the four “activity was not attempted” codes to specify the reason why an activity was not attempted.

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.

- **Code 05, Setup or clean-up assistance:** if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).

- **Code 04, Supervision or touching assistance:** if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.

- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

- **Code 07, Resident refused:** if the resident refused to complete the activity.

- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - For the 5-Day PPS assessment, code the resident’s functional status based on a clinical assessment of the resident’s performance that occurs soon after the resident’s admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident’s admission baseline status and are to be based on an assessment. The scores should reflect the resident’s status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident’s true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident’s Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident’s Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident’s Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
  - For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident’s discharge functional status, based on a clinical assessment of the resident’s performance that occurs as close to the time of the resident’s discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident’s Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

Coding Tips: Admission or Discharge Performance

**General Coding Tips**

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
Resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.

• A dash (“-”) indicates “No information.” CMS expects dash use to be a rare occurrence.

• Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

Tips for Coding the Resident's Usual Performance

• When coding the resident’s usual performance, “effort” refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

• Do not record the resident’s best performance, and do not record the resident’s worst performance, but rather record the resident’s usual performance during the assessment period.

• Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity.

• If the resident performs the activity more than once during the assessment period and the resident’s performance varies, coding in Section GG should be based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident’s Self-Care performance varies during the assessment period, report the resident’s usual performance, not the resident’s most independent performance and not the resident’s most dependent performance. A provider may need to use the entire three-day assessment period to obtain the resident’s usual performance.

Coding Tips for GG0130A, Eating

• Resident receives tube feedings or total parenteral nutrition (TPN):
  o If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN because of a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding Eating.
  o If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Assistance with tube feedings or TPN is not considered when coding Eating.
  o If the resident eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding Eating.

• If the resident eats finger foods using his or her hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for Coding Admission Performance or Discharge Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for GG0130A, Eating

1. **Eating:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-fourths of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

   **Coding:** GG0130A would be coded 03, Partial/moderate assistance.
   
   **Rationale:** The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

2. **Eating:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M’s hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food and liquids to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

   **Coding:** GG0130A would be coded 02, Substantial/maximal assistance.
   
   **Rationale:** The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

3. **Eating:** Mr. A eats all meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

   **Coding:** GG0130A would be coded 06, Independent.
   
   **Rationale:** The resident can independently complete the activity without any assistance from a helper for this activity. In this scenario, the presence of a G-tube does not affect the eating score.

4. **Eating:** The dietary aide opens all of Mr. S’s cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S’s ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

   **Coding:** GG0130A would be coded 05, Setup or clean-up assistance.
   
   **Rationale:** The helper provided setup assistance prior to the eating activity.
GG0130: Self-Care (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay)  (cont.)

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   **Coding:** GG0130A would be coded 04, Supervision or touching assistance.
   **Rationale:** Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

6. **Eating:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, the certified nursing assistant has to remind her to scan her entire meal tray to ensure she has seen all the food.

   **Coding:** GG0130A would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, the certified nursing assistant provides verbal and tactile cueing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

   **Coding:** GG0130A would be coded 04, Supervision or touching assistance.
   **Rationale:** The resident requires supervision and touching assistance in order to eat safely.

8. **Eating:** Mr. R is unable to eat by mouth since he had a stroke one week ago. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   **Coding:** GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.
   **Rationale:** The resident does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

9. **Eating:** Mr. F is fed all meals by the certified nursing assistant, because Mr. F has severe arm weakness and he is unable to assist.

   **Coding:** GG0130A would be coded 01, Dependent.
   **Rationale:** The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

10. **Eating:** Mr. J had a stroke that affects his left side. He is left-handed and feeds himself more than half of his meals, but tires easily. Mr. J requests assistance from the certified nursing assistant with the remainder of his meals.

   **Coding:** GG0130A would be coded 03, Partial/moderate assistance.
   **Rationale:** The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating.

11. **Eating:** Mrs. M has osteoporosis, which contributed to the fracture of her right wrist and hip during a recent fall. She is right-handed. Mrs. M starts eating on her own, but she does not have the coordination in her left hand to manage the eating utensils to feed herself without great effort. Mrs. M tires easily and cannot complete eating the meal. The certified nursing assistant feeds her more than half of the meal.

   **Coding:** GG0130A would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provides more than half the effort for the resident to complete the activity of eating.

**Coding Tip for GG0130B, Oral hygiene**

- *If a resident does not perform oral hygiene during therapy, determine the resident’s abilities based on performance on the nursing care unit.*

**Examples for GG0130B, Oral hygiene**

1. **Oral hygiene:** In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. Each time, the certified nursing assistant gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

   **Coding:** GG0130B would be coded 05, Setup or clean-up assistance.
   **Rationale:** The helper provides setup and clean-up assistance. The resident brushes her teeth without any help.

2. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S’s toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns and provides steadying assistance as the resident walks back to his bed.

   **Coding:** GG0130B would be coded 05, Setup or clean-up assistance.
   **Rationale:** The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Mr. S brushes his teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Oral hygiene**: At night, the certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

   **Coding**: GG0130B would be coded 03, Partial/moderate assistance.
   **Rationale**: The helper provided less than half the effort to complete oral hygiene.

4. **Oral hygiene**: Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. In the morning and evening, Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

   **Coding**: GG0130B would be coded 02, Substantial/maximal assistance.
   **Rationale**: The resident begins the activity. The helper completes the activity by performing more than half the effort.

5. **Oral hygiene**: Mr. G has Parkinson’s disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts *by brushing his upper and lower front teeth* and the certified nursing assistant completes the activity by *brushing the rest of his teeth*.

   **Coding**: GG0130B would be coded 02, Substantial/maximal assistance.
   **Rationale**: The helper provided more than half the effort for the resident to complete the activity of oral hygiene.

6. **Oral hygiene**: Ms. T has Lewy body dementia and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

   **Coding**: GG0130B would be coded 01, Dependent.
   **Rationale**: The helper provides all the effort for the activity to be completed.
GG0130: Self-Care (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

7. **Oral hygiene:** Mr. D has experienced a stroke. He can brush his teeth while sitting on the side of the bed, but when the certified nursing assistant hands him the toothbrush and toothpaste, he looks up at her puzzled what to do next. The certified nursing assistant cues Mr. D to put the toothpaste on the toothbrush and instructs him to brush his teeth. Mr. D then completes the task of brushing his teeth.

   **Coding:** GG0130B would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides verbal cues to assist the resident in completing the activity of brushing his teeth.

8. **Oral hygiene:** Ms. K suffered a stroke a few months ago that resulted in cognitive limitations. She brushes her teeth at the sink, but is unable to initiate the task on her own. The occupational therapist cues Ms. K to put the toothpaste onto the toothbrush, brush all areas of her teeth, and rinse her mouth after brushing. The occupational therapist remains with Ms. K providing verbal cues until she has completed the task of brushing her teeth.

   **Coding:** GG0130B would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides verbal cues to assist the resident in completing the activity of brushing her teeth.

9. **Oral hygiene:** Mrs. N has early stage amyotrophic lateral sclerosis. She starts brushing her teeth and completes cleaning her upper teeth and part of her lower teeth when she becomes fatigued and asks the certified nursing assistant to help her finish the rest of the brushing.

   **Coding:** GG0130B would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provided less than half the effort to complete oral hygiene.

**Coding Tips for GG0130C, Toileting hygiene**

- **Toileting hygiene** includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. **If the resident does not usually use undergarments, then assess the resident’s need for assistance to manage lower-body clothing and perineal hygiene.**

- **Toileting hygiene** takes place before and after use of the toilet, commode, bedpan, or urinal. **If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident’s need for assistance in managing clothing and perineal cleansing.**

- **If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving his or her bowels.**
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her pants and underwear before sitting down on the toilet. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her pants and underwear without assistance.

   **Coding:** GG0130C would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

2. **Toileting hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

   **Coding:** GG0130C would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides supervision as the resident performs the toilet hygiene activity. The resident is unsteady and the staff provide supervision for safety reasons.

3. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself and pulls her underwear back up.

   **Coding:** GG0130C would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

4. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

   **Coding:** GG0130C would be coded 01, Dependent.
   **Rationale:** The assistance of two helpers was needed to complete the activity of toileting hygiene.
5. **Toileting hygiene:** Mr. C has Parkinson’s disease and significant tremors that cause intermittent difficulty for him to perform perineal hygiene after having a bowel movement in the toilet. He walks to the bathroom with close supervision and lowers his pants, but asks the certified nursing assistant to help him with perineal hygiene after moving his bowels. He then pulls up his pants without assistance.

   **Coding:** GG0130C would be coded 03, Partial/moderate assistance.

   **Rationale:** The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by himself: Walking to the bathroom is not considered when scoring toileting hygiene.

6. **Toileting hygiene:** Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a hospital gown and underwear during the day. Ms. Q uses a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity due to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perineal hygiene as Ms. Q needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.

   **Coding:** GG0130C would be coded 02, Substantial/maximal assistance.

   **Rationale:** The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.

**Coding Tips for GG0130E, Shower/bathe self**

- **Shower/bathe self** includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident’s back or hair. **Shower/bathe self** does not include transferring in/out of a tub/shower.

- **Assessment of Shower/bathe self** can take place in a shower or bath or at a sink (i.e., full body sponge bath).

- **If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.**

- **If the resident cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity.**
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0130E, Shower/bathe self

1. **Shower/bathe self:** Mr. J sits on a tub bench as he washes, rinses, and dries himself. A certified nursing assistant stays with him to ensure his safety, as Mr. J has had instances of losing his sitting balance. The certified nursing assistant also provides lifting assistance as Mr. J gets onto and off of the tub bench.

   **Coding:** GG0130E would be coded 04, Supervision or touching assistance.

   **Rationale:** The helper provides supervision as Mr. J washes, rinses, and dries himself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** Mrs. E has a severe and progressive neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench with partial/moderate assistance. Mrs. E showers while sitting on a tub bench and washes her arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of her body, as a result of Mrs. E’s fatigue, to complete the activity. Mrs. E uses a long-handled shower to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E’s entire body.

   **Coding:** GG0130E would be coded 02, Substantial/maximal assistance.

   **Rationale:** The helper assists Mrs. E with more than half of the task of showering, which includes bathing, rinsing, and drying her body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** Mr. Y has limited mobility resulting from his multiple and complex medical conditions. He prefers to wash his body while sitting in front of the sink in his bathroom. A helper assists with washing, rinsing, and drying Mr. Y’s arms/hands, upper legs, lower legs, buttocks, and back.

   **Coding:** GG0130E would be coded 02, Substantial/maximal assistance.

   **Rationale:** The helper completed more than half the activity. Bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the resident’s back.
Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident’s clothing, then code 05, Setup or clean-up assistance.

- When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance.

- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.

- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.

- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.

- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

• For residents with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  o If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
  o If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
• For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  o If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  o If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. **Upper body dressing:** Mrs. Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress her upper body. During the day, she requires a certified nursing assistant only to place her clothing next to her bedside. Mrs. Y can now use compensatory strategies to put on her bra and top without any assistance. At night she removes her top and bra independently and puts the clothes on the nightstand, and the certified nursing assistant puts them away in her dresser.

   **Coding:** GG0130F would be coded 05, Setup or clean-up assistance.

   **Rationale:** Mrs. Y dresses and undresses her upper body and requires a helper only to retrieve her clothing, that is, setting up the clothing for her use. The description refers to Mrs. Y as “independent” (when removing clothes), but she needs setup assistance, so she is not independent with regard to the entire activity of upper body dressing.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Upper body dressing:** Mrs. Z wears a bra and a sweatshirt most days while in the SNF. She requires assistance from a certified nursing assistant to initiate the threading of her arms into her bra. Mrs. Z completes the placement of the bra over her chest. The helper hooks the bra clasps. Mrs. Z pulls the sweatshirt over her arms, head, and trunk. When undressing, Mrs. Z removes the sweatshirt, with the helper assisting her with one sleeve. Mrs. Z slides the bra off, once it has been unclasped by the helper.

   **Coding:** GG0130F would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides assistance with threading Mrs. Z’s arms into her bra and hooking and unhooking her bra clasps and assistance with removing one sleeve of the sweatshirt. Mrs. Z performs more than half of the effort.

3. **Upper body dressing:** Mr. K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one-third of his left sleeve of his shirt with much time and effort and is unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Mr. K.

   **Coding:** GG0130F would be coded 02, Substantial/maximal assistance.
   **Rationale:** Mr. K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

**Examples for GG0130G, Lower body dressing**

1. **Lower body dressing:** Mr. D is required to follow hip precautions as a result of recent hip surgery. He requires a helper to retrieve his clothing from the closet. Mr. D uses his adaptive equipment to assist in threading his legs into his pants. Because of balance issues, Mr. D needs the helper to steady him when standing to manage pulling on or pulling down his pants/undergarments. Mr. D also needs some assistance to put on and take off his socks and shoes.

   **Coding:** GG0130G would be coded 04, Supervision or touching assistance.
   **Rationale:** A helper steadies Mr. D when he is standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Lower body dressing:** Mrs. M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. She has been issued a knee brace, to be worn during the day. Mrs. M threads her legs into her garments, and pulls up and down her clothing to and from just below her hips. Only a little assistance from a helper is needed to pull up her garments over her hips. Mrs. M requires the helper to fasten her knee brace because of grasp and fine motor weakness.

   **Coding:** GG0130G would be coded 03, Partial/moderate assistance.
   **Rationale:** A helper provides only a little assistance when Mrs. M is putting on her lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace she wears is considered when determining the help needed when coding lower body dressing.

3. **Lower body dressing:** Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks.

   **Coding:** GG0130G would be coded 03, Partial/moderate assistance.
   **Rationale:** A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Mrs. R’s trunk or limbs, but provides less than half the effort for the task of lower body dressing. In contrast, coding level 04, Supervision or touching assistance, is used if the helper provides either verbal cues and/or only touching/steadying assistance as the resident completes the activity.

**Examples for GG0130H, Putting on/taking off footwear**

1. **Putting on/taking off footwear:** Mr. M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. He has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an ankle-foot orthosis that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks, and shoes within easy reach of his bed. While sitting on the bed, he needs to bend over to put on and take off his AFO, socks, and shoes, and he occasionally loses his sitting balance, requiring staff to place their hands on him to maintain his balance while performing this task.

   **Coding:** GG0130H would be coded 04, Supervision or touching assistance.
   **Rationale:** Mr. M puts on and takes off his AFO, socks, and shoes by himself; however, because of occasional loss of balance, he needs a helper to provide touching assistance when he is bending over.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. Putting on/taking off footwear: Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes.

**Coding:** GG0130H would be coded 03, Partial/moderate assistance.

**Rationale:** A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

**Examples of Probing Conversations with Staff**

1. Eating: Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident’s eating abilities:

   **Nurse:** “Please describe to me how Mr. S eats his meals. Once the food and liquid are presented to him, does he use utensils to bring food to his mouth and swallow?”

   **Certified nursing assistant:** “No, I have to feed him.”

   **Nurse:** “Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?”

   **Certified nursing assistant:** “No, he can’t do anything by himself. I scoop up each portion of the food and bring the fork or spoon to his mouth. I try to encourage him to feed himself or to help guide the spoon to his mouth but he can’t hold the fork. I even tried encouraging him to eat food he could pick up with his fingers, but he will not eat unless he is completely assisted for food and liquid.”

In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

**Coding:** GG0130A would be coded 01, Dependent.

**Rationale:** The resident requires complete assistance from the certified nursing assistant to eat his meals.
GG0130: Self-Care (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident’s oral hygiene score and a certified nursing assistant regarding the resident’s oral hygiene routine:

   Nurse: “Does Mrs. K help with brushing her teeth?”
   
   Certified nursing assistant: “She can help clean her teeth.”
   
   Nurse: “How much help does she need to brush her teeth?”
   
   Certified nursing assistant: “She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth.”

In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

**Coding:** GG0130B would be coded 02, Substantial/maximal assistance.

**Rationale:** The certified nursing assistant provides more than half the effort to complete Mrs. K’s oral hygiene.

**Discharge Goals: Coding Tips**

*Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.*

- **For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal.** Code the resident’s discharge goal(s) using the six-point scale. Use of the “activity was not attempted” codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.

- Licensed, qualified clinicians can establish a resident’s Discharge Goal(s) at the time of admission based on the resident’s prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the professional’s standard of practice, expected treatments, the resident’s motivation to improve, anticipated length of stay, and the resident’s discharge plan. Goals should be established as part of the resident’s care plan.

- If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a Discharge Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Discharge Goal: Coding Examples

1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code

   If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.

2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code

   The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain her admission functional performance level. The qualified clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident’s admission performance code.

   **Oral Hygiene 5-Day PPS Assessment Admission Performance:** In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident’s 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson’s disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes Mrs. E’s 5-Day PPS admission performance and discusses her usual performance with qualified clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E’s limb). The qualified clinician codes Mrs. E’s 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding her limb.

   **Oral Hygiene 5-Day PPS Assessment Discharge Goal:** The qualified clinician anticipates Mrs. E’s discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E’s progressive and degenerative condition, the qualified clinician and resident feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a Discharge Goal.
GG0130: Self-Care (3-day assessment period) 
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. Discharge Goal Code Is Lower than 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident’s 5-Day PPS assessment admission performance code.

**Toileting Hygiene:** Mrs. T’s participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The resident’s Discharge Goal code will be lower than the 5-Day PPS Admission Performance code.

**Toileting Hygiene 5-Day PPS Assessment Admission Performance:** Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. T’s toileting hygiene.

**Toileting Hygiene Discharge Goal:** By discharge, it is expected that Mrs. T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The qualified clinician codes her Discharge Goal as 02, Substantial/maximal assistance.
GG0170: Mobility (3-day assessment period)
Admission (Start of Medicare Part A Stay)

**GG0170. Mobility** (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A24008)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goals.

**Coding:**
- **Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
  - **Activities may be completed with or without assistive devices:**
    - **06. Independent** - Resident completes the activity by him/herself with no assistance from a helper.
    - **03. Setup or clean-up assistance** - Helper sets up or cleans up resident completes activity. Helper assists only prior to or following the activity.
    - **04. Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
    - **02. Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
    - **01. Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
    - **00. Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
- **07. Resident refused**
- **09. Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **08. Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
- **88. Not attempted due to medical condition or safety concerns**

<table>
<thead>
<tr>
<th>1. Admission Performance</th>
<th>2. Discharge Goal</th>
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<tr>
<td>Enter Codes in Boxes</td>
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- **A. Roll left and right**: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
- **B. Sit to lying**: The ability to move from sitting on side of bed to lying flat on the bed.
- **C. Lying to sitting on side of bed**: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- **D. Sit to stand**: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- **E. Chair-to-chair transfer**: The ability to transfer to and from a chair to a chair (or wheelchair).
- **F. Toilet transfer**: The ability to get on and off a toilet or commode.
- **G. Car transfer**: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
- **I. Walk 10 feet**: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.
  - If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
- **J. Walk 50 feet with two turns**: Once standing, the ability to walk at least 50 feet and make two turns.
- **K. Walk 150 feet**: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
GG0170: Mobility (3-day assessment period)  
Admission (Start of Medicare Part A Stay) (cont.)

| Code the resident’s usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident’s end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s). |

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<td>02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</td>
</tr>
<tr>
<td>01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</td>
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</table>

If activity was not attempted, code reason:

- 07. Resident refused
- 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical condition or safety concerns

### Admission Performance

| 1. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel. |
| 2. M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. |
| 3. N. 4 steps: The ability to go up and down four steps with or without a rail. |
| 4. O. 12 steps: The ability to go up and down 12 steps with or without a rail. |
| 5. P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor. |
| 6. Q1. Does the resident use a wheelchair and/or scooter? |
| 7. R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns. |

### Discharge Goal

| 1. Manual |
| 2. Motorized |

| S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space. |

S51. Indicate the type of wheelchair or scooter used.

- 1. Manual |
- 2. Motorized |
GG0170: Mobility (3-day assessment period)
Discharge (End of Medicare Part A Stay)

| GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS stay ending on A2400C) |
| Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03 |

| Coding: Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices. |
| 06. Independent - Resident completes the activity by him/herself with no assistance from a helper. |
| 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. |
| 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. |
| 03. Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. |
| 02. Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. |
| 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. |

If activity was not attempted, code reason:

| 07. Resident refused |
| 00. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. |
| 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints) |
| 08. Not attempted due to medical condition or safety concerns |

### 3. Discharge Performance

Enter Codes in Boxes

| A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. |
| B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed. |
| C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. |
| D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. |
| E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). |
| F. Toilet transfer: The ability to get on and off a toilet or commode. |
| G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt. |
| H. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 66, skip to GG0170M, 1 step (curb). |
| I. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns. |
| J. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. |
GG0170: Mobility (3-day assessment period)  
Discharge (End of Medicare Part A Stay) (cont.)

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<th>Code</th>
<th>Description</th>
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<tr>
<td>GG0170</td>
<td>Mobility (Assessment period is the last 3 days of the SNF PPS stay ending on A2400C) - Continued</td>
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Complete only if A0310G is not = 2 and A0310H = 1 and A2400C minus A24008 is greater than 2 and A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

**Coding:**
- **Safety** and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistive devices.
- **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- **Set up or clean-up assistance** - Helper sets up or cleans up resident completes activity. Helper assists only prior to or following the activity.
- **Superior or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
- 07. Resident refused
- 09. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
- 88. Not attempted due to medical condition or safety concerns

### 3. Discharge Performance

Enter Codes in Boxes

- **I. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
  - M. 1 step (curb): The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 — Skip to GG0170P, Picking up object
  - N. 4 steps: The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 — Skip to GG0170P, Picking up object
  - O. 12 steps: The ability to go up and down 12 steps with or without a rail.

- **P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
  - Q3. **Does the resident use a wheelchair and/or scooter?**
    - 0. No — Skip to I0100, Appliances
    - 1. Yes — Continue to GG0170R, Wheel 50 feet with two turns

- **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
  - RR1. **Indicate the type of wheelchair or scooter used.**
    - 1. Manual
    - 2. Motorized

- **S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
  - SS1. **Indicate the type of wheelchair or scooter used.**
    - 1. Manual
    - 2. Motorized
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Item Rationale

- During a Medicare Part A SNF stay, residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

Steps for Assessment

1. Assess the resident’s mobility performance based on direct observation, as well as the resident’s self-report and the reports of qualified clinicians, direct care staff, or family during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

3. For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.

4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

5. The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

**DEFINITION**

**USUAL PERFORMANCE**

A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status. If the resident’s functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worst performance, but rather record the resident’s usual performance.
Admission or Discharge Performance Coding Instructions

- **When coding the resident’s usual performance and the resident’s discharge goal(s), use the six-point scale, or one of the four “activity was not attempted” codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.**

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.

- **Code 05, Setup or clean-up assistance:** if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.

- **Code 04, Supervision or touching assistance:** if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.

- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.

- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.

- **Code 07, Resident refused:** if the resident refused to complete the activity.

- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Admission or Discharge Performance Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  
  - For the 5-Day PPS assessment, code the resident’s functional status based on a clinical assessment of the resident’s performance that occurs soon after the resident’s admission. This functional assessment must be completed within the first three days (three calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. **The admission function scores are to reflect the resident’s admission baseline status and are to be based on an assessment. The scores should reflect the resident’s status prior to any benefit from interventions.** The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident’s true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident’s Medicare Part A stay ends as documented in A2400C, End of Most Recent Medicare Stay, either as a standalone assessment when the resident’s Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident’s Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
  
  - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident’s discharge functional status, based on a clinical assessment of the resident’s performance that occurs as close to the time of the resident’s discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident’s Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

**Admission and Discharge Performance Coding Tips**

*General Coding Tips*

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet.

- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07, if the resident refused to attempt the activity; code as 09, if the activity is not applicable for the resident (the activity did not occur at the time of the assessment, and prior to the current illness, exacerbation, or injury); code as 10, if the resident was not able to attempt the activity due to environmental limitations; or code as 88, if the resident was not able to attempt the activity due to a medical condition or safety concerns.

- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.

- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.

- To clarify your own understanding and observations about a resident’s performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.

- A dash (“-”) indicates “No information.” CMS expects dash use to be a rare occurrence.

- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.
Tips for Coding the Resident’s Usual Performance

- When coding the resident’s usual performance, “effort” refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

- Do not record the resident’s best performance, and do not record the resident’s worst performance, but rather record the resident’s usual performance during the assessment period.

- Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity.

- If the resident performs the activity more than once during the assessment period and the resident’s performance varies, coding in Section GG is based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire three-day assessment period to obtain the resident’s usual performance.

Examples and Coding Tips for Admission or Discharge Performance

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for GG0170A, Roll left and right

1. **Roll left and right:** Mrs. R has a history of skin breakdown. A nurse instructs her to turn onto her right side, providing step-by-step instructions to use the bedrail, bend her left leg, and then roll onto her right side. Mrs. R attempts to roll with the use of the bedrail, but indicates she cannot perform the task. The nurse then rolls her onto her right side. Next, Mrs. R is instructed to return to lying on her back, which she successfully completes. Mrs. R then requires physical assistance from the nurse to roll onto her left side and to return to lying on her back to complete the activity.

   **Coding:** GG0170A would be coded 02, Substantial/maximal assistance.

   **Rationale:** The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move Mrs. R’s body weight to turn onto her right side. The nurse provides the same assistance when Mrs. R turns to her left side and when she returns to her back. Mrs. R is able to return to lying on her back from her right side by herself.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Roll left and right:** A physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. K completes the activity without physical assistance from the physical therapist.

   **Coding:** GG0170A would be coded 04, Supervision or touching assistance.
   **Rationale:** The physical therapist provides verbal cues (i.e., instructions) to Mr. K as he rolls from his back to his right side and returns to lying on his back, and then again as he performs the same activities with respect to his left side. The physical therapist does not provide any physical assistance.

3. **Roll left and right:** Mr. Z had a stroke that resulted in paralysis on his right side and is recovering from cardiac surgery. He requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and also when rolling onto his left side and returning to lying on his back.

   **Coding:** GG0170A would be coded 01, Dependent.
   **Rationale:** Two certified nursing assistants are needed to help Mr. Z roll onto his left and right side and back while in bed.

4. **Roll left and right:** Mr. M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician’s order allows him to roll onto his left hip as tolerated. A certified nursing assistant assists Mr. M in rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. M needs physical assistance from the certified nursing assistant to initiate his rolling right because of his left arm weakness when grasping the right bedrail to assist in rolling. Mr. M returns to lying on his back without assistance and uses his right arm to grasp the left bedrail to slowly roll onto his left hip and then return to lying on his back.

   **Coding:** GG0170A would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

**Examples for GG0170B, Sit to lying**

1. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H’s right leg. Mrs. H uses her arms to position her upper body and lowers herself to a lying position flat on her back.

   **Coding:** GG0170B would be coded 03, Partial/moderate assistance.
   **Rationale:** A helper lifts Mrs. H’s right leg and helps her position it as she moves from a seated to a lying position; the helper performs less than half of the effort.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. Sit to lying: Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

   **Coding:** GG0170B would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provided more than half the effort for the resident to complete the activity of sit to lying.

3. Sit to lying: Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

   **Coding:** GG0170B would be coded 01, Dependent.
   **Rationale:** The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. Sit to lying: Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   **Coding:** GG0170B would be coded 04, Supervision or touching assistance.
   **Rationale:** A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

5. Sit to lying: Mrs. G suffered a traumatic brain injury three months prior to admission. She requires the certified nursing assistant to steady her movements from sitting on the side of the bed to lying flat on the bed. Mrs. G requires steadying (touching) assistance throughout the completion of this activity.

   **Coding:** GG0170B would be coded 04, Supervision or touching assistance.
   **Rationale:** A helper provides steadying assistance in order for the resident to complete the activity of sit to lying flat on her bed.
6. **Sit to lying:** Mrs. E suffered a pelvic fracture during a motor vehicle accident. Mrs. E requires the certified nursing assistant to lift and position her left leg when she transfers from sitting at the edge of the bed to lying flat on the bed due to severe pain in her left pelvic area. Mrs. E uses her arms to position and lower her upper body to lying flat on the bed.

   **Coding:** GG0170B would be coded 03, Partial/moderate assistance.
   **Rationale:** A helper lifts Mrs. E’s left leg and helps her position it as Mrs. E transitions from a seated to a lying position; the helper does less than half of the effort.

7. **Sit to lying:** Mr. A suffered multiple vertebral fractures due to a fall off a ladder. He requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back. The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed. Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

   **Coding:** GG0170B would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provided more than half the effort for the resident to complete the activity of sit to lying.

### Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes resident transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The residents’ ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity is assessed.

- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a “lying” position for a particular resident.

- If the resident’s feet do not reach the floor upon lying to sitting, the qualified clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor.

- Back support refers to an object or person providing support for the resident’s back.

- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.
GG0170: Mobility (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Mr. B pushes up from the bed to get himself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Mr. B scoots himself to the edge of the bed and lowers his feet onto the floor.

   **Coding:** GG0170C would be coded 04, Supervision or touching assistance.  
   **Rationale:** The helper provides touching assistance as the resident moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides *additional lifting* assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor.

   **Coding:** GG0170C would be coded 02, Substantial/maximal assistance.  
   **Rationale:** The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

   **Coding:** GG0170C would be coded 01, Dependent.  
   **Rationale:** The helper fully completed the activity of lying to sitting on the side of bed for the resident.

4. **Lying to sitting on side of bed:** Ms. H is recovering from a spinal fusion. She rolls to her right side and pushes herself up from the bed to get from a lying to a seated position. The therapist provides verbal cues as Ms. H safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed. Ms. H then maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity.

   **Coding:** GG0170C would be coded 04, Supervision or touching assistance.  
   **Rationale:** The helper provides verbal cues as the resident moves from a lying to sitting position and does not lift the resident during the activity.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Lying to sitting on side of bed:** Mrs. P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Mrs. P’s trunk as she gets to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Mrs. P then scoots toward the edge of the bed and places both feet flat on the floor. Mrs. P completes most of the effort to get from lying to sitting on the side of the bed.

   **Coding:** GG0170C would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on side of bed.

**Coding Tip for GG0170D, Sit to stand**

- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.

**Examples for GG0170D, Sit to stand**

1. **Sit to stand:** Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse’s hand on Mr. M’s trunk.

   **Coding:** GG0170D would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides touching assistance only.

2. **Sit to stand:** Mrs. L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist her to stand up from sitting in a chair.

   **Coding:** GG0170D would be coded 01, Dependent.
   **Rationale:** Mrs. L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

   **Coding:** GG0170D would be coded 88, Not attempted due to medical condition or safety concerns.
   **Rationale:** The activity is not attempted due to the resident’s diagnosis of complete tetraplegia.

4. **Sit to stand:** Ms. Z has amyotrophic lateral sclerosis with moderate weakness in her lower and upper extremities. Ms. Z has prominent foot drop in her left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Ms. Z’s AFO and places the platform walker in front of her; Ms. Z uses the walker to steady herself once standing. The certified nursing assistant provides lifting assistance to get Ms. Z
GG0130: Self-Care (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

to a standing position and must also provide assistance to steady Ms. Z’s balance to complete the activity.

**Coding:** GG0170D would be coded 02, Substantial/maximal assistance.

**Rationale:** The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.

**Coding:** GG0170D would be coded 03, Partial/moderate assistance.

**Rationale:** The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

**Coding Tips for GG0170E, Chair/bed-to-chair transfer**

- **Item GG0170E, Chair/bed-to-chair transfer,** begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.

- **If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.**

**Examples for GG0170E, Chair/bed-to-chair transfer**

1. **Chair/bed-to-chair transfer:** Mr. L had a stroke and currently is not able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

   **Coding:** GG0170E would be coded 05, Setup or clean-up assistance.

   **Rationale:** Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Chair/bed-to-chair transfer**: Mr. C is sitting on the side of the bed. He stands and pivots into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Mr. C only required verbal cues for safety, but usually Mr. C requires touching assistance.

   **Coding:** GG0170E would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer**: Mr. F’s medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

   **Coding:** GG0170E would be coded 01, Dependent.
   **Rationale:** The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer**: Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides limited trunk support with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance.

   **Coding:** GG0170E would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

5. **Chair/bed-to-chair transfer**: Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, *but assists with the transfer*. The physical therapist assists him in side scooting by lifting his trunk in a rocking motion across the transfer board and into the wheelchair.

   **Coding:** GG0170E would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips the footrests back down herself.
   - **Coding:** GG0170F would be coded 05, Setup or clean-up assistance.
   - **Rationale:** The helper provides setup assistance (moving the footrest out of the way) before Mrs. T can transfer safely onto the toilet.

2. **Toilet transfer:** Mrs. Q transfers onto and off the elevated toilet seat with the certified nursing assistant supervising due to her unsteadiness.
   - **Coding:** GG0170F would be coded 04, Supervision or touching assistance.
   - **Rationale:** The helper provides supervision as the resident transfers onto and off the toilet. The resident may use an assistive device.

3. **Toilet transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.
   - **Coding:** GG0170F would be coded 04, Supervision or touching assistance.
   - **Rationale:** The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.
   - **Coding:** GG0170F would be coded 04, Supervision or touching assistance.
   - **Rationale:** The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene and is not considered when rating the Toilet transfer item.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Toilet transfer: The therapist supports Mrs. M’s trunk with a gait belt *by providing weight-bearing* as Mrs. M pivots and lowers herself onto the toilet.

**Coding:** GG0170F would be coded 03, Partial/moderate assistance.
**Rationale:** The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

Toilet transfer: Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The certified nursing assistant *provides weight-bearing assistance as she* slowly *rotates and* lowers Ms. W onto the bedside commode.

**Coding:** GG0170F would be coded 02, Substantial/maximal assistance.
**Rationale:** The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

Toilet transfer: Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

**Coding:** GG0170F would be coded 01, Dependent.
**Rationale:** The activity required the assistance of two or more helpers for the resident to complete the activity.

Toilet transfer: Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

**Coding:** GG0170F would be coded 88, Not attempted due to medical condition or safety concerns.
**Rationale:** The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0170G, Car transfer

1. **Car transfer:** Mrs. W uses a wheelchair and ambulates for only short distances. She requires lifting assistance from a physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the therapist. She lifts her legs into the car with support from the therapist.

   **Coding:** GG0170G would be coded 02, Substantial/maximal assistance.
   
   **Rationale:** Although Mrs. W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer Mrs. W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During her rehabilitation stay Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Mrs. N requires verbal reminders for safety and light touching assistance. The therapist instructs her on strategic hand placement while Mrs. N transitions to sitting in the car’s passenger seat. The therapist opens and closes the door.

   **Coding:** GG0170G would be coded 04, Supervision or touching assistance.
   
   **Rationale:** The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

**Coding Tips for GG0170I–G0170L Walking Items**

- **Walking activities do not need to occur during one session.** Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.

- **When coding GG0170 walking items, do not consider the resident’s mobility performance when using parallel bars.** Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.

- **The turns included in item GG0170J, Walk 50 feet with two turns, are 90-degree turns.** The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person’s ability level and can include use of an assistive device (for example, cane).
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Mrs. C has resolving sepsis and has not walked in three weeks because of her medical condition. A physical therapist determines that it is unsafe for Mrs. C to use a walker, and the resident only walks using the parallel bars. On day 3 of the Admission assessment period, Mrs. C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

   **Coding:** GG0170I would be coded 88, Not attempted due to medical condition or safety concerns.
   **Rationale:** When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident is unable to walk without the use of parallel bars because of his or her medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.

2. **Walk 10 feet:** Mr. L had bilateral amputations three years ago, and prior to the current admission he used a wheelchair and did not walk. Currently Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L’s care plan includes fitting and use of bilateral lower extremity prostheses.

   **Coding:** GG0170I would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
   **Rationale:** When assessing a resident for GG0170I, Walk 10 feet, consider the resident’s status prior to the current episode of care and current three-day assessment status. Use code 09, Not applicable, because Mr. L did not walk prior to the current episode of care and did not walk during the three-day assessment period. Mr. L’s care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the resident’s care plan.

3. **Walk 10 feet:** Mrs. C has Parkinson’s disease and walks with a walker. A physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C’s foot, during the activity of walking 10 feet.

   **Coding:** GG0170I would be coded 02, Substantial/maximal assistance.
   **Rationale:** A helper provides more than half the effort as the resident completes the activity.
GG0170: Mobility (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson’s disease. A therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last two feet of the 10-foot walk.

   **Coding:** GG0170I would be coded 03, Partial/moderate assistance.  
   **Rationale:** The helper provides less than half the effort required for the resident to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Mr. O supported his own body weight with his arms and legs and propelled his legs forward for 8 of the 10 feet. The helper supported part of Mr. O’s weight only for 2 of the 10 feet; thus Mr. O contributed more than half the effort.

5. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker while walking. The nurse places his hand on Mrs. U’s back to steady her toward the last half of her 10-foot walk.

   **Coding:** GG0170I would be coded 04, Supervision or touching assistance.  
   **Rationale:** A helper provides touching assistance in order for the resident to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

**Examples for GG0170J, Walk 50 feet with two turns**

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Mrs. W gets up from a sitting position to a standing position. After the therapist places Mrs. W’s walker within reach, Mrs. W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while she walks.

   **Coding:** GG0170J would be coded 05, Setup or clean-up assistance.  
   **Rationale:** Mrs. W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance).

2. **Walk 50 feet with two turns:** Mrs. P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Mrs. P turns.

   **Coding:** GG0170J would be coded 04, Supervision or touching assistance.  
   **Rationale:** The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Walk 50 feet with two turns:** Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the certified nursing assistant supports her trunk *providing weight-bearing assistance.*

   **Coding:** GG0170J would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Mr. T walks 50 feet with the therapist providing trunk support and the therapy assistant providing supervision. Mr. T walks the 50 feet with two turns.

   **Coding:** GG0170J would be coded 01, Dependent.
   **Rationale:** Mr. T requires two helpers to complete the activity.

5. **Walk 50 feet with two turns:** Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides *significant trunk support for about 30 to 35 feet.*

   **Coding:** GG0170J would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

**Examples for GG0170K, Walk 150 feet**

1. **Walk 150 feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D, who intermittently loses her balance while she uses the walker.

   **Coding:** GG0170K would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provides touching assistance intermittently throughout the activity.

2. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

   **Coding:** GG0170K would be coded 88, Activity not attempted due to medical condition or safety concerns, *and the resident’s ability to walk a shorter distance would be coded in item GG0170I. The resident did not complete the activity, and a helper cannot complete the activity for the resident.*
   **Rationale:** The activity was not attempted.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Walk 150 feet:** Mrs. T has an unsteady gait due to balance impairment. Mrs. T walks the length of the hallway using her quad cane in her right hand. The physical therapist supports her trunk, helping her to maintain her balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   **Coding:** GG0170K would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Mr. W, who has Parkinson’s disease, walks the length of the hallway using his rolling walker. The physical therapist provides trunk support and advances Mr. W’s right leg in longer strides with each step. The therapist occasionally prevents Mr. W from falling as he loses his balance during the activity.

   **Coding:** GG0170K would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

**Example for GG0170L, Walking 10 feet on uneven surfaces**

1. **Walking 10 feet on uneven surfaces:** Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During her SNF stay, a physical therapist takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the therapist’s weight-bearing assistance less than half the time during walking in order to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.

   **Coding:** GG0170L would be coded 03, Partial/moderate assistance.
   **Rationale:** Mrs. N requires a helper to provide weight-bearing assistance several times to prevent her from falling as she walks 10 feet on uneven surfaces. The helper contributes less than half the effort required for Mrs. N to walk 10 feet on uneven surfaces.

**Example for GG0170M, 1 step (curb)**

1. **1 step (curb):** Mrs. Z has had a stroke; she must be able to step up and down one step to enter and exit her home. A physical therapist provides standby assistance as she uses her quad cane to support her balance in stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step.

   **Coding:** GG0170M would be coded 04, Supervision or touching assistance.
   **Rationale:** A helper provides touching assistance as Mrs. Z completes the activity of stepping up and down one step.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Example for GG0170N, 4 steps

1. 4 steps: Mr. J has lower body weakness, and a physical therapist provides steadying assistance when he ascends 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Mr. J holds the stair railing.

   **Coding:** GG0170N would be coded 03, Partial/moderate assistance.
   **Rationale:** A helper provides touching assistance as Mr. J ascends 4 steps. The helper provides trunk support (more than touching assistance) when he descends the 4 steps.

Example for GG0170O, 12 steps

1. 12 steps: Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y’s home has 12 stairs, with a railing, and she needs to use these stairs to enter and exit her home. Her physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.

   **Coding:** GG0170O would be coded 03, Partial/moderate assistance.
   **Rationale:** The helper provides less than half the required effort in providing the necessary support for Ms. Y as she ascends and descends 12 stairs.

Examples for GG0170P, Picking up object

1. Picking up object: Mr. P has a neurologic condition that has resulted in balance problems. He wants to be as independent as possible. Mr. P lives with his wife and will soon be discharged from the SNF. He tends to drop objects and has been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind Mr. P of safety strategies when he bends to pick up objects from the floor, and she needs to steady him to prevent him from falling.

   **Coding:** GG0170P would be coded 04, Supervision or touching assistance.
   **Rationale:** A helper is needed to provide verbal cues and touching or steadying assistance when Mr. P picks up an object because of his coordination issues.

2. Picking up object: Ms. C has recently undergone a hip replacement. When she drops items she uses a long-handled reacher that she had been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket she requires a certified nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher.

   **Coding:** GG0170P would be coded 05, Setup or clean-up assistance.
   **Rationale:** The helper provides set-up assistance so that Ms. C can use her long-handled reacher.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

**Coding Tips for GG0170R and GG0170S, Wheelchair Items**

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair prior to admission. Use clinical judgment to determine whether a resident’s use of a wheelchair is for self-mobilization as a result of the resident’s medical condition or safety.

- Do not code wheelchair mobility if the resident uses a wheelchair only when transported between locations within the facility or for staff convenience (e.g., because the resident walks slowly). Only code wheelchair mobility based on an assessment of the resident’s ability to mobilize in the wheelchair.

- If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.

- Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission
  - The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments.

- If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.

- The turns included in item GG0170R (wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person’s ability level.
Example for GG0170Q1, Does the resident use a wheelchair/scooter?

1. Does the resident use a wheelchair/scooter? On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD.

   **Coding:** GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Mr. T uses for GG0170RR1 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

   **Rationale:** The resident currently uses a wheelchair. Coding the resident’s performance and the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair/scooter used

1. **Wheel 50 feet with two turns:** Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Mrs. M from the bed into the wheelchair. Once in her wheelchair, Mrs. M propels herself about 60 feet down the hall using her left leg and makes two turns without any physical assistance or supervision.

   **Coding:** GG0170R would be coded 06, Independent.

   **Rationale:** The resident wheels herself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

2. **Indicate the type of wheelchair/scooter used:** In the above example Mrs. M used a manual wheelchair during the 3-day assessment period.

   **Coding:** GG0170RR would be coded 1, Manual.

   **Rationale:** Mrs. M used a manual wheelchair during the 3-day assessment period.

3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The therapy assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. R’s wheelchair for him so that he may continue mobilizing/wheeling himself.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

**Coding:** GG0170R would be coded 03, Partial/moderate assistance.
**Rationale:** The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. R used a motorized wheelchair during the 3-day assessment period.
   
   **Coding:** GG0170RR would be coded 2, Motorized.
   **Rationale:** Mr. R used a motorized wheelchair during the 3-day assessment period.

5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The therapy assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.
   
   **Coding:** GG0170R would be coded 04, Supervision or touching assistance.
   **Rationale:** The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example Mr. V used a manual wheelchair during the 3-day assessment period.
   
   **Coding:** GG0170RR would be coded 1, Manual.
   **Rationale:** Mr. V used a manual wheelchair during the 3-day assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into her room and then turning into her bathroom.
   
   **Coding:** GG0170R would be coded 02, Substantial/maximal assistance.
   **Rationale:** The helper provides more than half the effort to assist the resident to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example Ms. R used a manual wheelchair during the 3-day assessment period.
   
   **Coding:** GG0170RR would be coded 1, Manual.
   **Rationale:** Ms. R used a manual wheelchair during the 3-day assessment period.
Examples for GG0170S, Wheel 150 feet and GG0170SS, Indicate the type of wheelchair/scooter used

1. **Wheel 150 feet:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).
   - **Coding:** GG0170S would be coded 04, Supervision or touching assistance.
   - **Rationale:** The helper provides verbal cues to complete the activity.

2. **Indicate the type of wheelchair/scooter used:** In the example above, Mr. G uses a motorized scooter.
   - **Coding:** GG0170SS would be coded 2, Motorized.
   - **Rationale:** Mr. G used a motorized scooter during the 3-day assessment period.

3. **Wheel 150 feet:** Mr. N uses a below-the-knee prosthetic limb. Mr. N has peripheral neuropathy and limited vision due to complications of diabetes. Mr. N’s prior preference was to ambulate within the home and use a manual wheelchair when mobilizing himself within the community. Mr. N is assessed for the activity of 150 feet wheelchair mobility. Mr. N’s usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.
   - **Coding:** GG0170S would be coded 04, Supervision or touching assistance.
   - **Rationale:** Mr. N requires the helper to provide verbal cues for his safety when using a wheelchair for 150 feet.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. N used a manual wheelchair during the 3-day assessment period.
   - **Coding:** GG0170SS would be coded 1, Manual.
   - **Rationale:** Mr. N used a manual wheelchair during the 3-day assessment period.

5. **Wheel 150 feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.
   - **Coding:** GG0170S would be coded 03, Partial/moderate assistance.
   - **Rationale:** The helper provides less than half of the effort to complete the activity of wheel 150 feet.
GG0170: Mobility (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

6. **Indicate the type of wheelchair/scooter used:** Mr. L used a motorized wheelchair during the 3-day assessment period.
   
   **Coding:** GG0170SS would be coded 2, Motorized.  
   **Rationale:** Mr. L used a motorized wheelchair during the 3-day assessment period.

7. **Wheel 150 feet:** Mr. M has had a mild stroke, resulting in muscle weakness in his right upper and lower extremities. Mr. M uses a manual wheelchair. He usually can self-propel himself about 60 to 70 feet but needs assistance from a helper to complete the distance of 150 feet.
   
   **Coding:** GG0170S would be coded 02, Substantial/Maximal assistance.  
   **Rationale:** The helper provides more than half of the effort to complete the activity of wheel 150 feet.

8. **Indicate the type of wheelchair/scooter used:** In the above example, Mr. M used a manual wheelchair during the 3-day assessment period.
   
   **Coding:** GG0170SS would be coded 1, Manual.  
   **Rationale:** Mr. M used a manual wheelchair during the 3-day assessment period.

9. **Wheel 150 feet:** Mr. A has a cardiac condition with medical precautions that do not allow him to participate in wheelchair mobilization. Mr. A is completely dependent on a helper to wheel him 150 feet using a manual wheelchair.
   
   **Coding:** GG0170S would be coded 01, Dependent.  
   **Rationale:** The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate the type of wheelchair/scooter used:** In the above example, Mr. A is wheeled using a manual wheelchair during the 3-day assessment period.
    
    **Coding:** GG0170SS would be coded 1, Manual.  
    **Rationale:** Mr. A is assisted using a manual wheelchair during the 3-day assessment period.
GG0170: Mobility (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident’s score for sit to lying and a certified nursing assistant regarding the resident’s bed mobility:
   
   **Nurse:** “Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?”

   **Certified nursing assistant:** “She can lie down with some help.”

   **Nurse:** “Please describe how much help she needs and exactly how you help her.”

   **Certified nursing assistant:** “I have to lift and position her right leg, but once I do that, she can use her arms to position her upper body.”

   In this example, the nurse inquired specifically about how Mrs. H moves from a sitting position to a lying position. The nurse asked about physical assistance.

   **Coding:** GG0170B would be coded 03, Partial/moderate assistance.  
   **Rationale:** The certified nursing assistant lifts Mrs. H’s right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident’s score for lying to sitting on side of bed and a certified nursing assistant regarding the resident’s bed mobility:

   **Nurse:** “Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?”

   **Certified nursing assistant:** “She can sit up by herself.”

   **Nurse:** “She sits up without any instructions or physical help?”

   **Certified nursing assistant:** “No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself.”

   In this example, the nurse inquired specifically about how Mrs. L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   **Coding:** GG0170C would be coded 04, Supervision or touching assistance.  
   **Rationale:** The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident’s sit to stand score and a certified nursing assistant regarding the resident’s sit to stand ability:

   **Nurse:** “Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?”

   **Certified nursing assistant:** “She needs help to get to sitting up and then standing.”

   **Nurse:** “I’d like to know how much help she needs for safely rising up from sitting in a chair or sitting on the bed to get to a standing position.”

   **Certified nursing assistant:** “She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair.”

In this example, the nurse inquired specifically about how Mrs. L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   **Coding:** GG0170D would be coded 01, Dependent.

   **Rationale:** Mrs. L requires the assistance of two helpers to complete the activity.

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident’s score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident’s chair/bed-to-chair transfer ability:

   **Nurse:** “Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?”

   **Certified nursing assistant:** “He needs me to help him move from the bed to the chair.”

   **Nurse:** “Does he help with these transfers when you give him any instructions, setup, or physical help?”

   **Certified nursing assistant:** “Yes, he will follow some of my instructions to get ready to transfer, such as moving his feet from being spread out to placing them under his knees. I have to place the chair close to the bed and then I lift him because he is very weak. I then tell him to reach for the armrest of the chair. Mr. C follows these directions and that helps a little in transferring him from the bed to the chair. He does help with the transfer.”

In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

   **Coding:** GG0170E would be coded 02, Substantial/maximal assistance.

   **Rationale:** The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.
GG0170: Mobility (3-day assessment period)  
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident’s score and a certified nursing assistant regarding a resident’s toilet transfer assessment:

   **Nurse:** “I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?”

   **Certified nursing assistant:** “It is hard for her, but she does it with my help.”

   **Nurse:** “Can you describe the amount of help in more detail?”

   **Certified nursing assistant:** “I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself.”

   In this example, the nurse inquired specifically about how Mrs. M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

   **Coding:** GG0170F would be coded 03, Partial/moderate assistance.

   **Rationale:** The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident’s score for walking 50 feet with two turns and a certified nursing assistant regarding the resident’s walking ability:

   **Nurse:** “How much help does Mr. T need to walk 50 feet and make two turns once he is standing?”

   **Certified nursing assistant:** “He needs help to do that.”

   **Nurse:** “How much help does he need?”

   **Certified nursing assistant:** “He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down.”

   In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

   **Coding:** GG0170J would be coded 01, Dependent.

   **Rationale:** Mr. T requires two helpers to complete this activity.
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident’s score for walking 150 feet and a certified nursing assistant regarding the resident’s walking ability:

   Nurse: “Please describe how Mrs. D walks 150 feet in the corridor once she is standing.”

   **Certified nursing assistant:** “She uses a walker and some help.”

   Nurse: “She uses a walker and how much instructions or physical help does she need?”

   **Certified nursing assistant:** “I have to support her by holding onto the gait belt that is around her waist so that she doesn’t fall. She does push the walker forward most of the time.”

   Nurse: “Do you help with more than or less than half the effort?”

   **Certified nursing assistant:** “I have to hold onto her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort.”

In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

**Coding:** GG0170K would be coded 02, Substantial/maximal assistance.

**Rationale:** The certified nursing assistant provides trunk support that is more than half the effort as Mrs. D walks 150 feet.

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident’s score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident’s mobility:

   Nurse: “I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair.”

   **Certified nursing assistant:** “She wheels herself.”

   Nurse: “She wheels herself without any instructions or physical help?”

   **Certified nursing assistant:** “Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself.”
GG0170: Mobility (3-day assessment period)
Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

In this example, the nurse inquired specifically about how Ms. R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

**Coding:** GG0170R would be coded 03, Partial/Moderate assistance.

**Rationale:** The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident’s score for wheel 150 feet and a certified nursing assistant regarding the resident’s mobility:

   **Nurse:** “I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?”

   **Certified nursing assistant:** “He drives the scooter himself … he’s very slow.”

   **Nurse:** “He uses the scooter himself without any instructions or physical help?”

   **Certified nursing assistant:** “That is correct.”

In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

**Coding:** GG0170S would be coded 06, Independent.

**Rationale:** The resident navigates in the corridor for at least 150 feet without assistance.
Discharge Goals: Coding Tips

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident’s discharge goal(s) using the six-point scale. Use of “activity not attempted” codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.

- Licensed qualified clinicians can establish a resident’s discharge goal(s) at the time of admission based on the resident’s prior medical condition, Admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the profession’s practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident’s discharge plan. Goals should be established as part of the resident’s care plan.

- If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.
SECTION I: ACTIVE DIAGNOSES

**Intent:** The items in this section are intended to code diseases that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident’s current health status.

**I0020: Indicate the resident’s primary medical condition category**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Indicate the resident’s primary medical condition category that best describes the primary reason for admission Complete only if A0310B = 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Stroke</td>
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<tr>
<td>02</td>
<td>Non-Traumatic Brain Dysfunction</td>
</tr>
<tr>
<td>03</td>
<td>Traumatic Brain Dysfunction</td>
</tr>
<tr>
<td>04</td>
<td>Non-Traumatic Spinal Cord Dysfunction</td>
</tr>
<tr>
<td>05</td>
<td>Traumatic Spinal Cord Dysfunction</td>
</tr>
<tr>
<td>06</td>
<td>Progressive Neurological Conditions</td>
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<tr>
<td>07</td>
<td>Other Neurological Conditions</td>
</tr>
<tr>
<td>08</td>
<td>Amputation</td>
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<tr>
<td>09</td>
<td>Hip and Knee Replacement</td>
</tr>
<tr>
<td>10</td>
<td>Fractures and Other Multiple Trauma</td>
</tr>
<tr>
<td>11</td>
<td>Other Orthopedic Conditions</td>
</tr>
<tr>
<td>12</td>
<td>Debility, Cardiorespiratory Conditions</td>
</tr>
<tr>
<td>13</td>
<td>Medically Complex Conditions</td>
</tr>
<tr>
<td>14</td>
<td>Other Medical Condition If “Other Medical Condition,” enter the ICD code in the boxes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Disease processes can have a significant adverse effect on residents’ functional improvement.

**Planning for Care**

- This item identifies the primary medical condition category that resulted in the resident’s admission to the facility and that influences the resident’s functional outcomes.

**Steps for Assessment**

1. Review the documentation in the medical record to identify the resident’s primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

**Coding Instructions**

**Complete only if A0310B = 01**

- Enter the code that represents the primary medical condition that resulted in the resident’s admission. If codes 1–13 do not apply, use code 14, “Other Medical Condition,” and proceed to I0020A.
I0020: Indicate the resident’s primary medical condition category (cont.)

- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
  - **Code 01, Stroke**, if the resident’s primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
  - **Code 02, Non-Traumatic Brain Dysfunction**, if the resident’s primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer’s disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.
  - **Code 03, Traumatic Brain Dysfunction**, if the resident’s primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.
  - **Code 04, Non-Traumatic Spinal Cord Dysfunction**, if the resident’s primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
  - **Code 05, Traumatic Spinal Cord Dysfunction**, if the resident’s primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.
  - **Code 06, Progressive Neurological Conditions**, if the resident’s primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson’s disease.
  - **Code 07, Other Neurological Conditions**, if the resident’s primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
  - **Code 08, Amputation**, if the resident’s primary medical condition category is an amputation. An example is acquired absence of limb.
  - **Code 09, Hip and Knee Replacement**, if the resident’s primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.
  - **Code 10, Fractures and Other Multiple Trauma**, if the resident’s primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
  - **Code 11, Other Orthopedic Conditions**, if the resident’s primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.
  - **Code 12, Debility, Cardiorespiratory Conditions**, if the resident’s primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
I0020: Indicate the resident’s primary medical condition category (cont.)

— Code 13, Medically Complex Conditions, if the resident’s primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

— Code 14, Other Medical Condition, if the resident’s primary medical condition category is not one of the listed categories. Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.

Examples of Primary Medical Condition

1. Ms. K is a 67-year-old female with a history of Alzheimer’s dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer’s dementia and diabetes, is documented in Ms. K’s history and physical by the admitting physician.

   Coding: I0020 would be coded 01, Stroke.

   Rationale: The physician’s history and physical documents the diagnosis stroke as the reason for Ms. K’s admission.

2. Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E’s primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

   Coding: I0020 would be coded 10, Fractures and Other Multiple Trauma.

   Rationale: Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E’s primary medical condition category is 10, Fractures and Other Multiple Trauma.

3. Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis. The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician’s discharge summary from the acute care hospital and are incorporated into Mrs. H’s medical record.

   Coding: I0020 would be coded 13, Medically Complex Conditions.

   Rationale: The physician’s discharge summary from the acute care hospital documents the need for IV antibiotics due to urosepsis as the reason for Mrs. H’s admission to the facility.
I: Active Diagnoses in the Last 7 Days

<table>
<thead>
<tr>
<th>Active Diagnoses in the last 7 days - Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists</td>
</tr>
</tbody>
</table>

- **Cancer**
  - 10100. Cancer (with or without metastasis)

- **Heart/Circulation**
  - 10200. Anemia (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
  - 10300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradycardias and tachycardias)
  - 10400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
  - 10500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)
  - 10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)
  - 10700. Hypertension
  - 10800. Orthostatic Hypotension
  - 10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

- **Gastrointestinal**
  - 11100. Cirrhosis
  - 11200. Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g., esophageal, gastric, and peptic ulcers)
  - 11300. Ulcerative Colitis, Crohn’s Disease, or Inflammatory Bowel Disease

- **Genitourinary**
  - 11400. Benign Prostatic Hyperplasia (BPH)
  - 11500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)
  - 11550. Neuropenic Bladder
  - 11650. Obstructive Uropathy

- **Infections**
  - 11700. Multidrug-Resistant Organism (MDRO)
  - 12000. Pneumonia
  - 12100. Septicemia
  - 12200. Tuberculosis
  - 12300. Urinary Tract Infection (UTI) (LAST 30 DAYS)
  - 12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E)
  - 12500. Wound Infection (other than foot)

- **Metabolic**
  - 12900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
  - 13100. Hypoglycemia
  - 13200. Hyperkalemia
  - 13300. Hyperlipidemia (e.g., hypercholesterolemia)
  - 13400. Thyroid Disorder (e.g., hypothyroidism, hyperthyroidism, and Hashimoto’s thyroiditis)

- **Musculoskeletal**
  - 13700. Arthritis (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RAI))
  - 13800. Osteoporosis
  - 13900. Hip Fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
  - 14000. Other Fracture

- **Neurological**
  - 14200. Alzheimer’s Disease
  - 14300. Aphasia
  - 14400. Cerebral Palsy
  - 14500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke
  - 14800. Non-Alzheimer’s Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia, frontotemporal dementia such as Pick’s disease; and dementia related to stroke, Parkinson’s or Creutzfeldt-Jakob diseases)

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Neurological Diagnoses continued on next page
### I: Active Diagnoses in the Last 7 Days (cont.)

<table>
<thead>
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<th>Active Diagnoses in the last 7 days - Check all that apply</th>
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<td>15100. Quadriplegia</td>
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<td>15400. Seizure Disorder or Epilepsy</td>
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<td>Psychiatric/Mood Disorder</td>
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<td>15700. Anxiety Disorder</td>
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<td>15900. Manic Depression (bipolar disease)</td>
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<td>15950. Psychotic Disorder (other than schizophrenia)</td>
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<td>16000. Schizophrenia (e.g., schizoaffective and schizopreniform disorders)</td>
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<td>16100. Post Traumatic Stress Disorder (PTSD)</td>
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<td>16300. Respiratory Failure</td>
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<td>16500. Cataracts, Glaucoma, or Macular Degeneration</td>
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<td>Other</td>
<td></td>
</tr>
<tr>
<td>18000. Additional active diagnoses</td>
<td></td>
</tr>
</tbody>
</table>

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.
B.
C.
D.
E.
F.
G.
H.
I.
J.
I: Active Diagnoses in the Last 7 Days (cont.)

Item Rationale

Health-related Quality of Life

• Disease processes can have a significant adverse effect on an individual’s health status and quality of life.

Planning for Care

• This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

There are two look-back periods for this section:

• Diagnosis identification (Step 1) is a 60-day look-back period.

• Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).

1. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

• Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.

• Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

2. Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident’s current status, or do not drive the resident’s plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

DEFINITIONS

ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.

NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).
I: Active Diagnoses in the Last 7 Days (cont.)

- Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300 UTI.

- Check the following information sources in the medical record for the last 7 days to identify “active” diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor’s orders, consults and official diagnostic reports, and other sources as available.

**Coding Instructions**

*Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-8 for specific coding instructions).*

- Document active diagnoses on the MDS as follows:
  - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
  - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia**, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).

- Check off each active disease. Check all that apply.

- If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.

- Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code’s decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes and on the left.)

- If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: [https://www.cms.gov/Medicare/Coding/ICD10/index.html](https://www.cms.gov/Medicare/Coding/ICD10/index.html).

**Cancer**

- **I0100**, cancer (with or without metastasis)
I: Active Diagnoses in the Last 7 Days (cont.)

Heart/Circulation
- **I0200**, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- **I0300**, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- **I0400**, coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500**, deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)
- **I0600**, heart failure (e.g., congestive heart failure [CHF], pulmonary edema)
- **I0700**, hypertension
- **I0800**, orthostatic hypotension
- **I0900**, peripheral vascular disease or peripheral arterial disease

Gastrointestinal
- **I1100**, cirrhosis
- **I1200**, gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)
- **I1300**, ulcerative colitis or Crohn’s disease or inflammatory bowel disease

Genitourinary
- **I1400**, benign prostatic hyperplasia (BPH)
- **I1500**, renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550**, neurogenic bladder
- **I1650**, obstructive uropathy

Infections
- **I1700**, multidrug resistant organism (MDRO)
- **I2000**, pneumonia
- **I2100**, septicemia
- **I2200**, tuberculosis
- **I2300**, urinary tract infection (UTI) (last 30 days)
- **I2400**, viral hepatitis (e.g., hepatitis A, B, C, D, and E)
- **I2500**, wound infection (other than foot)

Metabolic
- **I2900**, diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)
I: Active Diagnoses in the Last 7 Days (cont.)

- **I3100**, hyponatremia
- **I3200**, hyperkalemia
- **I3300**, hyperlipidemia (e.g., hypercholesterolemia)
- **I3400**, thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto’s thyroiditis)

**Musculoskeletal**

- **I3700**, arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])
- **I3800**, osteoporosis
- **I3900**, hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)
- **I4000**, other fracture

**Neurological**

- **I4200**, Alzheimer’s disease
- **I4300**, aphasia
- **I4400**, cerebral palsy
- **I4500**, cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800**, dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick’s disease; and dementia related to stroke, Parkinson’s disease or Creutzfeldt-Jakob diseases)
- **I4900**, hemiplegia or hemiparesis
- **I5000**, paraplegia
- **I5100**, quadriplegia
- **I5200**, multiple sclerosis (MS)
- **I5250**, Huntington’s disease
- **I5300**, Parkinson’s disease
- **I5350**, Tourette’s syndrome
- **I5400**, seizure disorder or epilepsy
- **I5500**, traumatic brain injury (TBI)

**Nutritional**

- **I5600**, malnutrition (protein or calorie) or at risk for malnutrition

**Psychiatric/Mood Disorder**

- **I5700**, anxiety disorder
I: Active Diagnoses in the Last 7 Days (cont.)

- **I5800**, depression (other than bipolar)
- **I5900**, manic depression (bipolar disease)
- **I5950**, psychotic disorder (other than schizophrenia)
- **I6000**, schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- **I6100**, post-traumatic stress disorder (PTSD)

**Pulmonary**

- **I6200**, asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6300**, respiratory failure

**Vision**

- **I6500**, cataracts, glaucoma, or macular degeneration

**None of Above**

- **I7900**, none of the above active diagnoses within the past 7 days

**Other**

- **I8000**, additional active diagnoses

**Coding Tips**

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
  - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
  - For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.

- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
  - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor’s orders, etc.
I: Active Diagnoses in the Last 7 Days (cont.)

— Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

— Listing a disease/diagnosis (e.g., arthritis) on the resident’s medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an “active” diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor’s orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

— Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug’s effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

• It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice. For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.

• Item I2300 Urinary tract infection (UTI):
  — The UTI has a look-back period of 30 days for active disease instead of 7 days.
  — Code only if both of the following are met in the last 30 days:
    1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,
       
      AND

    2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
I: Active Diagnoses in the Last 7 Days (cont.)

— In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility’s surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.

— Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility’s Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.

— If the diagnosis of UTI was made prior to the resident’s admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.

— When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

— Resources for evidence-based UTI criteria:
  • Surveillance Definitions of Infections in LTC (updated McGeer criteria): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/

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

A physician often prescribes empiric antimicrobial therapy for a suspected infection after a culture is obtained, but prior to receiving the culture results. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not
I: Active Diagnoses in the Last 7 Days (cont.)

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

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

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

- **Item I5100 Quadriplegia:**
  - Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
  - Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
  - Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

**Examples of Active Disease**

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

   **Coding:** Hypertension item (I0700), would be **checked**.
   **Rationale:** This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

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

   **Coding:** Atrial fibrillation item (I0300), would be **checked**.
   **Rationale:** This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.
I: Active Diagnoses in the Last 7 Days (cont.)

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

   **Coding:** Arthritis item (I3700), would be **checked.**
   **Rationale:** Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

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

   **Coding:** Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke item (I4500), would be **checked.**
   **Rationale:** The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

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

   **Coding:** Pneumonia item (I2000), would **not be checked.**
   **Rationale:** The pneumonia diagnosis would not be considered active because of the resident’s complete recovery and the discontinuation of any treatment during the look-back period.

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

   **Coding:** CAD item (I0400), would **not be checked.**
   **Rationale:** The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

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

   **Coding:** Hip Fracture item (I3900), would **not be checked.**
   **Rationale:** Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.
J0100: Pain Management (cont.)

**Coding:** J0100A would be **coded 0, no.**

**Rationale:** The medical record documented that the resident did not receive scheduled pain medication during the 5-day look-back period. Residents may refuse scheduled medications; however, medications are not considered “received” if the resident refuses the dose.

**Coding:** J0100B would be **coded 0, no.**

**Rationale:** The medical record contained no documentation that the resident received or was offered and declined any PRN medications during the 5-day look-back period.

**Coding:** J0100C would be **coded 0, no.**

**Rationale:** The medical record contains no documentation that the resident received non-medication pain intervention during the 5-day look-back period.

J0200: Should Pain Assessment Interview Be Conducted?

**Item Rationale**

**Health-related Quality of Life**

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about pain directly from the resident, sometimes called “hearing the resident’s voice,” is more reliable and accurate than observation alone for identifying pain.
- If a resident cannot communicate (e.g., verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used.

**Planning for Care**

- Interview allows the resident’s voice to be reflected in the care plan.
- Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.

**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.
J0200: Should Pain Assessment Interview Be Conducted? (cont.)

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.

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.

Coding Instructions

*Attempt to complete the interview if the resident is at least sometimes understood and an interpreter is present or not required.*

- **Code 0, no:** if the resident is rarely/never understood or an interpreter is required but not available. Skip to Indicators of Pain or Possible Pain item (J0800).
- **Code 1, yes:** if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300).

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 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.**
J0300-J0600: Pain Assessment Interview

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0300. Pain Presence</td>
<td>Ask resident: “Have you had pain or hurting at any time in the last 5 days?”&lt;br&gt;&lt;br&gt; 0. No → Skip to J1100, Shortness of Breath&lt;br&gt; 1. Yes → Continue to J0400, Pain Frequency&lt;br&gt; 9. Unable to answer → Skip to J0800, Indicators of Pain or Possible Pain</td>
</tr>
<tr>
<td>J0400. Pain Frequency</td>
<td>Ask resident: “How much of the time have you experienced pain or hurting over the last 5 days?”&lt;br&gt;&lt;br&gt; 1. Almost constantly&lt;br&gt; 2. Frequently&lt;br&gt; 3. Occasionally&lt;br&gt; 4. Rarely&lt;br&gt; 9. Unable to answer</td>
</tr>
<tr>
<td>J0500. Pain Effect on Function</td>
<td>A. Ask resident: “Over the past 5 days, has pain made it hard for you to sleep at night?”&lt;br&gt;&lt;br&gt; 0. No&lt;br&gt; 1. Yes&lt;br&gt; 9. Unable to answer&lt;br&gt;&lt;br&gt;B. Ask resident: “Over the past 5 days, have you limited your day-to-day activities because of pain?”&lt;br&gt;&lt;br&gt; 0. No&lt;br&gt; 1. Yes&lt;br&gt; 9. Unable to answer</td>
</tr>
<tr>
<td>J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)</td>
<td>A. Numeric Rating Scale (00-10)&lt;br&gt;&lt;br&gt; Ask resident: “Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.” (Show resident 00-10 pain scale)&lt;br&gt;&lt;br&gt; Enter two-digit response. Enter 99 if unable to answer.</td>
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<tr>
<td>B. Verbal Descriptor Scale</td>
<td>Ask resident: “Please rate the intensity of your worst pain over the last 5 days.” (Show resident verbal scale)&lt;br&gt;&lt;br&gt; 1. Mild&lt;br&gt; 2. Moderate&lt;br&gt; 3. Severe&lt;br&gt; 4. Very severe, horrible&lt;br&gt; 9. Unable to answer</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- Pain significantly adversely affects a person’s quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired residents.
- Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.
J0300-J0600: Pain Assessment Interview (cont.)

Planning for Care

• Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.

• Resident self-report is the most reliable means for assessing pain.

• Pain assessment provides a basis for evaluation, treatment need, and response to treatment.

• Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications.

• Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities.

• Pain assessment prompts discussion about factors that aggravate and alleviate pain.

• Similar pain stimuli can have varying impact on different individuals.

• Consistent use of a standardized pain intensity scale improves the validity and reliability of pain assessment. Using the same scale in different settings may improve continuity of care.

• Pain intensity scales allow providers to evaluate whether pain is responding to pain medication regimen(s) and/or non-pharmacological intervention(s).

Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200).

2. The Pain Assessment Interview for residents consists of four items: the primary question Pain Presence item (J0300), and three follow-up questions Pain Frequency item (J0400); Pain Effect on Function item (J0500); and Pain Intensity item (J0600). If the resident is unable to answer the primary question on Pain Presence item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).
J0300-J0600: Pain Assessment Interview (cont.)

3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
4. Conduct the interview in a private setting.
5. Be sure the resident can hear you.
   - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
6. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident’s face.
7. Give an introduction before starting the interview. Suggested language: “I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.”
8. Directly ask the resident each item in J0300 through J0600 in the order provided.
   - Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant. Some residents avoid use of the term “pain” but may report that they “hurt.” Residents may use other terms such as “aching” or “burning” to describe pain.
9. If the resident chooses not to answer a particular item, accept his/her refusal, code 9, and move on to the next item.
10. If the resident is unsure about whether the pain occurred in the 5-day time interval, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

**DEFINITION**

**PAIN**

Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.

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**J0300: Pain Presence (5-Day Look Back)**

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J0300: Pain Presence (cont.)

Steps for Assessment

1. Ask the resident: “Have you had pain or hurting at any time in the last 5 days?”

Coding Instructions for J0300, Pain Presence

**Code for the presence or absence of pain regardless of pain management efforts during the 5-day look-back period.**

- **Code 0, no:** if the resident responds “no” to any pain in the 5-day look-back period. **Code 0, no:** even if the reason for no pain is that the resident received pain management interventions. If coded 0, the pain interview is complete. Skip to **Shortness of Breath** item (J1100).

- **Code 1, yes:** if the resident responds “yes” to pain at any time during the look-back period. If coded 1, proceed to items J0400, J0500, J0600 AND J0700.

- **Code 9, unable to answer:** if the resident is unable to answer, does not respond, or gives a nonsensical response. If coded 9, skip to the **Staff Assessment for Pain** beginning with **Indicators of Pain or Possible Pain** item (J0800).

Coding Tips

- Rates of self-reported pain are higher than observed rates. Although some observers have expressed concern that residents may not complain and may deny pain, the regular and objective use of self-report pain scales enhances residents’ willingness to report.

Examples

1. When asked about pain, Mrs. S. responds, “No. I have been taking the pain medication regularly, so fortunately I have had no pain.”

   **Coding:** J0300 would be **coded 0, no.** The assessor would skip to **Shortness of Breath** item (J1100).

   **Rationale:** Mrs. S. reports having no pain during the look-back period. Even though she received pain management interventions during the look-back period, the item is coded “No,” because there was no pain.

2. When asked about pain, Mr. T. responds, “No pain, but I have had a terrible burning sensation all down my leg.”

   **Coding:** J0300 would be **coded 1, yes.** The assessor would proceed to **Pain Frequency** item (J0400).

   **Rationale:** Although Mr. T.’s initial response is “no,” the comments indicate that he has experienced pain (burning sensation) during the look-back period.
J0300: Pain Presence (cont.)

3. When asked about pain, Ms. G. responds, “I was on a train in 1905.”
   
   **Coding:** J0300 would be **coded 9, unable to respond.** The assessor would skip to **Indicators of Pain** item (J0800).
   
   **Rationale:** Ms. G. has provided a nonsensical answer to the question. The assessor will complete the **Staff Assessment for Pain** beginning with **Indicators of Pain** item (J0800).

J0400: Pain Frequency (5-Day Look Back)

![Image of Pain Frequency Scale]

**Steps for Assessment**

1. Ask the resident: “How much of the time have you experienced pain or hurting over the last 5 days?” Staff may present response options on a written sheet or cue card. This can help the resident respond to the items.

2. If the resident provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the resident’s own comment and providing related response options. This interview approach frequently helps the resident clarify which response option he or she prefers.

3. If the resident, despite clarifying statement and repeating response options, continues to have difficulty selecting between two of the provided responses, then select the more frequent of the two.

**Coding Instructions**

*Code for pain frequency during the 5-day look-back period.*

- **Code 1, almost constantly:** if the resident responds “almost constantly” to the question.
- **Code 2, frequently:** if the resident responds “frequently” to the question.
- **Code 3, occasionally:** if the resident responds “occasionally” to the question.
- **Code 4, rarely:** if the resident responds “rarely” to the question.
- **Code 9, unable to answer:** if the resident is unable to respond, does not respond, or gives a nonsensical response. Proceed to items J0500, J0600 AND J0700.
J0400: Pain Frequency (cont.)

Coding Tips

- No predetermined definitions are offered to the resident related to frequency of pain.
  - The response should be based on the resident’s interpretation of the frequency options.
  - Facility policy should provide standardized tools to use throughout the facility in assessing pain to ensure consistency in interpretation and documentation of the resident’s pain.

Examples

1. When asked about pain, Mrs. C. responds, “All the time. It has been a terrible week. I have not been able to get comfortable for more than 10 minutes at a time since I started physical therapy four days ago.”
   
   **Coding:** J0400 would be **coded 1, almost constantly**.
   
   **Rationale:** Mrs. C. describes pain that has occurred “all the time.”

2. When asked about pain, Mr. J. responds, “I don’t know if it is frequent or occasional. My knee starts throbbing every time they move me from the bed or the wheelchair.”
   
   The interviewer says: “Your knee throbs every time they move you. If you had to choose an answer, would you say that you have pain frequently or occasionally?”
   
   Mr. J. is still unable to choose between frequently and occasionally.
   
   **Coding:** J0400 would be **coded 2, frequently**.
   
   **Rationale:** The interviewer appropriately echoed Mr. J.’s comment and provided related response options to help him clarify which response he preferred. Mr. J. remained unable to decide between frequently and occasionally. The interviewer therefore coded for the higher frequency of pain.

3. When asked about pain, Miss K. responds: “I can’t remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away.”
   
   The interviewer clarifies by echoing what Miss K. said: “You’ve had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen. If you had to choose from the answers, would you say you had pain occasionally or rarely?”
   
   Miss K. replies “Occasionally.”
   
   **Coding:** J0400 would be **coded 3, occasionally**.
   
   **Rationale:** After the interviewer clarified the resident’s choice using echoing, the resident selected a response option.
J0400: Pain Frequency (cont.)

4. When asked about pain, Ms. M. responds, “I would say rarely. Since I started using the patch, I don’t have much pain at all, but four days ago the pain came back. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day.”

   **Coding:** J0400 would be **coded 4, rarely**.
   **Rationale:** Ms. M. selected the “rarely” response option.

J0500: Pain Effect on Function (5-Day Look Back)

**Steps for Assessment**

1. Ask the resident each of the two questions exactly as they are written.
2. If the resident’s response does not lead to a clear “yes” or “no” answer, repeat the resident’s response and then try to narrow the focus of the response. For example, if the resident responded to the question, “Has pain made it hard for you to sleep at night?” by saying, “I always have trouble sleeping,” then the assessor might reply, “You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?”

**Coding Instructions for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?**

- **Code 0, no:** if the resident responds “no,” indicating that pain did not interfere with sleep.
- **Code 1, yes:** if the resident responds “yes,” indicating that pain interfered with sleep.
- **Code 9, unable to answer:** if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0500B, J0600 AND J0700.

**Coding Instructions for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?**

- **Code 0, no:** if the resident indicates that pain did not interfere with daily activities.
- **Code 1, yes:** if the resident indicates that pain interfered with daily activities.
- **Code 9, unable to answer:** if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to items J0600 AND J0700.
J0500: Pain Effect on Function (5-Day Look Back) (cont.)

Examples for J0500A, Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?

1. Mrs. D. responds, “I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby.”
   
   **Coding:** J0500A would be **coded 0, no.**
   
   **Rationale:** Mrs. D. reports no sleep problems related to pain.

2. Mr. E. responds, “I can’t sleep at all in this place.”
   The interviewer clarifies by saying, “You can’t sleep here. Would you say that was because pain made it hard for you to sleep at night?”
   Mr. E. responds, “No. It has nothing to do with me. I have no pain. It is because everyone is making so much noise.”
   
   **Coding:** J0500A would be **coded 0, no.**
   
   **Rationale:** Mr. E. reports that his sleep problems are not related to pain.

3. Miss G. responds, “Yes, the back pain makes it hard to sleep. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much.”
   
   **Coding:** J0500A would be **coded 1, yes.**
   
   **Rationale:** The resident reports pain-related sleep problems.

Examples for J0500B, Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?

1. Ms. L. responds, “No, I had some pain on Wednesday, but I didn’t want to miss the shopping trip, so I went.”
   
   **Coding:** J0500B would be **coded 0, no.**
   
   **Rationale:** Although Ms. L. reports pain, she did not limit her activity because of it.

2. Mrs. N. responds, “Yes, I haven’t been able to play the piano, because my shoulder hurts.”
   
   **Coding:** J0500B would be **coded 1, yes.**
   
   **Rationale:** Mrs. N. reports limiting her activities because of pain.

3. Mrs. S. responds, “I don’t know. I have not tried to knit since my finger swelled up yesterday, because I am afraid it might hurt even more than it does now.”
   
   **Coding:** J0500B would be **coded 1, yes.**
   
   **Rationale:** Resident avoided a usual activity because of fear that her pain would increase.

4. Mr. Q. responds, “I don’t like painful activities.”
   Interviewer repeats question and Mr. Q. responds, “I designed a plane one time.”
   
   **Coding:** J0500B would be **coded 9, unable to answer.**
   
   **Rationale:** Resident has provided a nonsensical answer to the question. Proceed to items J0600 AND J0700.
J0600: Pain Intensity (5-Day Look Back)

Steps for Assessment

1. You may use either Numeric Rating Scale item (J0600A) or Verbal Descriptor Scale item (J0600B) to interview the resident about pain intensity.
   - For each resident, try to use the same scale used on prior assessments.
2. If the resident is unable to answer using one scale, the other scale should be attempted.
3. Record either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B). Leave the response for the unused scale blank.
4. Read the question and item choices slowly. While reading, you may show the resident the response options (the Numeric Rating Scale or Verbal Descriptor Scale) clearly printed on a piece of paper, such as a cue card. Use large, clear print.
   - For the Numeric Rating Scale, say, “Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine.”
   - For Verbal Descriptor Scale, say, “Please rate the intensity of your worst pain over the last 5 days.”
5. The resident may provide a verbal response, point to the written response, or both.

Coding Instructions for J0600A. Numeric Rating Scale (00-10)

Enter the two digit number (00-10) indicated by the resident as corresponding to the intensity of his or her worst pain during the 5-day look-back period, where zero is no pain, and 10 is the worst pain imaginable.

- Enter 99 if unable to answer.
- If the Numeric Rating Scale is not used, leave the response box blank.

Coding Instructions for J0600B. Verbal Descriptor Scale

- **Code 1, mild:** if resident indicates that his or her pain is “mild.”
- **Code 2, moderate:** if resident indicates that his or her pain is “moderate.”
- **Code 3, severe:** if resident indicates that his or her pain is “severe.”
- **Code 4, very severe, horrible:** if resident indicates that his or her pain is “very severe or horrible.”
J0600: Pain Intensity (cont.)

- **Code 9, unable to answer:** if resident is unable to answer, chooses not to respond, does not respond or gives a nonsensical response. Proceed to item J0700.
- If the Verbal Descriptor Scale is not used, leave the response box blank.

**Examples for J0600A. Numeric Rating Scale (00-10)**
1. The nurse asks Ms. T. to rate her pain on a scale of 0 to 10. Ms. T. states that she is not sure, because she has shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK. The nurse reminds Ms. T. to think about all the pain she had during the last 5 days and select the number that describes her worst pain. She reports that her pain is a “6.”

   **Coding:** J0600A would be **coded 06**.
   **Rationale:** The resident said her pain was 6 on the 0 to 10 scale. Because a 2-digit number is required, it is entered as 06.

2. The nurse asks Mr. S. to rate his pain, reviews use of the scale, and provides the 0 to 10 visual aid. Mr. S. says, “My pain doesn’t have any numbers.” The nurse explains that the numbers help the staff understand how severe his pain is, and repeats that the “0” end is no pain and the “10” end is the worst pain imaginable. Mr. S. replies, “I don’t know where it would fall.”

   **Coding:** Item J0600A would be **coded 99, unable to answer**. The interviewer would go on to ask about pain intensity using the Verbal Descriptor Scale item (J0600B).
   **Rationale:** The resident was unable to select a number or point to a location on the 0-10 scale that represented his level of pain intensity.

**Examples for J0600B. Verbal Descriptor Scale**
1. The nurse asks Mr. R. to rate his pain using the verbal descriptor scale. He looks at the response options presented using a cue card and says his pain is “severe” sometimes, but most of the time it is “mild.”

   **Coding:** J0600B would be **coded 3, severe**.
   **Rationale:** The resident said his worst pain was “Severe.”

2. The nurse asks Ms. U. to rate her pain, reviews use of the verbal descriptor scale, and provides a cue card as a visual aid. Ms. U. says, “I’m not sure whether it’s mild or moderate.” The nurse reminds Ms. U. to think about her worst pain during the last 5 days. Ms. U. says “At its worst, it was moderate.”

   **Coding:** Item J0600B would be **coded 2, moderate**.
   **Rationale:** The resident indicated that her worst pain was “Moderate.”
J0700: Should the Staff Assessment for Pain be Conducted? (5-Day Look Back)

**Item Rationale**

Item J0700 closes the pain interview and determines if the resident interview was complete or incomplete and based on this determination, whether a staff assessment needs to be completed.

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**Health-related Quality of Life**

- Resident interview for pain is preferred because it improves the detection of pain. However, a small percentage of residents are unable or unwilling to complete the pain interview.

- Persons unable to complete the pain interview may still have pain.

**Planning for Care**

- Resident self-report is the most reliable means of assessing pain. However, when a resident is unable to provide the information, staff assessment is necessary.

- Even though the resident was unable to complete the interview, important insights may be gained from the responses that were obtained, observing behaviors and observing the resident’s affect during the interview.

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**Steps for Assessment**

1. Review the resident’s responses to items J0200-J0400.

2. The Staff Assessment for Pain should only be completed if the Pain Assessment Interview (J0200-J0600) was not completed.

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**Coding Instructions for J0700. Should the Staff Assessment for Pain be Conducted?** This item is to be coded at the completion of items J0400-J0600.

- **Code 0, no:** if the resident completed the Pain Assessment Interview item (J0400 = 1, 2, 3, or 4). Skip to Shortness of Breath (dyspnea) item (J1100).

- **Code 1, yes:** if the resident was unable to complete the Pain Assessment Interview (J0400 = 9). Continue to Indicators of Pain or Possible Pain item (J0800).
J0800: Indicators of Pain (5-Day Look Back)

Complete this item only if the Pain Assessment Interview (J0200-J0600) was not completed.

Item Rationale

Health-related Quality of Life

- Residents who cannot verbally communicate about their pain are at particularly high risk for underdetection and undertreatment of pain.

- Severe cognitive impairment may affect the ability of residents to verbally communicate, thus limiting the availability of self-reported information about pain. In this population, fewer complaints may not mean less pain.

- Individuals who are unable to verbally communicate may be more likely to use alternative methods of expression to communicate their pain.

- Even in this population some verbal complaints of pain may be made and should be taken seriously.

Planning for Care

- Consistent approach to observation improves the accuracy of pain assessment for residents who are unable to verbally communicate their pain.

- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking and potentially during eating).

- Staff must carefully monitor, track, and document any possible signs and symptoms of pain.

- Identification of these pain indicators can:
  - provide a basis for more comprehensive pain assessment,
  - provide a basis for determining appropriate treatment, and
  - provide a basis for ongoing monitoring of pain presence and treatment response.

- If pain indicators are present, assessment should identify aggravating/alleviating factors related to pain.
J0800: Indicators of Pain (cont.)

Steps for Assessment

1. **Review the medical record** for documentation of each indicator of pain listed in J0800 that occurred during the 5-day look-back period. If the record documents the presence of any of the signs and symptoms listed, confirm your record review with the direct care staff on all shifts who work most closely with the resident during activities of daily living (ADL).

2. **Interview staff** because the medical record may fail to note all observable pain behaviors. For any indicators that were not noted as present in medical record review, interview direct care staff on all shifts who work with the resident during ADL. Ask directly about the presence of each indicator that was not noted as being present in the record.

3. **Observe resident** during care activities. If you observe additional indicators of pain during the 5-day look-back period, code the corresponding items.
   - Observations for pain indicators may be more sensitive if the resident is observed during ADL, or wound care.

Coding Instructions

*Check all that apply in the past 5 days based on staff observation of pain indicators.*

- If the medical record review and the interview with direct care providers and observation on all shifts provide no evidence of pain indicators, Check J0800Z, None of these signs observed or documented, and proceed to Shortness of Breath item (J1100).

- **Check J0800A, nonverbal sounds**: included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported during the look-back period.

- **Check J0800B, vocal complaints of pain**: included but not limited to if the resident was observed to make vocal complaints of pain (e.g. “that hurts,” “ouch,” or “stop”).

- **Check J0800C, facial expressions**: included but not limited to if grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported during the look-back period.

- **Check J0800D, protective body movements or postures**: included but not limited to if bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement were observed or reported during the look-back period.

**DEFINITIONS**

**NON VERBAL SOUNDS**
e.g., crying, whining, gasping, moaning, groaning or other audible indications associated with pain.

**VOCAL COMPLAINTS OF PAIN**
e.g., “That hurts,” “ouch,” “stop,” etc.

**FACIAL EXPRESSIONS THAT MAY BE INDICATORS OF PAIN**
e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw, etc.

**PROTECTIVE BODY MOVEMENTS OR POSTURES**
e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement, etc.
J0800: Indicators of Pain (cont.)

- **Check J0800Z, none of these signs observed or documented:** if none of these signs were observed or reported during the look-back period.

**Coding Tips**

- Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain. These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the contribution of pain should be considered when following up on those symptoms and behaviors.

**Examples**

1. Mr. P. has advanced dementia and is unable to verbally communicate. A note in his medical record documents that he has been awake during the last night crying and rubbing his elbow. When you go to his room to interview the certified nurse aide (CNA) caring for him, you observe Mr. P. grimacing and clenching his teeth. The CNA reports that he has been moaning and said “ouch” when she tried to move his arm.
   
   **Coding:** Nonverbal Sounds item (J0800A); Vocal Complaints of Pain item (J0800B); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be checked.
   
   **Rationale:** Mr. P. has demonstrated vocal complaints of pain (ouch), nonverbal sounds (crying and moaning), facial expression of pain (grimacing and clenched teeth), and protective body movements (rubbing his elbow).

2. Mrs. M. has end-stage Parkinson’s disease and is unable to verbally communicate. There is no documentation of pain in her medical record during the 5-day look-back period. The CNAs caring for her report that on some mornings she moans and winces when her arms and legs are moved during morning care. During direct observation, you note that Mrs. M. cries and attempts to pull her hand away when the CNA tries to open the contracted hand to wash it.
   
   **Coding:** Nonverbal Sounds items (J0800A); Facial Expressions item (J0800C); and Protective Body Movements or Postures item (J0800D), would be checked.
   
   **Rationale:** Mrs. M. has demonstrated nonverbal sounds (crying, moaning); facial expression of pain (wince), and protective body movements (attempt to withdraw).

3. Mrs. E. has been unable to verbally communicate following a massive cerebrovascular accident (CVA) several months ago and has a Stage 3 pressure ulcer. There is no documentation of pain in her medical record. The CNA who cares for her reports that she does not seem to have any pain. You observe the resident during her pressure ulcer dressing change. During the treatment, you observe groaning, facial grimaces, and a wrinkled forehead.
   
   **Coding:** Nonverbal Sounds item (J0800A), and Facial Expressions item (J0800C), would be checked.
   
   **Rationale:** The resident has demonstrated nonverbal sounds (groaning) and facial expression of pain (wrinkled forehead and grimacing).
J0800: Indicators of Pain (cont.)

Examples (cont.)

4. Mr. S. is in a persistent vegetative state following a traumatic brain injury. He is unable to verbally communicate. There is no documentation of pain in his medical record during the 5-day look-back period. The CNA reports that he appears comfortable whenever she cares for him. You observe the CNA providing morning care and transferring him from bed to chair. No pain indicators are observed at any time.

   **Coding:** None of These Signs Observed or Documented item (J0800Z), would be checked.
   **Rationale:** All steps for the assessment have been followed and no pain indicators have been documented, reported or directly observed.

J0850: Frequency of Indicator of Pain or Possible Pain (5-Day Look Back)

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**Item Rationale**

**Health-related Quality of Life**

- Unrelieved pain adversely affects function and mobility contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person’s quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired residents.

**Planning for Care**

- Assessment of pain frequency provides:
  - A basis for evaluating treatment need and response to treatment.
  - Information to aide in identifying optimum timing of treatment.

**Steps for Assessment**

1. Review medical record and interview staff and direct caregivers to determine the number of days the resident either complained of pain or showed evidence of pain as described in J0800 over the past 5 days.
J0850: Frequency of Indicator of Pain or Possible Pain (cont.)

Coding Instructions

Code for pain frequency over the last 5 days.

- **Code 1:** if based on staff observation, the resident complained or showed evidence of pain 1 to 2 days.
- **Code 2:** if based on staff observation, the resident complained or showed evidence of pain on 3 to 4 of the last 5 days.
- **Code 3:** if based on staff observation, the resident complained or showed evidence of pain on a daily basis.

Examples

1. Mr. M. is an 80-year old male with advanced dementia. During the 5-day look-back period, Mr. M. was noted to be grimacing and verbalizing “ouch” over the past 2 days when his right shoulder was moved.

   **Coding:** Item J0850 would be **coded 1, indicators of pain observed 1 to 2 days.**
   **Rationale:** He has demonstrated vocal complaints of pain (“ouch”), facial expression of pain (grimacing) on 2 of the last 5 days.

2. Mrs. C. is a 78-year old female with a history of CVA with expressive aphasia and dementia. During the 5-day look-back period, the resident was noted on a daily basis to be rubbing her right knee and grimacing.

   **Coding:** Item J0850 would be **coded 3, indicators of pain observed daily.**
   **Rationale:** The resident was observed with a facial expression of pain (grimacing) and protective body movements (rubbing her knee) every day during the look-back period.

J1100: Shortness of Breath (dyspnea)

<table>
<thead>
<tr>
<th>J1100, Shortness of Breath (dyspnea)</th>
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<tbody>
<tr>
<td>Check all that apply</td>
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<tr>
<td>A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)</td>
</tr>
<tr>
<td>B. Shortness of breath or trouble breathing when sitting at rest</td>
</tr>
<tr>
<td>C. Shortness of breath or trouble breathing when lying flat</td>
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<tr>
<td>Z. None of the above</td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.
- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.
J1100: Shortness of Breath (dyspnea) (cont.)

Planning for Care

• Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.

• The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

Steps for Assessment

Interview the resident about shortness of breath. Many residents, including those with mild to moderate dementia, may be able to provide feedback about their own symptoms.

1. If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.

2. Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing. Interview staff on all shifts, and family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.

3. Observe the resident for shortness of breath or trouble breathing. Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe.

4. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

Coding Instructions

Check all that apply during the 7-day look-back period.

Any evidence of the presence of a symptom of shortness of breath should be captured in this item. A resident may have any combination of these symptoms.

• **Check J1100A**: if shortness of breath or trouble breathing is present when the resident is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.

• **Check J1100B**: if shortness of breath or trouble breathing is present when the resident is sitting at rest.

• **Check J1100C**: if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath.

• **Check J1100Z**: if the resident reports no shortness of breath or trouble breathing and the medical record and staff interviews indicate that shortness of breath appears to be absent or well controlled with current medication.
J1100: Shortness of Breath (dyspnea) (cont.)

Examples

1. Mrs. W. has diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure. She is on 2 liters of oxygen and daily respiratory treatments. With oxygen she is able to ambulate and participate in most group activities. She reports feeling “winded” when going on outings that require walking one or more blocks and has been observed having to stop to rest several times under such circumstances. Recently, she describes feeling “out of breath” when she tries to lie down.

   Coding: J1100A and J1100C would be checked.

   Rationale: Mrs. W. reported being short of breath when lying down as well as during outings that required ambulating longer distances.

2. Mr. T. has used an inhaler for years. He is not typically noted to be short of breath. Three days ago, during a respiratory illness, he had mild trouble with his breathing, even when sitting in bed. His shortness of breath also caused him to limit group activities.

   Coding: J1100A and J1100B would be checked.

   Rationale: Mr. T. was short of breath at rest and was noted to avoid activities because of shortness of breath.

J1300: Current Tobacco Use

Item Rationale

Health-related Quality of Life

- The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life.

Planning for Care

- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.

- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.

Steps for Assessment

1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period.

2. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes.
J1300: Current Tobacco Use (cont.)

3. If the resident is unable to answer or indicates that he or she did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.

Coding Instructions

- **Code 0, no:** if there are no indications that the resident used any form of tobacco.
- **Code 1, yes:** if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

J1400: Prognosis

<table>
<thead>
<tr>
<th>J1400. Prognosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation)</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services in the nursing home.

**Planning for Care**

- If life expectancy is less than 6 months, interdisciplinary team care planning should be based on the resident’s preferences for goals and interventions of care whenever possible.

**Steps for Assessment**

1. Review the medical record for documentation by the physician that the resident’s condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If the physician states that the resident’s life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record.
3. Review the medical record to determine whether the resident is receiving hospice services.
J1400: Prognosis (cont.)

Coding Instructions

- **Code 0, no:** if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
- **Code 1, yes:** if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services.

Examples

1. Mrs. T. has a diagnosis of heart failure. During the past few months, she has had three hospital admissions for acute heart failure. 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.

   **Coding:** J1400 would be **coded 1, yes**.
   **Rationale:** The physician documented that her life expectancy is likely to be less than 6 months.

2. Mr. J. was diagnosed with non-small cell lung cancer that is metastatic to his bone. He is not a candidate for surgical or curative treatment. With his consent, Mr. J. has been referred to hospice by his physician, who documented that his life expectancy was less than 6 months.

   **Coding:** J1400 would be **coded 1, yes**.
   **Rationale:** The physician referred the resident to hospice and documented that his life expectancy is likely to be less than 6 months.

J1550: Problem Conditions

<table>
<thead>
<tr>
<th>J1550. Problem Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>□  A. Fever</td>
</tr>
<tr>
<td>□  B. Vomiting</td>
</tr>
<tr>
<td>□  C. Dehydrated</td>
</tr>
<tr>
<td>□  D. Internal bleeding</td>
</tr>
<tr>
<td>□  Z. None of the above</td>
</tr>
</tbody>
</table>
J1550: Problem Conditions (cont.)

**Intent:** This item provides an opportunity for screening in the areas of fever, vomiting, fluid deficits, and internal bleeding. Clinical screenings provide indications for further evaluation, diagnosis and clinical care planning.

**Item Rationale**

*Health-related Quality of Life*

- Timely assessment is needed to identify underlying causes and risk for complications.

*Planning for Care*

- Implementation of care plans to treat underlying causes and avoid complications is critical.

**Steps for Assessment**

1. Review the medical record, interview staff on all shifts and observe the resident for any indication that the resident had vomiting, fever, potential signs of dehydration, or internal bleeding during the 7-day look-back period.

**Coding Instructions**

Check all that apply (blue box)

- **J1550A**, fever
- **J1550B**, vomiting
- **J1550C**, dehydrated
- **J1550D**, internal bleeding
- **J1550Z**, none of the above

**Coding Tips**

- **Fever:** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident’s baseline temperature should be established prior to the Assessment Reference Date.

- **Fever assessment prior to establishing base line temperature:** A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.

- **Vomiting:** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).
J1550: Problem Conditions (cont.)

- **Dehydrated:** Check this item if the resident presents with two or more of the following potential indicators for dehydration:
  1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
  2. Resident has one or more potential clinical signs (indicators) 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, or 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).

- **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, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding.

J1700: Fall History on Admission/Entry or Reentry

![Image of J1700: Fall History on Admission/Entry or Reentry]

**Item Rationale**

**Health-related Quality of Life**

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.
J1700: Fall History on Admission (cont.)

Planning for Care

- Determine the potential need for further assessment and intervention, including evaluation of the resident’s need for rehabilitation or assistive devices.

- Evaluate the physical environment as well as staffing needs for residents who are at risk for falls.

Steps for Assessment

The period of review is 180 days (6 months) prior to admission, looking back from the resident’s entry date (A1600).

1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. This would include any fall, no matter where it occurred.

2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls.

3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls.

Coding Instructions for J1700A, Did the Resident Have a Fall Any Time in the Last Month Prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident’s entry date item (A1600).

- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the month preceding the resident’s entry date item (A1600).

- **Code 9, unable to determine:** if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred.

**DEFINITION**

**FALL**

Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall.

CMS understands that challenging a resident’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.
J1700: Fall History on Admission (cont.)

Coding Instructions for J1700B, Did the Resident Have a Fall Any Time in the Last 2-6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident’s entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident’s entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

Coding Instructions for J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission/Entry or Reentry?

- **Code 0, no:** if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident’s entry date item (A1600).
- **Code 1, yes:** if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the resident’s entry date item (A1600).
- **Code 9, unable to determine:** if the resident is unable to provide the information, or if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

**Definitions**

**Fracture Related to a Fall**

Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

Examples

1. On admission interview, Mrs. J. is asked about falls and says she has “not really fallen.” However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.
   - **Coding:** J1700A would be **coded 1, yes**.
   - **Rationale:** Falls caused by slipping meet the definition of falls.
J1700: Fall History on Admission (cont.)

2. On admission interview a resident denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.

   Coding: J1700B would be **coded 1, yes.**
   Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On admission interview, Mr. M. and his family deny any history of falling. However, nursing notes in the transferring hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to nursing home transfer.

   Coding: J1700A would be **coded 1, yes.**
   Rationale: Medical records from an outside facility document that Mr. M. was found on a mat on the floor. This is defined as a fall.

4. Medical records note that Miss K. had hip surgery 5 months prior to admission to the nursing home. Miss K.’s daughter says the surgery was needed to fix a broken hip due to a fall.

   Coding: Both J1700B and J1700C would be **coded 1, yes.**
   Rationale: Miss K. had a fall related fracture 1-6 months prior to nursing home entry.

5. Mr. O.’s hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.

   Coding: J1700C would be **coded 0, no.**
   Rationale: The fractures were not related to a fall.

6. Ms. P. has a history of a “Colles’ fracture” of her left wrist about 3 weeks before nursing home admission. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

   Coding: Both J1700A and J1700C would be **coded 1, yes.**
   Rationale: Ms. P. had a fall-related fracture less than 1 month prior to entry.

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

**Item Rationale**

**Health-related Quality of Life**

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Fear of falling can limit an individual’s activity and negatively impact quality of life.
J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident’s need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

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. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident 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.

Coding Instructions

- **Code 0, no:** if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100).
- **Code 1, yes:** if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent.

Example

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

   **Coding:** J1800 would be **coded 1, yes**.
   **Rationale:** An intercepted fall is considered a fall.
J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

### Item Rationale

**Health-related Quality of Life**
- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

**Planning for Care**
- Identification of residents who are at high risk of falling is a top priority for care planning.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- 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.
J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Steps for Assessment

1. If this is the first assessment (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 (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. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment. All relevant records received from acute and post-acute facilities where the resident was admitted during the look-back period should be reviewed for evidence of one or more falls.
4. Review nursing home incident reports and medical record (physician, nursing, therapy, and nursing assistant notes) for falls and level of injury.
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.

Coding Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.

Coding Instructions for J1900A, No Injury

- **Code 0, none**: if the resident had no injurious fall since the admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one**: if the resident had one non-injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more**: if the resident had two or more non-injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900B, Injury (Except Major)

- **Code 0, none**: if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one**: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

- **Code 2, two or more:** if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

### Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

### 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.

### Examples

1. A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, an assessment was completed that indicated no injury.

   **Coding:** J1900A would be **coded 1, one**.
   **Rationale:** Slipping to the floor is a fall. No injury was noted.

2. Nurse’s notes describe a situation in which Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she fell in the bathroom. No injury was noted when she returned from dinner.

   **Coding:** J1900A would be **coded 1, one**.
   **Rationale:** Falls during the nursing home stay, even if on outings, are captured here.

3. A nurse’s note describes a resident who, while being treated for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. He was sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   **Coding:** J1900B would be **coded 1, one**.
   **Rationale:** Lacerations and swelling without fracture are classified as injury (except major).
J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

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.

J2000: Prior Surgery

<table>
<thead>
<tr>
<th>J2000. Prior Surgery</th>
<th>- Complete only if A0310B = 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>Did the resident have major surgery during the 100 days prior to admission?</td>
</tr>
<tr>
<td>0. No</td>
<td>1. Yes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- A recent history of major surgery during the 100 days prior to admission can affect a resident’s recovery.

**Planning for Care**

- 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.
J2000: Prior Surgery (cont.)

Steps for Assessment

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.
   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.
J2000: Prior Surgery (cont.)

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 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 four-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.
K0510: Nutritional Approaches (cont.)

Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

Coding Instructions for Column 1

- **CMS does not require completion of Column 1 for items K0510C and K0510D; however, some States continue to require its completion. It is important to know your State’s requirements for completing these items.**

- Check all nutritional approaches performed prior to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.

- **If the State does not require the completion of Column 1 for items K0510C and K0510D, use the standard “no information” code (a dash, “-”).**

Coding Instructions for Column 2

Check all nutritional approaches performed after admission/entry or reentry to the facility and within the 7-day look-back period.

*Check all that apply. If none apply, check K0510Z, None of the above*

- **K0510A**, parenteral/IV feeding
- **K0510B**, feeding tube – nasogastric or abdominal (PEG)
- **K0510C**, mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- **K0510D**, therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0510Z**, none of the above

Coding Tips for K0510A

**K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.**

- Parenteral/IV feeding—The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident’s medical record according to State and/or internal facility policy:

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**DEFINITIONS**

**MECHANICALLY ALTERED DIET**

A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

**THERAPEUTIC DIET**

A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).
K0510: Nutritional Approaches (cont.)

— IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
— IV fluids running at KVO (Keep Vein Open)
— IV fluids contained in IV Piggybacks
— Hypodermoclysis and subcutaneous ports in hydration therapy
— IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

• The following items are NOT to be coded in K0510A:
  — IV Medications—Code these when appropriate in O0100H, IV Medications.
  — IV fluids used to reconstitute and/or dilute medications for IV administration.
  — 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 in conjunction with chemotherapy or dialysis.

• Enteral feeding formulas:
  — Should not be coded as a mechanically altered diet.
  — Should only be coded as K0510D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

Coding Tips for K0510D

• Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.

• A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).

• Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.
K0510: Nutritional Approaches (cont.)

Examples

1. Mrs. H is receiving an antibiotic in 100 cc of normal saline via IV. She has a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. She is placed on the nursing home’s hydration plan to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

   **Coding:** K0510A would be checked. The IV medication would be coded at IV Medications item (O0100H).
   
   **Rationale:** The resident received 100 cc of IV fluid and there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

2. Mr. J is receiving an antibiotic in 100 cc of normal saline via IV. He has a UTI, no fever, and documented adequate fluid intake. He is placed on the nursing home’s hydration plan to ensure adequate hydration.

   **Coding:** K0510A would NOT be checked. The IV medication would be coded at IV Medications item (O0100H).
   
   **Rationale:** Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

K0710: Percent Intake by Artificial Route

*Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B.*

| K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B |
|---|---|---|
| **1. While NOT a Resident** |
| Performed while NOT a resident of this facility and within the last 7 days. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank |
| **2. While a Resident** |
| Performed while a resident of this facility and within the last 7 days |
| **3. During Entire 7 Days** |
| Performed during the entire last 7 days |

A. Proportion of total calories the resident received through parenteral or tube feeding

1. 25% or less
2. 26-50%
3. 51% or more

B. Average fluid intake per day by IV or tube feeding

1. 500 cc/day or less
2. 501 cc/day or more

**CMS does not require completion of Column 1. While Not a Resident for items K0710A and K0710B; however, some States continue to require its completion. It is important to know your State’s requirements for completing these items.**
K0710: Percent Intake by Artificial Route (cont.)

Item Rationale

Health-related Quality of Life
- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual’s sense of dignity and self-worth as well as diminish pleasure from eating.

Planning for Care
- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake as indicated by the resident’s condition.

K0710A, Proportion of Total Calories the Resident Received through Parental or Tube Feeding

Steps for Assessment
1. Review intake records to determine actual intake through parenteral or tube feeding routes.
2. Calculate proportion of total calories received through these routes.
   - If the resident took no food or fluids by mouth or took just sips of fluid, stop here and code 3, 51% or more.
   - If the resident had more substantial oral intake than this, consult with the dietician.

Coding Instructions
- Select the best response:
  1. 25% or less
  2. 26% to 50%
  3. 51% or more
- If the State does not require the completion of Column 1 for this item, use the standard “no information” code (a dash, “-”).
K0710: Percent Intake by Artificial Route (cont.)

Example

1. Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery two weeks ago. 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 7 days, he has been receiving tube feedings for nutritional supplementation. The dietitian has totaled his calories per day as follows:

<table>
<thead>
<tr>
<th>Oral and Tube Feeding Intake</th>
<th>Oral</th>
<th>Tube</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun.</td>
<td>500</td>
<td>2,000</td>
</tr>
<tr>
<td>Mon.</td>
<td>250</td>
<td>2,250</td>
</tr>
<tr>
<td>Tues.</td>
<td>250</td>
<td>2,250</td>
</tr>
<tr>
<td>Wed.</td>
<td>350</td>
<td>2,250</td>
</tr>
<tr>
<td>Thurs.</td>
<td>500</td>
<td>2,000</td>
</tr>
<tr>
<td>Fri.</td>
<td>250</td>
<td>2,250</td>
</tr>
<tr>
<td>Sat.</td>
<td>350</td>
<td>2,000</td>
</tr>
<tr>
<td>Total</td>
<td>2,450</td>
<td>15,000</td>
</tr>
</tbody>
</table>

**Coding:** K0710A columns 2 and 3 would be coded 3, 51% or more.

**Rationale:**
- Total Oral intake is 2,450 calories
- Total Tube intake is 15,000 calories
- Total calories is 2,450 + 15,000 = 17,450
- Calculation of the percentage of total calories by tube feeding:
  \[
  \frac{15,000}{17,450} = .859 \times 100 = 85.9\%
  \]
- Mr. H received 85.9% of his calories by tube feeding, therefore K0710A code 3, 51% or more is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding

Steps for Assessment

1. Review intake records from the last 7 days.
2. Add up the total amount of fluid received each day by IV and/or tube feedings only.
3. Divide the week’s total fluid intake by 7 to calculate the average of fluid intake per day.
4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days.

Coding Instructions

*Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.*

- **Code 1:** 500 cc/day or less
- **Code 2:** 501 cc/day or more
K0710: Percent Intake by Artificial Route (cont.)

- If the State does not require the completion of Column 1 for this item, use the standard “no information” code (a dash, “-”).

Examples

1. Calculation for Average Daily Fluid Intake

Ms. A, a long term care resident, 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.

<table>
<thead>
<tr>
<th>IV Fluid Intake</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun.</td>
<td>1250 cc</td>
</tr>
<tr>
<td>Mon.</td>
<td>775 cc</td>
</tr>
<tr>
<td>Tues.</td>
<td>925 cc</td>
</tr>
<tr>
<td>Wed.</td>
<td>1200 cc</td>
</tr>
<tr>
<td>Thurs.</td>
<td>1200 cc</td>
</tr>
<tr>
<td>Fri.</td>
<td>500 cc</td>
</tr>
<tr>
<td>Sat.</td>
<td>450 cc</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,300 cc</strong></td>
</tr>
</tbody>
</table>

**Coding:** K0710B columns 2 and 3 would be coded 2, **501 cc/day or more**.

**Rationale:** The total fluid intake by supplemental tube feedings = 6,300 cc

6,300 cc divided by 7 days = 900 cc/day

900 cc is greater than 500 cc, therefore code **2, 501 cc/day or more** is correct.

2. Calculation for Average Daily Fluid Intake

Mrs. G. received 1 liter of IV fluids in the hospital on the Tuesday prior to her admission to the nursing home on Saturday afternoon. She received no other intake via IV or tube feeding during the last 7 days.

<table>
<thead>
<tr>
<th>IV Fluid Intake</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sun.</td>
<td>0 cc</td>
</tr>
<tr>
<td>Mon.</td>
<td>0 cc</td>
</tr>
<tr>
<td>Tues.</td>
<td>1,000 cc</td>
</tr>
<tr>
<td>Wed.</td>
<td>0 cc</td>
</tr>
<tr>
<td>Thurs.</td>
<td>0 cc</td>
</tr>
<tr>
<td>Fri.</td>
<td>0 cc</td>
</tr>
<tr>
<td>Sat.</td>
<td>0 cc</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,000 cc</strong></td>
</tr>
</tbody>
</table>
K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B column 1 would be coded **1, 500 cc/day or less**.

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc
1000 cc divided by 7 days = 142.9 cc/day
142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.

3. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

<table>
<thead>
<tr>
<th></th>
<th>While in the Hospital</th>
<th>While in the Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon.</td>
<td>400 cc</td>
<td>Fri.</td>
</tr>
<tr>
<td>Tues.</td>
<td>520 cc</td>
<td>Sat.</td>
</tr>
<tr>
<td>Wed.</td>
<td>500 cc</td>
<td>Sun.</td>
</tr>
<tr>
<td>Thurs.</td>
<td>480 cc</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1,900 cc</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,520 cc</td>
</tr>
</tbody>
</table>

Coding: K0710B1 would be coded 1, 500 cc/day or less. K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident**.

The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more is correct for K0710B2, While a Resident**.

The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days**.
SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident’s risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

M0100: Determination of Pressure Ulcer/Injury Risk

<table>
<thead>
<tr>
<th>M0100. Determination of Pressure Ulcer/Injury Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>A.</td>
</tr>
<tr>
<td>B.</td>
</tr>
<tr>
<td>C.</td>
</tr>
<tr>
<td>Z.</td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development.
- The underlying health of a resident’s soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.

Planning for Care

- The care planning process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate based on the individualized needs of the resident.
M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- Throughout this section, terminology referring to “healed” versus “unhealed” ulcers refers to whether or not the ulcer is “closed” versus “open.” When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although “closed” (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered “healed.”
- Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses’ notes, and pressure ulcer/injury risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

Coding Instructions

For this item, check all that apply:

- Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. Review descriptions of pressure ulcers/injuries and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
M0100: Determination of Pressure Ulcer/Injury Risk (cont.)

- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*©. Other tools may be used.

- **Check C if the resident’s risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability
  - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
  - drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
  - resident refusal of some aspects of care and treatment;
  - cognitive impairment;
  - urinary and fecal incontinence;
  - malnutrition and hydration deficits; and
  - healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.

- **Check Z if none of the above apply.**

M0150: Risk of Pressure Ulcers/Injuries

<table>
<thead>
<tr>
<th>M0150. Risk of Pressure Ulcers/Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Is this resident at risk of developing pressure ulcers/injuries?</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- It is important to recognize and evaluate each resident’s risk factors and to identify and evaluate all areas at risk of constant pressure.

**Planning for Care**

- The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

**Steps for Assessment**

1. Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer/injury.
M0150: Risk of Pressure Ulcers/Injuries (cont.)

2. If the medical record reveals that the resident currently has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries.
3. Review formal risk assessment tools to determine the resident’s “risk score.”
4. Review the components of the clinical assessment conducted for evidence of pressure ulcer/injury risk.

Coding Instructions

- **Code 0, no:** if the resident is not at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.
- **Code 1, yes:** if the resident is at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcers/Injuries

<table>
<thead>
<tr>
<th>Item Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health-related Quality of Life</strong></td>
</tr>
<tr>
<td>- Pressure ulcers/injuries and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.</td>
</tr>
<tr>
<td><strong>Planning for Care</strong></td>
</tr>
<tr>
<td>- The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2016 Pressure Injury Staging System.</td>
</tr>
<tr>
<td>- An existing pressure ulcer/injury identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.</td>
</tr>
<tr>
<td>- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you must code the MDS according to the instructions in this manual.</td>
</tr>
</tbody>
</table>

**DEFINITION**

**PRESSURE ULCER/INJURY**

A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
M0210: Unhealed Pressure Ulcers/Injuries (cont.)

- Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.
- The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any skin ulcers/injuries are present.
   - Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.
   - Without a full body skin assessment, a pressure ulcer/injury can be missed.
   - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers/injuries.

Coding Instructions

Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days.

- Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers.
- Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Coding Tips

- If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.
M0210: Unhealed Pressure Ulcers/Injuries (cont.)

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, code 1 and proceed to code items in M0300 as appropriate for the pressure ulcer/injury.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident’s ulcer when the ulcer is in this location.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.
- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment.
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer’s deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer’s tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.
3. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
4. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or backstaging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer’s/injury’s anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg.
4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
5. A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg.
6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

Step 3: Determine “Present on Admission”

For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

1. Review the medical record for the history of the ulcer/injury.
2. Review for location and stage at the time of admission/entry or reentry.
3. If the pressure ulcer/injury was present on admission/entry or reentry and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage should not be considered as “present on admission.”
4. If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and should not be coded as “present on admission.”
5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should not be coded as “present on admission.”

DEFINITION
ON ADMISSION
As close to the actual time of admission as possible.
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

6. If a resident who has a pressure ulcer/injury that was originally acquired in the facility is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury should not be coded as “present on admission” because it was present and acquired at the facility prior to the hospitalization.

7. If a resident who has a pressure ulcer/injury that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.

8. If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable due to slough or eschar during the hospitalization, it should be coded as “present on admission” upon reentry.

9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as not present on admission.

10. If two pressure ulcers merge, that were both “present on admission,” continue to code the merged pressure ulcer as “present on admission.” Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not “present on admission.”
M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (cont.)

Examples

1. Ms. K is admitted to the facility without a pressure ulcer/injury. During the stay, she develops a stage 2 pressure ulcer. This is a facility acquired pressure ulcer and was not “present on admission.” Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was originally acquired in the nursing home and should not be considered as “present on admission” when she returns from the hospital.

2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as “present on admission” as it was not acquired in the facility. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is still considered “present on admission” because it was originally acquired outside the facility and has not changed.
M0300A: Number of Stage 1 Pressure Injuries

**Item Rationale**

**Health-related Quality of Care**
- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.

**Planning for Care**
- Development of a Stage 1 pressure injury should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.

**Steps for Assessment**

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Reliance on only one descriptor is inadequate to determine the staging of a pressure injury between Stage 1 and deep tissue injury (see definition of “deep tissue injury” on page M-24). The descriptors are similar for these two types of injuries (e.g., temperature [warmth or coolness]; tissue consistency [firm or boggy]).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blancheable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes as well as surrounding tissue that may be painful, firm, or soft.

**DEFINITIONS**

**STAGE 1 PRESSURE INJURY**
An observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues.

**NON-BLANCHABLE**
Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.
M0300A: Number of Stage 1 Pressure Injuries (cont.)

Coding Instructions for M0300A

- **Enter the number** of Stage 1 pressure injuries that are currently present.
- **Enter 0** if no Stage 1 pressure injuries are currently present.

M0300B: Stage 2 Pressure Ulcers

<table>
<thead>
<tr>
<th>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</td>
</tr>
<tr>
<td>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

Item Rationale

**Health-related Quality of Life**

- Stage 2 pressure ulcers may worsen without proper interventions.
- These residents are at risk for further complications or skin injury.

**Planning for Care**

- Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient’s overall clinical condition should be reassessed.
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

**DEFINITION**

**STAGE 2 PRESSURE ULCER**

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister.
M0300B: Stage 2 Pressure Ulcers (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).

2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.

3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, bogging or firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 pressure ulcer.

4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-8).

Coding Instructions for M0300B

M0300B1

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.

- **Enter 0** if no Stage 2 pressure ulcers are present and skip to M0300C, Stage 3.

M0300B2

- **Enter the number** of these Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

- **Enter 0** if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- *Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.*

- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here.

- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.
M0300C: Stage 3 Pressure Ulcers

**Item Rationale**

**Health-related Quality of Life**

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

**Planning for Care**

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.

- An existing pressure ulcer may put residents at risk for further complications or skin injury.

- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed.

- **Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.**

- **Changes in tissue characteristics over time are indicative of wound healing or degeneration.**

**Steps for Assessment**

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 3 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

**DEFINITION**

**STAGE 3 PRESSURE ULCER**

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-17).
M0300C: Stage 3 Pressure Ulcers (cont.)

Coding Instructions for M0300C

**M0300C1**

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- **Enter 0** if no Stage 3 pressure ulcers are present and skip to M0300D, Stage 4.

**M0300C2**

- **Enter the number** of these Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

**Coding Tips**

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment. Do **not** code moisture-associated skin damage or excoriation here.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.
M0300C: Stage 3 Pressure Ulcers (cont.)

Examples

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident’s medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.

   **Coding:** The current Stage 3 pressure ulcer would be coded at **M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.**

   **Rationale:** The designation of “present on admission” requires that the pressure ulcer be at the same location and not have increased in numerical stage or become unstageable due to slough or eschar. This pressure ulcer worsened from Stage 2 to Stage 3 after admission. **M0300C1 is coded as 1 and M0300C2 is coded as 0 on the current assessment** because the ulcer was not a Stage 3 pressure ulcer on admission.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

   **Coding:** The pressure ulcer would be coded at **M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.**

   **Rationale:** Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as Stage 3, present on admission/entry or reentry.

3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer.

   **Coding:** The two merged pressure ulcers would be coded at **M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry.** The **Stage 3 pressure ulcer** would be coded at **M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.**

   **Rationale:** Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, **M0300B1 and M0300B2 would be coded as 1;** the pressure ulcer that increased in numerical stage to a **Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.  
M0300C: Stage 3 Pressure Ulcers (cont.)

4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.

   **Coding:** The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission/entry or reentry; the Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.

   **Rationale:** The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here.

5. A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast. Two weeks after admission to the nursing facility, the cast is removed by the physician. Following the removal of the cast, the right heel is observed and assessed as a Stage 3 pressure ulcer, which remains until the subsequent assessment.

   **Coding:** Code M0300C1 as 1, and M0300C2 as 1, present on admission/entry or reentry.

   **Rationale:** The resident was admitted with a documented unstageable pressure ulcer/injury due to non-removable dressing/device. The cast was removed, and a Stage 3 pressure ulcer was assessed. Because this is the first time the ulcer has been numerically staged, this stage will be coded as present on admission/entry or reentry.

6. Mrs. P was admitted to the nursing facility with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains at Stage 3.

   **Coding:** Code M0300C1 as 1, and M0300C2 as 1, present on admission/entry or reentry.

   **Rationale:** This resident was admitted with an unstageable DTI that subsequently was debrided and could be numerically staged. The first numerical stage was 3, and it remained a Stage 3 for the subsequent assessment; therefore it is coded as present on admission/entry or reentry.
M0300C: Stage 3 Pressure Ulcers (cont.)

7. Mr. H was admitted with a known pressure ulcer/injury due to a non-removable dressing. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3. It remained Stage 3 at the time of the next assessment.

**Coding:** Code M0300C1 as 1, and M0300C2 as 0, not present on admission/entry reentry.

**Rationale:** This resident was admitted with an unstageable pressure ulcer due to non-removable dressing or device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage. Subsequent to this first stage, the ulcer worsened to Stage 3 and therefore is not coded as present on admission/entry or reentry.

M0300D: Stage 4 Pressure Ulcers

**Item Rationale**

**Health-related Quality of Life**

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

**Planning for Care**

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed.

**DEFINITION**

**STAGE 4 PRESSURE ULCER**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
M0300D: Stage 4 Pressure Ulcers (cont.)

**Steps for Assessment**

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of these pressure ulcers that were present on admission/entry or reentry.

**Coding Instructions for M0300D**

**M0300D1**

- **Enter the number** of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- **Enter 0** if no Stage 4 pressure ulcers are present and skip to M0300E, Unstageable – Non-removable dressing.

**M0300D2**

- **Enter the number** of these Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no Stage 4 pressure ulcers were first noted at the time of admission/entry or reentry.

**Coding Tips**

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

**Definitions**

**Tunneling**
A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

**Undermining**
The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.
M0300D: Stage 4 Pressure Ulcers (cont.)

- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS, but should be assessed, monitored, and treated as part of the comprehensive care plan.

M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device

<table>
<thead>
<tr>
<th>E. Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for residents because it may limit activity and may be painful.

**Planning for Care**

- Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

**Steps for Assessment**

1. Review the medical record for documentation of a pressure ulcer/injury covered by a non-removable dressing/device.
2. Determine the number of documented pressure ulcers/injuries covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or an orthopedic device that is not to be removed per physician’s order, or a cast.
3. Identify the number of these pressure ulcers/injuries that were present on admission/entry or reentry (see page M-8 for assessment process).

**Coding Instructions for M0300E**

**M0300E1**

- **Enter the number** of pressure ulcers/injuries that are unstageable related to non-removable dressing/device.
M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device (cont.)

- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar.

**M0300E2**

- **Enter the number** of these unstageable pressure ulcers/injuries related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer/injury related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).

- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

**Item Rationale**

**Health-related Quality of Life**

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

**Planning for Care**

- Visualization of the wound bed is necessary for accurate staging.

- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.

- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

**DEFINITIONS**

**SLOUGH TISSUE**

Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

**ESCHAR TISSUE**

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.
M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Steps for Assessment
1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar.
2. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-8 for assessment process).

Coding Instructions for M0300F

**M0300F1**
- **Enter the number** of pressure ulcers that are unstageable related to slough and/or eschar.
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar are present and skip to M0300G, Unstageable – Deep tissue injury.

**M0300F2**
- **Enter the number** of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry.

Coding Tips
- Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

**DEFINITION**

**FLUCTUANCE**
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.
M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Examples

1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.
   
   **Coding:** The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.
   **Rationale:** The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission.

2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.
   
   **Coding:** The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.
   **Rationale:** After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D.

3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.
   
   **Coding:** Code M0300F1 as 1, and M0300F2 as 0, not present on admission/entry or reentry.
   **Rationale:** The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

4. Mr. M. was admitted to the nursing facility with eschar tissue covering both the right and left heels, as well as a Stage 2 pressure ulcer on the coccyx. Mr. M’s pressure ulcers were reassessed before the subsequent assessment, and the Stage 2 coccyx pressure ulcer had healed. The left-heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer. The right-heel eschar remained stable and dry (i.e., remained unstageable).
   
   **Coding:** Code M0300D1 as 1, and M0300D2 as 1, present on admission/entry or reentry. Code M0300F1 as 1, and M0300F2 as 1, present on admission/entry or reentry.
   **Rationale:** Mr. M was admitted with an unstageable pressure injury due to slough/eschar on each heel. One of the heels was subsequently debrided, and the first numerical stage was Stage 4; thus this is coded as present on admission/entry or reentry. The other heel eschar remained unstageable, and is coded as present on admission/entry or reentry.
M0300G: Unstageable Pressure Injuries Related to Deep Tissue Injury

**Item Rationale**

**Health-related Quality of Life**

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident’s ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of deep tissue injury (DTI) is imperative.

**Planning for Care**

- Deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

**Steps for Assessment**

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister does not show signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do not code as a deep tissue injury.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure injuries that are unstageable related to deep tissue injury.
6. Identify the number of these pressure injuries that were present on admission/entry or reentry (see page M-8 for instructions).
7. Clearly document assessment findings in the resident’s medical record, and track and document appropriate wound care planning and management.
M0300G: Unstageable Pressure *Injuries* Related to Deep Tissue Injury (cont.)

**Coding Instructions for M0300G**

**M0300G1**

- **Enter the number** of unstageable pressure *injuries* related to deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of deep tissue injury.

- **Enter 0** if no unstageable pressure *injuries* related to deep tissue injury are present and skip to *M1030, Number of Venous and Arterial Ulcers*.

**M0300G2**

- **Enter the number** of these unstageable pressure *injuries* related to deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure *injury* related to deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).

- **Enter 0** if no unstageable pressure *injuries* related to deep tissue injury were first noted at the time of admission/entry or reentry.

**Coding Tips**

- Once deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.

- Deep tissue injury may be difficult to detect in individuals with dark skin tones.

- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here (see definition of Stage 2 pressure ulcer on page *M-12*). 

M1030: Number of Venous and Arterial Ulcers

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheet or other skin tracking form.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any venous or arterial ulcers are present.
   - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
   - Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
   - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
   - Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

DEFINITIONS

VENOUS ULCERS
Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

ARTERIAL ULCERS
Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

HEMOSIDERIN
An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment.
M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Instructions

Check all that apply in the last 7 days.

Pressure ulcers coded in M0210 through M0300 should not be coded here.

- Enter the number of venous and arterial ulcers present.
- Enter 0: if there were no venous or arterial ulcers present.

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of the ulcer.

Example

1. A resident has three toes on her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

   **Coding:** Code M1030 as 3.
   **Rationale:** Ischemic changes point to the ulcer being vascular.
M1040: Other Ulcers, Wounds and Skin Problems

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Infection of the foot (e.g., cellulitis, purulent drainage)</td>
</tr>
<tr>
<td>B</td>
<td>Diabetic foot ulcer(s)</td>
</tr>
<tr>
<td>C</td>
<td>Other open lesion(s) on the foot</td>
</tr>
<tr>
<td>D</td>
<td>Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)</td>
</tr>
<tr>
<td>E</td>
<td>Surgical wound(s)</td>
</tr>
<tr>
<td>F</td>
<td>Burn(s) (second or third degree)</td>
</tr>
<tr>
<td>G</td>
<td>Skin tear(s)</td>
</tr>
<tr>
<td>H</td>
<td>Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)</td>
</tr>
</tbody>
</table>

None of the Above

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.
M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
   - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.

Pressure ulcers/injuries coded in items M0200 through M0300 should not be coded here.

- **M1040A**, Infection of the foot (e.g., cellulitis, purulent drainage)
- **M1040B**, Diabetic foot ulcer(s)
- **M1040C**, Other open lesion(s) on the foot (e.g., cuts, fissures)
- **M1040D**, Open lesion(s) other than ulcers, rashes, cuts (e.g., bullous pemphigoid)
- **M1040E**, Surgical wound(s)
- **M1040F**, Burn(s)(second or third degree)
- **M1040G**, Skin tear(s)
- **M1040H**, Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage)
- **M1040Z**, None of the above were present

DEFINITIONS

**DIABETIC FOOT ULCERS**
Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

**SURGICAL WOUNDS**
Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

**OPEN LESION(S) OTHER THAN ULCERS, RASHES, CUTS**
Most typically skin lesions that develop as a result of diseases and conditions such as syphilis and cancer.

**BURNS (SECOND OR THIRD DEGREE)**
Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.
M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Coding Tips

**M1040B Diabetic Foot Ulcers**

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.

- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.

- Do not include pressure ulcers/injuries that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

**M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts**

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.

- Do not code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

- Do not code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

**M1040E Surgical Wounds**

- This category does not include healed surgical sites and healed 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.

- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound.
M1040: Other Ulcers, Wounds and Skin Problems (cont.)

**M1040F Burns (Second or Third Degree)**
- Do **not** include first degree burns (changes in skin color only).

**M1040G Skin Tear(s)**
- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.
- *Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.*

**M1040H Moisture Associated Skin Damage (MASD)**
- MASD is also referred to as *maceration and includes* incontinence-associated dermatitis, intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.
- *Moisture exposure and MASD are risk factors for pressure ulcer/injury development.* Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- *MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.*
- *MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.*
- *If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.*
- *If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.*
M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Examples

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.

   **Coding:** This ulcer is **not checked at M1040B.** This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210–M0300).
   
   **Rationale:** Persons with diabetes can still develop pressure ulcers.

2. A resident is readmitted from the hospital after myocutaneous flap surgery to excise and close his sacral pressure ulcer.

   **Coding:** Check **M1040E**, Surgical Wound.
   
   **Rationale:** A surgical flap procedure was used to close the resident’s pressure ulcer. The pressure ulcer is now considered a surgical wound.

3. Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.

   **Coding:** Check **M1040G**, Skin Tear(s).
   
   **Rationale:** The resident sustained a skin tear while reaching for a magazine.

4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

   **Coding:** Check **M1040H**, Moisture Associated Skin Damage (MASD).
   
   **Rationale:** Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.

   **Coding:** Check **M1040A**, Infection of the foot.
   
   **Rationale:** Mrs. F. has an infected right great toe due to an ingrown toenail.

6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.

   **Coding:** Check **M1040D**, Open lesion other than ulcers, rashes, cuts.
   
   **Rationale:** Mr. G. has open bullous pemphigoid blisters.

7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy.

   **Coding:** Check **M1040F**, Burns (second or third degree).
   
   **Rationale:** Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.
M1200: Skin and Ulcer/Injury Treatments

<table>
<thead>
<tr>
<th>M1200. Skin and Ulcer/Injury Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>□ A. Pressure reducing device for chair</td>
</tr>
<tr>
<td>□ B. Pressure reducing device for bed</td>
</tr>
<tr>
<td>□ C. Turning/repositioning program</td>
</tr>
<tr>
<td>□ D. Nutrition or hydration intervention</td>
</tr>
<tr>
<td>□ E. Pressure ulcer/injury care</td>
</tr>
<tr>
<td>□ F. Surgical wound care</td>
</tr>
<tr>
<td>□ G. Application of nonsurgical dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>□ H. Applications of ointments/medications other than to feet</td>
</tr>
<tr>
<td>□ I. Application of dressings to feet (with or without topical medications)</td>
</tr>
<tr>
<td>□ Z. None of the above were provided</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

**Planning for Care**

- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

**Steps for Assessment**

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility’s policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident’s wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

**DEFINITION**

**PRESSURE REDUCING DEVICE(S)**

Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.
M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A**, Pressure reducing device for chair
- **M1200B**, Pressure reducing device for bed
- **M1200C**, Turning/repositioning program
- **M1200D**, Nutrition or hydration intervention to manage skin problems
- **M1200E**, Pressure ulcer/injury care
- **M1200F**, Surgical wound care
- **M1200G**, Application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids.
- **M1200H**, Application of ointments/medications other than to feet
- **M1200I**, Application of dressings to feet (with or without topical medications)
- **M1200Z**, None of the above were provided
M1200: Skin and Ulcer/Injury Treatments (cont.)

Coding Tips

**M1200A/M1200B Pressure Reducing Devices**

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

**M1200C Turning/Repositioning Program**

- The turning/repositioning program is specific as to the approaches for changing the resident’s position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

**M1200D Nutrition or Hydration Intervention to Manage Skin Problems**

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident’s diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

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**DEFINITIONS**

**TURNING/REPOSITIONING PROGRAM**
Includes a 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 based on an assessment of the resident’s needs.

**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 supplementation to prevent skin breakdown, high-protein supplementation for wound healing.
M1200: Skin and Ulcer/Injury Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment. If it is determined that nutritional supplementation, that is, adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.

- It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis.

M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G). Examples may include the use of topical dressings; enzymatic, mechanical or surgical debridement; wound irrigations; negative pressure wound therapy (NPWT); and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.

- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in M1200E, Pressure Ulcer Care. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.

- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.

- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.
M1200: Skin and Ulcer/Injury Treatments (cont.)

**M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet**

- Do not code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M1200E, Pressure ulcer/injury care.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include, but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

**M1200H Application of Ointments/Medications Other than to Feet**

- Do not code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

**M1200I Application of Dressings to the Feet (with or without Topical Medications)**

- Includes interventions to treat any foot wound or ulcer other than a pressure ulcer/injury.
- Do not code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure ulcer/injury care.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.
M1200: Skin and Ulcer/Injury Treatments (cont.)

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing pad on the resident’s wheelchair. The medical record documents delivery of care and notes that the resident is on a two-hour turning/repositioning program that is organized, planned, documented, monitored, and evaluated based on an individualized assessment of her needs. The physician documents, after reviewing the resident’s nutritional intake, healing progress of the resident’s pressure ulcer, dietician’s nutritional assessment, and laboratory results, that the resident has protein-calorie malnutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients, and micronutrients. All mattresses in the nursing home are pressure reducing mattresses.

**Coding:** Check items M1200A, M1200B, M1200C, M1200D, and M1200E.  
**Rationale:** Interventions include pressure reducing pad on the wheelchair (M1200A) and pressure reducing mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the last 7 days the resident has had a three-layer compression-bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure reducing mattress and pad for the wheelchair.

**Coding:** Check items M1200A, M1200B, and M1200G.  
**Rationale:** Treatments include pressure reducing mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression-bandaging system (M1200G).

3. Mrs. S. has a diagnosis of right-sided hemiplegia from a previous stroke. As part of her assessment, it was noted that while in bed Mrs. S. is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every 3 hours while in bed. When she is in her wheelchair, it is difficult for her to offload the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when she is sitting, and therefore, Mrs. S. is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident’s response to the interventions.

**Coding:** Check M1200C.  
**Rationale:** Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident’s unique needs.
M1200: Skin and Ulcer/Injury Treatments (cont.)

4. Mr. J. has a diagnosis of Advanced Alzheimer’s and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

   **Coding:** Do not check item M1200C.
   **Rationale:** Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident’s response to turning and repositioning. There are not any skin or ulcer treatments being provided.

Scenarios for Pressure Ulcer Coding

**Example M0100-M1200**

1. Mrs. P was admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance.

**5-Day PPS #1:**

**Coding:**

- **M0100B** (Formal assessment instrument), Check box.
- **M0100C** (Clinical assessment), Check box.
- **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
- **M0210** (One or more unhealed pressure ulcers/injuries), Code 0 and skip to **M1030** (Number of Venous and Arterial Ulcers).
- **M1030** (Number of Venous and Arterial Ulcers), Code 0.
- **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
- **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).
**Scenarios for Pressure Ulcer Coding (cont.)**

**Rationale:** The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident’s skin was noted to be intact, therefore, **M0210** was coded 0. **M1030** was coded 0 due to the resident not having any of these conditions. **M1040Z** was checked since none of these problems were noted. **M1200Z** was checked because none of these treatments were provided.

<table>
<thead>
<tr>
<th>M1030. Number of Venous and Arterial Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Number</td>
</tr>
<tr>
<td>0 Enter the total number of venous and arterial ulcers present</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M1040. Other Ulcers, Wounds and Skin Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>Foot Problems</td>
</tr>
<tr>
<td>A. Infection of the foot (e.g., cellulitis, purulent drainage)</td>
</tr>
<tr>
<td>B. Diabetic foot ulcer(s)</td>
</tr>
<tr>
<td>C. Other open lesion(s) on the foot</td>
</tr>
<tr>
<td>Other Problems</td>
</tr>
<tr>
<td>D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)</td>
</tr>
<tr>
<td>E. Surgical wound(s)</td>
</tr>
<tr>
<td>F. Burn(s) (second or third degree)</td>
</tr>
<tr>
<td>G. Skin tear(s)</td>
</tr>
<tr>
<td>H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)</td>
</tr>
<tr>
<td>None of the Above</td>
</tr>
<tr>
<td>X Z. None of the above were present</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M1200. Skin and Ulcer/Injury Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all that apply</td>
</tr>
<tr>
<td>A. Pressure reducing device for chair</td>
</tr>
<tr>
<td>B. Pressure reducing device for bed</td>
</tr>
<tr>
<td>C. Turning/repositioning program</td>
</tr>
<tr>
<td>D. Nutrition or hydration intervention to manage skin problems</td>
</tr>
<tr>
<td>E. Pressure ulcer/injury care</td>
</tr>
<tr>
<td>F. Surgical wound care</td>
</tr>
<tr>
<td>G. Application of nonsurgical dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>H. Applications of ointments/medications other than to feet</td>
</tr>
<tr>
<td>I. Application of dressings to feet (with or without topical medications)</td>
</tr>
<tr>
<td>X Z. None of the above were provided</td>
</tr>
</tbody>
</table>
Scenarios for Pressure Ulcer Coding (cont.)

14-Day PPS:

Coding:

- **M0100A** (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box.
- **M0100B** (Formal assessment instrument), Check box.
- **M0100C** (Clinical assessment), Check box.
- **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
- **M0210** (One or more unhealed pressure ulcers/injuries), Code 1.
- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).
- **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device).
- **M0300E1** (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar).
- **M0300F1** (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury).
- **M0300G1** (Unstageable – Deep tissue injury), Code 0 and skip to **M1030** (Number of Venous and Arterial Ulcers).
- **M1030** (Number of Venous and Arterial Ulcers), Code 0.
- **M1040** (Other Ulcers, Wounds and Skin Problems), Check Z (None of the above).
Scenarios for Pressure Ulcer Coding (cont.)

- **M1200A** (Pressure reducing device for chair), **M1200B** (Pressure reducing device for bed), **M1200C** (Turning/repositioning program), and **M1200E** (Pressure ulcer/injury care) are all checked.

**Rationale:** The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-day PPS assessment, the resident’s skin was noted to be intact, however, on the 14-day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-day PPS completed, the 14-day PPS would be coded 0 at A0310E. This is because the 14-day PPS is not the first assessment since the most recent admission/entry or reentry. There were no other skin problems noted. However, the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, had preventative measures put in place, with pressure reducing devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings [with or without topical medications]) would not be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).
### M0100. Determination of Pressure Ulcer/Injury Risk

Check all that apply

- A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
- B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- C. Clinical assessment
- Z. None of the above

### M0150. Risk of Pressure Ulcers/Injuries

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Is this resident at risk of developing pressure ulcers/injuries?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### M0210. Unhealed Pressure Ulcers/Injuries

Enter Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Does this resident have one or more unhealed pressure ulcers/injuries?</td>
<td>No ➔ Skip to M0100, Number of Venous and Arterial Ulcers</td>
<td>Yes ➔ Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</td>
</tr>
</tbody>
</table>

### M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- **A. Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
  - 1. Number of Stage 1 pressure injuries

- **B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
  - 1. Number of Stage 2 pressure ulcers - If 0 ➔ Skip to M0300C, Stage 3
  - 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

- **C. Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling
  - 1. Number of Stage 3 pressure ulcers - If 0 ➔ Skip to M0300D, Stage 4
  - 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

- **D. Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
  - 1. Number of Stage 4 pressure ulcers - If 0 ➔ Skip to M0300E, Unstageable - Non-removable dressing/device
  - 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page
### Scenarios for Pressure Ulcer Coding (cont.)

<table>
<thead>
<tr>
<th>M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Unstageable - Non-removable dressing/device:</strong> Known but not stageable due to non-removable dressing/device</td>
</tr>
<tr>
<td>1. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device - If 0 ➔ Skip to M0300F, Unstageable - Slough and/or eschar</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
<tr>
<td><strong>F. Unstageable - Slough and/or eschar:</strong> Known but not stageable due to coverage of wound bed by slough and/or eschar</td>
</tr>
<tr>
<td>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 ➔ Skip to M0300G, Unstageable - Deep tissue injury</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
<tr>
<td><strong>G. Unstageable - Deep tissue injury:</strong></td>
</tr>
<tr>
<td>1. Number of unstageable pressure injuries presenting as deep tissue injury - If 0 ➔ Skip to M1030, Number of Venous and Arterial Ulcers</td>
</tr>
<tr>
<td>2. Number of these unstageable pressure injuries that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</td>
</tr>
</tbody>
</table>
## Scenarios for Pressure Ulcer Coding (cont.)

### M1030. Number of Venous and Arterial Ulcers

<table>
<thead>
<tr>
<th>Enter Number</th>
<th>Enter the total number of venous and arterial ulcers present</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### M1040. Other Ulcers, Wounds and Skin Problems

- **Foot Problems**
  - A. Infection of the foot (e.g., cellulitis, purulent drainage)
  - B. Diabetic foot ulcer(s)
  - C. Other open lesion(s) on the foot

- **Other Problems**
  - D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
  - E. Surgical wound(s)
  - F. Burn(s) (second or third degree)
  - G. Skin tear(s)
  - H. Moisture Associated Skin Damage (MASD) [e.g., incontinence-associated dermatitis (IAD), perspiration, drainage]

### M1200. Skin and Ulcer/Injury Treatments

- A. Pressure reducing device for chair
- B. Pressure reducing device for bed
- C. Turning/repositioning program
- D. Nutrition or hydration intervention to manage skin problems
- E. Pressure ulcer/injury care
- F. Surgical wound care
- G. Application of nonsurgical dressings (with or without topical medications) other than to feet
- H. Applications of ointments/medications other than to feet
- I. Application of dressings to feet (with or without topical medications)
- Z. None of the above were provided
N0410: Medications Received (cont.)

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


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

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

N0450: Antipsychotic Medication Review

<table>
<thead>
<tr>
<th>N0450. Antipsychotic Medication Review</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?</strong></td>
</tr>
<tr>
<td>0. No - Antipsychotics were not received ➔ Skip N045OB, N0450C, N0450D, and N0450E</td>
</tr>
<tr>
<td>1. Yes - Antipsychotics were received on a routine basis only ➔ Continue to N0450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>2. Yes - Antipsychotics were received on a PRN basis only ➔ Continue to N0450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td>3. Yes - Antipsychotics were received on a routine and PRN basis ➔ Continue to N0450B, Has a GDR been attempted?</td>
</tr>
<tr>
<td><strong>B. Has a gradual dose reduction (GDR) been attempted?</strong></td>
</tr>
<tr>
<td>0. No ➔ Skip to N0450D, Physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>1. Yes ➔ Continue to N0450C, Date of last attempted GDR</td>
</tr>
<tr>
<td><strong>C. Date of last attempted GDR:</strong></td>
</tr>
<tr>
<td>Month</td>
</tr>
<tr>
<td><strong>D. Physician documented GDR as clinically contraindicated</strong></td>
</tr>
<tr>
<td>0. No - GDR has not been documented by a physician as clinically contraindicated ➔ Skip N0450E Date physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>1. Yes - GDR has been documented by a physician as clinically contraindicated ➔ Continue to N0450E, Date physician documented GDR as clinically contraindicated</td>
</tr>
<tr>
<td>E. Date physician documented GDR as clinically contraindicated:</td>
</tr>
<tr>
<td>Month</td>
</tr>
</tbody>
</table>
N0450: Antipsychotic Medication Review (cont.)

Item Rationale

**Health-related Quality of Life**

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

**Planning for Care**

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

**Steps for Assessment**

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

**Coding Instructions for N0450A**

- **Code 0, no:** if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E.
- **Code 1, yes:** if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 2, yes:** if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 3, yes:** if antipsychotics were received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted?
N0450: Antipsychotic Medication Review (cont.)

- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication to another.

- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic medication.

- In cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C.

- If multiple dose reductions have been attempted since admission OR since initiation of the antipsychotic medication, record the date of the most recent reduction attempt in N0450C.

- Federal requirements regarding GDRs are found at 42 CFR 483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

Coding Instructions for N0450D

- **Code 0, no:** if a GDR has not been documented by a physician as clinically contraindicated. Skip **N0450E Date physician documented GDR as clinically contraindicated.**

- **Code 1, yes:** if a GDR has been documented by a physician as clinically contraindicated. Continue to N0450E, Date physician documented GDR as clinically contraindicated.

Coding Instructions for N0450E

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

Coding Tips and Special Populations (N0450D and N0450E)

- In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.

- In N0450D and N0450E, include physician documentation that a GDR attempt is clinically contraindicated since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted to the facility.

- Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident’s function, well-being, safety, and quality of life.
N2001: Drug Regimen Review

**Intent:** The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident’s admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident’s stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.

<table>
<thead>
<tr>
<th>N2001. Drug Regimen Review - Complete only if A0310B = 01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code:</td>
</tr>
<tr>
<td>0. No - No issues found during review</td>
</tr>
<tr>
<td>1. Yes - Issues found during review</td>
</tr>
<tr>
<td>9. NA - Resident is not taking any medications</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Potential and actual resident medication adverse consequences and errors are prevalent in health care settings and often occur during transitions in care.
- Adverse consequences related to medications may result in serious harm or death, emergency department visits, and rehospitalizations and affect the resident’s health, safety, and quality of life.
- Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident’s admission (start of SNF PPS stay) and throughout the resident’s stay (through Part A PPS discharge).

**Planning for Care**

- Drug regimen review is an important component of the overall management and monitoring of a resident’s medication regimen.
- Prevention and timely identification of potential and actual medication-related adverse consequences reduces the resident’s risk for harm and improves quality of life.
- Educate staff in proper medication administration techniques and adverse effects of medications, as well as to be observant for these adverse effects.
- Implement a system to ensure that each resident’s medication usage is evaluated upon admission and on an ongoing basis and that risks and problems are identified and acted upon.

**DEFINITION**

**DRUG REGIMEN REVIEW**

A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences. The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.
N2001: Drug Regimen Review (cont.)

Steps for Assessment

Complete if $A0310B = 01$.

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.

   Medical record sources include medical records received from facilities where the resident received health care, the resident’s most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

   Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident’s family/significant other) may supplement and/or clarify the information gleaned from the resident’s medical records.

3. Clinically significant medication issues may include, but are not limited to:

   • Medication prescribed despite documented medication allergy or prior adverse reaction.
   • Excessive or inadequate dose.
   • Adverse reactions to medication.
   • Ineffective drug therapy.
   • Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
   • Duplicate therapy (for example, generic-name and brand-name equivalent drugs are coprescribed).
   • Wrong resident, drug, dose, route, and time errors.
   • Medication dose, frequency, route, or duration not consistent with resident’s condition, manufacturer’s instructions, or applicable standards of practice.
   • Use of a medication without evidence of adequate indication for use.
   • Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed).
   • Omissions (medications missing from a prescribed regimen).
   • Nonadherence (purposeful or accidental).
N2001: Drug Regimen Review (cont.)

Coding Instructions

• **Code 0, No**: if no clinically significant medication issues were identified during the drug regimen review.

• **Code 1, Yes**: if one or more clinically significant medication issues were identified during the drug regimen review.

• **Code 9, NA**: if the resident was not taking any medications at the time of the drug regimen review.

Coding Tips

• A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

• The drug regimen review includes all medications, prescribed and over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

Examples

1. The admitting nurse reviewed and compared the acute care hospital discharge medication orders and the physician’s admission medication orders for Ms. D. The nurse interviewed Ms. D, who confirmed the medications she was taking for her current medical conditions. The nurse found no discrepancies between the acute care hospital discharge medications and the admitting physician’s medication orders. After the nurse contacted the pharmacy to request the medication, the pharmacist reviewed and confirmed the medication orders as appropriate for Ms. D. As a result of this collected and communicated information, the nurse determined that there were no potential or actual clinically significant medication issues.

   **Coding:** N2001 would be coded 0, No—No issues found during review.
N2001: Drug Regimen Review (cont.)

**Rationale:** The admitting nurse reviewed and compared Ms. D’s discharge medication records from the acute care hospital with the physician’s admission medication orders, collaborated with the pharmacist, and interviewed the resident. The nurse determined there were no potential or actual clinically significant medication issues.

2. Mr. H was admitted to the nursing facility after undergoing cardiac surgery for mitral valve replacement. The acute care hospital discharge information indicated that Mr. H had a mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of Mr. H’s discharge records from the hospital with the physician’s admission medication orders and admission note, the nurse noted that the admitting physician had ordered Mr. H’s anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0, however, the physician’s admission note indicated that the desired therapeutic INR parameters for Mr. H were 2.5–3.5. The nurse questioned the INR level listed on the admitting physician’s order, based on the therapeutic parameters of 2.5–3.5 documented in the physician’s admission note, which prompted the nurse to call the physician immediately to address the issue.

**Coding:** N2001 would be coded 1, Yes—Issues found during review.

**Rationale:** The admitting nurse reviewed and compared Mr. H’s discharge health care records from the acute care hospital with the nursing facility physician’s admission medication orders and admission note. The nurse identified a discrepancy between the physician’s documented therapeutic INR level (2.5–3.5) for Mr. H in the admission note and the physician’s order to hold anticoagulation medication for an INR level of 1.0. The nurse considered this discrepancy to be a potential clinically significant medication issue that could lead to potential clotting issues for Mr. H.

N2003: Medication Follow-up

**Item Rationale**

**Health-related Quality of Life**

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

**DEFINITION**

**MEDICATION FOLLOW-UP**

The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest.
N2003: Medication Follow-up (cont.)

Planning for Care

- When a potential or actual clinically significant medication issue is identified, prompt communication with the physician and implementation of prescribed actions is necessary to protect the health and safety of the resident.

Steps for Assessment

This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).

1. Review the resident’s medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:
   - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
   - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

Medical record sources include medical records received from facilities where the resident received health care, the resident’s most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident’s family/significant other) may supplement and/or clarify the information gleaned from the resident’s medical records.

Coding Instructions

- **Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions in response to each identified potential or actual clinically significant medication issue by midnight of the next calendar day.

- **Code 1, Yes:** if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.

Coding Tips

- If the physician prescribes/recommends an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes**, should still be entered, if by midnight of the next calendar day the

**DEFINITION**

**CONTACT WITH PHYSICIAN**

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, and a response from the physician to convey prescribed/recommended actions in response to the medication issue.

- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident’s status.
N2003: Medication Follow-up (cont.)

facility has taken the appropriate steps to comply with the prescribed/recommended action.

— Example of a physician-recommended action that would take longer than midnight of the next calendar day to complete:
  
  o The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.

— Examples of by midnight of the next calendar day:
  
  o A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
  
  o A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.

• A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

Examples

1. Mr. P was admitted to the nursing facility with active diagnoses of pneumonia and atrial fibrillation. The acute care facility medication record indicated that Mr. P was on a seven-day course of antibiotics and had three remaining days of this treatment plan. The nurse reviewing the discharge records from the acute care facility and the nursing facility admission medication orders noted that Mr. P had an order for an anticoagulant medication that required INR monitoring, as well as the antibiotic. On the date of admission, the nurse contacted the physician responsible for Mr. P and communicated a concern about a potential increase in Mr. P’s INR with this combination of medications that could place him at greater risk for bleeding. The physician provided orders for laboratory testing so that Mr. P’s INR levels would be monitored over the next three days, starting that day. However, the nurse did not request the first INR laboratory test until after midnight of the next calendar day.

   **Coding:** N2003 would be coded 0, No.

   **Rationale:** A potential clinically significant medication issue was identified during the drug regimen review; the staff did contact the physician before midnight of the next calendar day, but did not complete, to the extent possible, the physician-prescribed actions related to the INR laboratory test until after midnight of the next calendar day.

2. Ms. S was admitted to the facility from an acute care hospital. During the admitting nurse’s review of Ms. S’s hospital discharge records, it was noted that Ms. S had been prescribed metformin. However, laboratory tests at admission indicated that Ms. S had a serum creatinine of 2.4, consistent with renal insufficiency. The admitting nurse contacted the physician to ask whether this medication would be contraindicated with Ms. S’s current serum creatinine level. Three hours after Ms. S’s admission to the facility, the physician provided orders to discontinue the metformin and start Ms. S on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour.
N2003: Medication Follow-up (cont.)

Coding: N2003 would be coded 1, Yes.

Rationale: A potential clinically significant medication issue was identified during the drug regimen review; the physician communication occurred, and the nurse completed the physician-prescribed actions, by midnight of the next calendar day.

N2005: Medication Intervention

<table>
<thead>
<tr>
<th>N2005. Medication Intervention</th>
<th>Complete only if A0310H = 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
<td>Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?</td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications</td>
<td></td>
</tr>
</tbody>
</table>

Item Rationale

Health-related Quality of Life

• Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.

• Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

• Potential or actual clinically significant medication issues can occur throughout the resident’s stay.

Planning for Care

• Every time a potential or actual clinically significant medication issue is identified throughout the resident’s stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

Steps for Assessment

The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

1. Review the resident’s medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident’s stay:

   • Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND

   • All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.
N2005: Medication Intervention (cont.)

Medical record sources include medical records received from facilities where the resident received health care, the resident’s most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident’s family/significant other) may supplement and/or clarify the information gleaned from the resident’s medical records.

Coding Instructions

- **Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).

- **Code 1, Yes:** if the facility contacted the physician and completed prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).

- **Code 9, NA:** if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident’s stay or the resident was not taking any medications at admission or at any time throughout the stay.

Coding Tips

- If the physician prescribes an action that will take longer than midnight of the next calendar day to complete, then code **1, Yes**, should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.
  - Example of a physician-recommended action that would take longer than midnight of the next calendar day to complete:
    - The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of by midnight of the next calendar day:
    - A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.

- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
N2005: Medication Intervention (cont.)

Examples

1. At the end of the resident’s Part A PPS stay, the discharging nurse reviewed Ms. T’s medical records, from the time of admission (start of SNF PPS stay) through her entire Part A PPS stay (Part A PPS discharge) and noted that a clinically significant medication issue was documented during the admission assessment. Ms. T’s medical records indicated that a nurse had attempted to contact the assigned physician several times about the clinically significant medication issue. After midnight of the second calendar day, the physician communicated to the nurse, via telephone, orders for changes to Ms. T’s medications to address the clinically significant medication issue. The nurse implemented the physician’s orders. Upon further review of Ms. T’s medical records, the discharging nurse determined that no additional issues had been recorded throughout the remainder of Ms. T’s stay.

   **Coding:** N2005 would be coded 0, No—the facility did not contact the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since the resident’s admission (start of SNF PPS stay).

   **Rationale:** Coding of this item includes all potential or actual clinically significant medication issues identified at any time during the resident’s stay. When reviewing Ms. T’s medical record at discharge, the nurse found that a clinically significant medication issue was identified during the admission (start of SNF PPS stay) drug regimen review, but the facility did not communicate with the physician and complete prescribed actions by midnight of the next calendar day. Although no other potential or actual clinically significant medication issues were identified during the remainder of the resident’s stay, the facility did not communicate with the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified during the resident’s SNF PPS stay.

2. At discharge, the nurse completing a review of Ms. K’s medical records found that two clinically significant medication issues had been identified during the resident’s stay. During the admission drug regimen review, the admitting nurse had identified a clinically significant medication issue, contacted the physician, and implemented new orders provided by the physician on the same day. Another potentially significant medication issue was identified on day 12 of Ms. K’s stay; the nurse communicated with the physician and carried out the orders within one hour of identifying the potential issue. Both medication issues identified during Ms. K’s stay were communicated to the physician and resolved by midnight of the next calendar day after identification. There were no other clinically significant medication issues identified during Ms. K’s stay.

   **Coding:** N2005 would be coded as 1, Yes—all potential or actual clinically significant medication issues identified at any time during the resident’s stay (admission through discharge) were communicated to the physician and prescribed/recommended actions were completed by midnight of the next calendar day after each issue was identified.
Rationale: While a medication issue was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. During Ms. K’s stay, an additional clinically significant medication issue was identified; it too was resolved by midnight of the following day. Each time a clinically significant medication issue was identified (at admission and during the stay), it was communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day after identification.
SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

O0100: Special Treatments, Procedures, and Programs

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

<table>
<thead>
<tr>
<th>O0100. Special Treatments, Procedures, and Programs</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. While NOT a Resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed while NOT a resident of this facility and within the last 14 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. While a Resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed while a resident of this facility and within the last 14 days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check all that apply:

Cancer Treatments
- A. Chemotherapy
- B. Radiation

Respiratory Treatments
- C. Oxygen therapy
- D. Suctioning
- E. Tracheostomy care
- F. Invasive Mechanical Ventilator (ventilator or respirator)
- G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)

Other
- H. IV medications
- I. Transfusions
- J. Dialysis
- K. Hospice care
- L. Respite care
- M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)
- None of the Above
- Z. None of the above

Item Rationale

Health-related Quality of Life
- The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an individual’s health status, self-image, dignity, and quality of life.
O0100: Special Treatments, Procedures, and Programs (cont.)

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.

- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

Steps for Assessment

1. Review the resident’s medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 1

Check all treatments, procedures, and programs received or performed by the resident prior to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, check Z, none of the above.

Coding Instructions for Column 2

Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

- O0100A, Chemotherapy

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS. IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O01001 (Transfusions).
O0100: Special Treatments, Procedures, and Programs (cont.)

Example: Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **O0100B, Radiation**
  Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

- **O0100C, Oxygen therapy**
  Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning**
  Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care**
  Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

- **O0100F, Invasive Mechanical Ventilator (ventilator or respirator)**
  Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support his or her own respiration in this item. During invasive mechanical ventilation the resident’s breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days, or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

Example: Mrs. J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day, because of an irreversible neurological injury and inability to breathe on her own. O0100F should be checked, as Mrs. J is using an invasive mechanical ventilator because she is unable to initiate spontaneous breathing on her own and the ventilator is controlling her breathing.
O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)**

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

*Example:* Mr. M has sleep apnea and requires a CPAP device to be worn when sleeping. The staff set-up the water receptacle and humidifier element of the machine. Mr. M puts on the CPAP mask and starts the machine prior to falling asleep. O0100G should be checked as Mr. M is able to breathe on his own and wears the CPAP mask when he is sleeping to manage his sleep apnea.

- **O0100H, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are not coded in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:


- **O0100I, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.

- **O0100J, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home 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 medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.
O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100K, Hospice care**
  Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided 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.

- **O0100L, Respite care**
  Code only when the resident’s care program involves a short-term stay in the facility for the purpose of providing relief to a primary home-based caregiver(s) in this item.

- **O0100M, Isolation for active infectious disease (does not include standard precautions)**
  Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns.
  Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

  Code for “single room isolation” only when all of the following conditions are met:
  1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
  2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
  3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
  4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

  The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

O0100: Special Treatments, Procedures, and Programs (cont.)

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident’s status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident’s function and plan of care. The definition and criteria of “significant change of status” is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident’s plan of care will likely need to be completed.

- **O0100Z, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

O0250: Influenza Vaccine

**Item Rationale**

**Health-related Quality of Life**

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.

- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
O0250: Influenza Vaccine (cont.)

- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

**Planning for Care**

- Influenza vaccines have been proven effective in preventing hospitalizations.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.

  — **Mild problems:** soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days.

  — **Severe problems:**

    ○ Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.

    ○ In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.

- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine.

- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC: [http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html](http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html)

- Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 ([https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases](https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases)) national goal of increasing to 90 percent, the percentage of adults aged 18 years or older in long-term care nursing homes who are vaccinated annually against seasonal influenza.
O0250: Influenza Vaccine (cont.)

Steps for Assessment

1. Review the resident’s medical record to determine whether an influenza vaccine was received in the facility for this year’s influenza vaccination season. If vaccination status is unknown, proceed to the next step.

2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year’s influenza vaccination season. If vaccination status is still unknown, proceed to the next step.

3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.

4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.

Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year’s influenza vaccination season?

- **Code 0, no:** if the resident did **NOT** receive the influenza vaccine **in this facility** during this year’s influenza vaccination season. Proceed to **If influenza vaccine not received, state reason** (O0250C).

- **Code 1, yes:** if the resident **did receive the influenza vaccine in this facility** during this year’s influenza season. Continue to **Date influenza vaccine received** (O0250B).

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank.
  - If the month contains only a single digit, fill in the first box of the month with a “0”.
    - For example, January 17, 2014 should be entered as 01-17-2014.
  - If the day only contains a single digit, then fill the first box of the day with the “0”.
    - For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
  - A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

Coding Instructions for O0250C, If influenza vaccine not received, state reason

*If the resident has not received the influenza vaccine for this year’s influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

- **Code 1, Resident not in this facility during this year’s influenza vaccination season:** resident was not in this facility during this year’s influenza vaccination season.
O0250: Influenza Vaccine (cont.)

- **Code 2, Received outside of this facility:** includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year’s influenza vaccination season.

- **Code 3, Not eligible—medical contraindication:** if influenza vaccine not received due to medical contraindications. *Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component.* Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.

- **Code 4, Offered and declined:** resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.

- **Code 5, Not offered:** resident or responsible party/legal guardian not offered the influenza vaccine.

- **Code 6, Inability to obtain influenza vaccine due to a declared shortage:** vaccine is unavailable at this facility due to a declared influenza vaccine shortage.

- **Code 9, None of the above:** if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

**Coding Tips and Special Populations**

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.

- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.

- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: [http://www.cdc.gov/flu/weekly/fluactivitysurv.htm](http://www.cdc.gov/flu/weekly/fluactivitysurv.htm), [http://www.cdc.gov/flu/weekly/usmap.htm](http://www.cdc.gov/flu/weekly/usmap.htm).

- Facilities can also contact their local health department website for local influenza surveillance information.

- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.

- A “high dose” inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident’s primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.
O0250: Influenza Vaccine (cont.)

Examples

1. Mrs. J. received the influenza vaccine in the facility during this year’s influenza vaccination season, on January 7, 2014.

   **Coding:** O0250A would be coded 1, yes; O0250B would be coded 01-07-2014, and O0250C would be skipped.
   
   **Rationale:** Mrs. J. received the vaccine in the facility on January 7, 2014, during this year’s influenza vaccination season.

2. Mr. R. did not receive the influenza vaccine in the facility during this year’s influenza vaccination season due to his known allergy to egg protein.

   **Coding:** O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 3, not eligible-medical contraindication.
   
   **Rationale:** Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Mr. R did not receive the vaccine.

3. Mrs. T. received the influenza vaccine at her doctor’s office during this year’s influenza vaccination season. Her doctor provided documentation of receipt of the vaccine to the facility to place in Mrs. T.’s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks of the influenza vaccine prior to administration.

   **Coding:** O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.
   
   **Rationale:** Mrs. T. received the influenza vaccine at her doctor’s office during this year’s influenza vaccination season.

4. Mr. K. wanted to receive the influenza vaccine if it arrived prior to his scheduled discharge on October 5th. Mr. K. was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Mr. K. did not receive the influenza vaccine in the facility.

   Mr. K. was encouraged to receive the influenza vaccine at his next scheduled physician visit.

   **Coding:** O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 9, none of the above.
   
   **Rationale:** Mr. K. was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after his discharge. None of the codes in O0250C, *Influenza vaccine not received, state reason*, are applicable.
O0300: Pneumococcal Vaccine

Item Rationale

Health-related Quality of Life

- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates.
- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive pneumococcal disease or its complications, i.e., those 65 years of age and older with certain medical conditions, should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include decreased immune function; damaged or no spleen; sickle cell and other hemoglobinopathies; cerebrospinal fluid (CSF) leak; cochlear implants; and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking.
- Determining the rate of pneumococcal vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23) national goal of 90% immunization among nursing home residents.

Steps for Assessment

1. Review the resident’s medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
O0300: Pneumococcal Vaccine (cont.)

4. If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.
   - If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
   - If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
   - If the resident has a minor illness (e.g., a cold) check with the resident’s physician before administering the vaccine.

Coding Instructions O0300A, Is the Resident’s Pneumococcal Vaccination Up to Date?

- **Code 0, no:** if the resident’s pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, *If Pneumococcal vaccine not received, state reason.*
- **Code 1, yes:** if the resident’s pneumococcal vaccination status is up to date. Skip to O0400, *Therapies.*

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason

*If the resident has not received a pneumococcal vaccine, code the reason from the following list:*

- **Code 1, Not eligible:** if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.
- **Code 2, Offered and declined:** resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- **Code 3, Not offered:** resident or responsible party/legal guardian not offered the pneumococcal vaccine.

Coding Tips

- *Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at [https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf](https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf).*
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

*For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at*

- [https://www.cdc.gov/vaccines/schedules/hcp/index.html](https://www.cdc.gov/vaccines/schedules/hcp/index.html)
- [http://www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
O0300: Pneumococcal Vaccine (cont.)

— https://www.cdc.gov/pneumococcal/vaccination.html

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident’s pneumococcal vaccination is up to date.

Examples

1. Mr. L., who is 72 years old, received the PCV13 pneumococcal vaccine at his physician’s office last year. He had previously been vaccinated with PPSV23 at age 66.

   **Coding:** O0300A would be **coded 1, yes**; skip to O0400, Therapies.

   **Rationale:** Mr. L, who is over 65 years old has received the recommended PCV13 and PPSV23 vaccines.

2. Mrs. B, who is 95 years old, has never received a pneumococcal vaccine. Her physician has an order stating that she is NOT to be immunized.

   **Coding:** O0300A would be **coded 0, no**; and O0300B would be **coded 1, not eligible**.

   **Rationale:** Mrs. B. has never received the pneumococcal vaccine; therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.

3. Mrs. A, who has congestive heart failure, received PPSV23 vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 years old and was admitted to the nursing home one week ago for rehabilitation. She was offered and given PCV13 on admission.

   **Coding:** O0300A would be **coded 1, yes**; skip to O0400, Therapies.

   **Rationale:** Mrs. A received PPSV23 before age 65 years because she has a chronic heart disease and received PCV13 at the facility because she is age 65 years or older. She should receive another dose of PPSV23 at least 1 year after PCV13 and 5 years after the last PPSV23 dose (i.e., Mrs. A should receive 1 dose of PPSV23 at age 79 years, but is currently up to date because she must wait at least 1 year since she received PCV13).

4. Mr. T., who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 64 years old and is being admitted to the nursing home for chemotherapy and respite care. He has not been offered any additional pneumococcal vaccines.

   **Coding:** O0300A would be **coded 0, no**; and O0300B would be **coded 3, Not offered**.

   **Rationale:** Mr. T received 1 dose of PPSV23 vaccine prior to 65 years of age because he is a smoker. Because Mr. T is now immunocompromised, he should receive PCV13 for this indication. He will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after his last dose of PPSV23 (i.e., Mr. T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).
## O0400: Therapies

### A. Speech-Language Pathology and Audiology Services

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident individually in the last 7 days.

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days.

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days.

   If the sum of individual, concurrent, and group minutes is zero, skip to O0400AS, Therapy start date.

4. **Days** - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started.

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended.

   - Enter dashes if therapy is ongoing.

### B. Occupational Therapy

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident individually in the last 7 days.

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days.

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days.

   If the sum of individual, concurrent, and group minutes is zero, skip to O0400OS, Therapy start date.

4. **Days** - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started.

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended.

   - Enter dashes if therapy is ongoing.

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O0400 continued on next page
O0400: Therapies (cont.)

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers, which contribute to diminished quality of life. The qualified 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.

- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.
O0400: Therapies (cont.)

**Planning for Care**

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician’s assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist’s assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person’s direct supervision) and treatment plan, (2) documented in the resident’s medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.

- For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.

**Steps for Assessment**

1. Review the resident’s medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

**Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies**

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. Enter 0 if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.

- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Enter 0 if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.

- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. Enter 0 if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
O0400: Therapies (cont.)

- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Skip the item if none were provided.

- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as **skilled** treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.

- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident’s EOT OMRA, in cases where the resident discontinued and then resumed therapy.

- **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. **Enter dashes if therapy is ongoing.**

**Coding Instructions for Respiratory, Psychological, and Recreational Therapies**

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.

- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

**Coding Tips and Special Populations**

- **Therapy Start Date:**
  1. Look at the date at A1600.
  2. Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.
  3. If so, enter the date that the therapy regimen started; if there was more than one therapy regimen since the A1600 date, enter the start date of the most recent therapy regimen.
O0400: Therapies (cont.)

- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

Minutes of Therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.

- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted.

- The therapist’s time spent on documentation or on initial evaluation is not included.

- The therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.

- Family education when the resident is present is counted and must be documented in the resident’s record.

- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.

- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.

- Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.
O0400: Therapies (cont.)

- Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives more than one mode of therapy per visit.
  - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
  - Code as concurrent minutes when the resident receives only concurrent therapy or concurrent therapy followed by another mode(s); and
  - Code as group minutes when the resident receives only group therapy or group therapy followed by another mode(s).

- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services must meet all of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):
  - for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
  - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
  - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
  - the services must be provided with the expectation, based on the assessment of the resident’s restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
  - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident’s condition; and,
  - the services must be reasonable and necessary for the treatment of the resident’s condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel.

- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.

- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.
O0400: Therapies (cont.)

- Record the actual minutes of therapy. **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute.** The conversion of units to minutes or minutes to units is not appropriate. 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.

- When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.

- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
  - the physician orders the therapy;
  - the physician’s order includes a statement of frequency, duration, and scope of treatment;
  - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - the services must be reasonable and necessary for treatment of the resident’s condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 Therapies, even when performed by a therapist or an assistant.

- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 Minutes, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident’s medical record.
O0400: Therapies (cont.)

- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are not to be reported in item O0400A, B, or C Therapies. The services may be reported on the MDS assessment in item O0500 Restorative Nursing Care, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are not skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

Co-treatment

For Part A:

When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of four participants who were doing the same or similar activities in each discipline. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

For Part B:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients cannot each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.
O0400: Therapies (cont.)

Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

Therapy Students

Medicare Part A—Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (Federal Register, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed.

Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

- Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
  - The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
  - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
  - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician’s service, not for the student’s services.)
  - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.
O0400: Therapies (cont.)

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. (Please also see the section on group therapy for limited exceptions related to group size.) The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look back period for an MDS assessment).

Individual Therapy

The treatment of one resident at a time. The resident is receiving the therapist’s or the assistant’s full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the resident individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals and he/she is able to immediately intervene/assist the student as needed.

Example:

• A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.’s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.’s therapy may be coded as 30 minutes of individual therapy on the MDS.

Concurrent Therapy

Medicare Part A

The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

• NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of concurrent therapy, the minutes will be divided by 2.
O0400: Therapies (cont.)

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

**Medicare Part B**

- The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment.

**Examples:**

- A physical therapist provides therapies that are not the same or similar, to Mrs. Q and Mrs. R at the same time, for 30 minutes. Mrs. Q’s stay is covered under the Medicare SNF PPS Part A benefit. Mrs. R. is paying privately for therapy. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  - Mrs. Q. received concurrent therapy for 30 minutes.
  - Mrs. R received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar to Mrs. S. and Mr. T. at the same time, for 30 minutes. Mrs. S.’s stay is covered under the Medicare SNF PPS Part A benefit. Mr. T.’s therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  - Mrs. S. received concurrent therapy for 30 minutes.
  - Mr. T. received group therapy (Medicare Part B definition) for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
O0400: Therapies (cont.)

- An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R’s stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  - Mr. K. received concurrent therapy for 60 minutes.
  - Mr. R. received concurrent therapy for 60 minutes.

**Group Therapy**

**Medicare Part A**

The treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of group therapy, the minutes will be divided by 4.

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

**Medicare Part B**

The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.
O0400: Therapies (cont.)

**Examples:**

- A Physical Therapist provides similar therapies to Mr. W, Mr. X, Mrs. Y, and Mr. Z at the same time, for 30 minutes. Mr. W. and Mr. X.’s stays are covered under the Medicare SNF PPS Part A benefit. Mrs. Y.’s therapy is covered under Medicare Part B, and Mr. Z has private insurance paying for therapy. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  — Mr. W. received group therapy for 30 minutes.
  — Mr. X. received group therapy for 30 minutes.
  — Mrs. Y. received group therapy for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
  — Mr. Z. received group therapy for 30 minutes.

- Mrs. V, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with Mr. S., whose therapy is covered by Medicare Part B, while Mrs. V. continues with her skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to Mrs. V. and Mr. S. for 24 minutes who are not performing the same or similar activities, at which time Mrs. V.’s therapy session ends. The therapist continues to treat Mr. S. individually for 10 minutes. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  — Mrs. V. received individual therapy for 13 minutes and concurrent therapy for 24.
  — Mr. S. received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)

- Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B are joined by Mr. T. and Mr. E., whose stays are also covered by Medicare Part A, and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Mr. A. becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual’s MDS for this day of treatment as follows:
  — Mr. A. received concurrent therapy for 30 minutes and group therapy for 15 minutes.
  — Mr. B. received concurrent therapy for 30 minutes and group therapy for 30 minutes.
  — Mr. T. received group therapy for 30 minutes.
  — Mr. E. received group therapy for 30 minutes.
O0400: Therapies (cont.)

**Therapy Modalities**

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met, see page O-17) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident’s condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the resident’s plan of care.

**Dates of Therapy**

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident’s episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. Therapy is considered to be ongoing if:

- The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
- The resident’s SNF benefit exhausted and therapy continued to be provided, or
- The resident’s payer source changed and therapy continued to be provided.

For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November 2011. Occupational and Physical therapy started December 3, 2011. His physical therapy ended January 27, 2012 and occupational therapy ended January 29, 2012. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson’s disease, he was referred to SLP and OT February 10, 2012 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.’s MDS assessment is February 28, 2012. Coding values for his MDS are:

- O0400A5 (SLP start date) is 02102012,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112012,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032011, and
- O0400C6 (PT end date) is 01272012.
O0400: Therapies (cont.)

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be dash filled.

For example, Mr. T. was admitted to the nursing home following a fall that resulted in a hip fracture in May 2013. Occupational and Physical therapy started May 10, 2013. His physical therapy ended May 23, 2013 but the occupational therapy continued. Due to observed swallowing issues, he was referred to SLP on May 31, 2013 and the speech-language pathologist evaluated him on that day. Though Mr. T was able to receive both occupational therapy and speech therapy on June 12, he is unable to receive therapy on June 13 or June 14 due to a minor bout with the flu. The facility does not provide therapy on the weekends, which means that June 15, 2013 represents the third day of missed therapy, triggering an EOT OMRA. The therapy staff and nurses discuss Mr. T’s condition and agree that Mr. T should be able to resume the same level of therapy beginning on June 18, 2013, so the facility decides to complete the EOT OMRA as an EOT-R, with an ARD of June 15, 2013.

Coding values for Mr. T’s EOT-R are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is 06122013,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is 06122013,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

Subsequent to the EOT-R, the next PPS assessment completed for Mr. T is the 30-day assessment, with an ARD of June 23, 2013. There were no changes in the therapy services delivered to Mr. T since the EOT-R was completed.

Coding values for Mr. T’s 30-day assessment are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.
O0400: Therapies (cont.)

**General Coding Example:**

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

Speech-language pathology services that were provided over the 7-day look-back period:

- Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

**Coding:**

- O0400A1 would be **coded 190**;
- O0400A2 would be **coded 70**;
- O0400A3 would be **coded 75**;
- O0400A4 would be **coded 5**;
- O0400A5 would be **coded 10062011**;
- and O0400A6 would be **coded with dashes**.

**Rationale:**

Individual minutes totaled 190 over the 7-day look-back period

\[(30 \times 5) + (20 \times 2) = 190\]; concurrent minutes totaled 70 over the 7-day look-back period \((35 \times 2 = 70)\); and group minutes totaled 75 over the 7-day look-back period \((25 \times 3 = 75)\). Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.

**Coding:**

- O0400B1 would be **coded 113**, O0400B2 would be **coded 0**, O0400B3 would be **coded 80**, O0400B3A would be **coded 60**, O0400B4 would be **coded 5**, O0400B5 would be **coded 10092011**, and O0400B6 would be **coded with dashes**.
O0400: Therapies (cont.)

**Rationale:**
Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period \([(30 \times 2) + 23 + 18 + 12 = 113]\); concurrent minutes totaled 0 over the 7-day look-back period \((0 \times 0 = 0)\); and group minutes totaled 80 over the 7-day look-back period \((20 \times 4 = 80)\). Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

**Coding:**
O0400C1 would be **coded 287**, O0400C2 would be **coded 100**, O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 10072011**, and O0400C6 would be **coded with dashes**.

**Rationale:**
Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period \([(30 \times 2) + (35 \times 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]\); concurrent minutes totaled 100 over the 7-day look-back period \((20 \times 5 = 100)\); and group minutes totaled 0 over the 7-day look-back period \((0 \times 0 = 0)\). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

- Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

**Coding:**
O0400D1 would be **coded 50**, O0400D2 would be **coded 0**.

**Rationale:**
Total minutes were 50 over the 7-day look-back period \((10 \times 5 = 50)\). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.
O0400: Therapies (cont.)

Psychological therapy services that were provided over the 7-day look-back period:

- Psychological therapy services were not provided at all over the 7-day look-back period.
  
  **Coding:**
  O0400E1 would be **coded 0**, O0400E2 would be **left blank**.

  **Rationale:**
  There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

Recreational therapy services that were provided over the 7-day look-back period:

- Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.
  
  **Coding:**
  O0400F1 would be **coded 90**, O0400F2 would be **coded 3**.

  **Rationale:**
  Total minutes were 90 over the 7-day look-back period (30 × 3 = 90). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.
**O0400: Therapies (cont.)**

### A. Speech-Language Pathology and Audiology Services

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident individually in the last 7 days.

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days.

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days.

If the sum of individual, concurrent, and group minutes is zero, skip to O0400AS, Therapy start date.

#### 3A. Co-treatment minutes
- record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.

4. **Days** - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started.

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended. Enter dashes if therapy is ongoing.

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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<tbody>
<tr>
<td>10</td>
<td>06</td>
<td>2011</td>
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</table>

### B. Occupational Therapy

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident individually in the last 7 days.

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days.

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days.

If the sum of individual, concurrent, and group minutes is zero, skip to O0400OS, Therapy start date.

#### 3A. Co-treatment minutes
- record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.

4. **Days** - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started.

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended. Enter dashes if therapy is ongoing.

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<tr>
<th>Month</th>
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<th>Year</th>
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<tr>
<td>10</td>
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O0400: Therapies (cont.)

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<tr>
<th>O0400. Therapies - Continued</th>
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<tbody>
<tr>
<td>C. Physical Therapy</td>
</tr>
<tr>
<td>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days.</td>
</tr>
<tr>
<td>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days.</td>
</tr>
<tr>
<td>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days.</td>
</tr>
<tr>
<td>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date.</td>
</tr>
<tr>
<td>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days.</td>
</tr>
<tr>
<td>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.</td>
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<tr>
<td>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started.</td>
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<tr>
<td>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended.</td>
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<tr>
<th>D. Respiratory Therapy</th>
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<tbody>
<tr>
<td>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days. If zero, → skip to O0400E, Psychological Therapy.</td>
</tr>
<tr>
<td>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.</td>
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<tr>
<th>E. Psychological Therapy (by any licensed mental health professional)</th>
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<tbody>
<tr>
<td>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days. If zero, → skip to O0400F, Recreational Therapy.</td>
</tr>
<tr>
<td>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.</td>
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<tr>
<th>F. Recreational Therapy (includes recreational and music therapy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days. If zero, → skip to O0420, Distinct Calendar Days of Therapy.</td>
</tr>
<tr>
<td>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.</td>
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O0420: Distinct Calendar Days of Therapy

<table>
<thead>
<tr>
<th>O0420. Distinct Calendar Days of Therapy</th>
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<tbody>
<tr>
<td>Enter Number of Days: 50</td>
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<tr>
<td>Enter Number of Days: 0</td>
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<tr>
<td>Enter Number of Days: 90</td>
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<tr>
<td>Enter Number of Days: 5</td>
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</table>

**Item Rationale**

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

**Coding Instructions:**

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past
O0420: Distinct Calendar Days of Therapy (cont.)

7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- **Example 1:** Mrs. T. received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mrs. T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the 7-day look-back period. Given the therapy services received by Mrs. T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).

- **Example 2:** Mr. F. received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mr. F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the 7-day look-back period. Finally, Mr. F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Mr. F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0450: Resumption of Therapy

**Item Rationale**

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

**Coding Instructions:**

When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy provided AND whether the therapy services will resume at the same level for each discipline, if **no**, skip to **O0500**, Restorative Nursing Programs. If **yes**, **code item O0450A as 1**. Determine when therapy will resume and code item **O0450B with the date** that therapy will resume. For example:
O0450: Resumption of Therapy (cont.)

- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor’s appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450 A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. Item **O0450B was coded as 11132011** because therapy resumed on November 13, 2011.

NOTE: If the EOT OMRA has not been accepted in the QIES ASAP when therapy resumes, code the EOT-R items (O0450A and O0450B) on the assessment and submit the record. If the EOT OMRA without the EOT-R items have been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy items (O0450A and O0450B) and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

O0500: Restorative Nursing Programs

<table>
<thead>
<tr>
<th>O0500. Restorative Nursing Programs</th>
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</thead>
<tbody>
<tr>
<td>Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
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<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D. Bed mobility</td>
</tr>
<tr>
<td></td>
<td>E. Transfer</td>
</tr>
<tr>
<td></td>
<td>F. Walking</td>
</tr>
<tr>
<td></td>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td></td>
<td>H. Eating and/or swallowing</td>
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<tr>
<td></td>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td></td>
<td>J. Communication</td>
</tr>
</tbody>
</table>

**Item Rationale**

**Health-related Quality of Life**

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers.
O0500: Restorative Nursing Programs (cont.)

**Planning for Care**

- Restorative nursing program refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

- A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

**Steps for Assessment**

1. Review the restorative nursing program notes and/or flow sheets in the medical record.

2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.

3. The following criteria for restorative nursing programs must be met in order to code O0500:
   - Measureable objective and interventions must be documented in the care plan and in the medical record. 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 resident’s medical record.
   - Evidence of periodic evaluation by the licensed nurse must be present in the resident’s medical 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.
   - Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
   - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician’s order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). 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.
O0500: Restorative Nursing Programs (cont.)

- This category does not include groups with more than four residents per supervising helper or caregiver.

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in Speech-Language Pathology and Audiology Services item O0400A, Occupational Therapy item O0400B, and Physical Therapy O0400C.

- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check Technique—Range of Motion [Passive] item O0500A, 15 or more minutes of passive range of motion (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 5 minutes of Technique—Range of Motion [Passive] item O0500A, 5 minutes of Technique—Range of Motion [Active] item O0500B, and 5 minutes of Splint or Brace Assistance item O0500C, over 2 days in the last 7 days.

- Review for each activity throughout the 24-hour period. Enter 0, if none.

Technique

Activities provided by restorative nursing staff.

- **O0500A, Range of Motion (Passive)**

  Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident’s needs, planned, monitored, evaluated and documented in the resident’s medical record.

- **O0500B, Range of Motion (Active)**

  Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record. Include active ROM and active-assisted ROM.

- **O0500C, Splint or Brace Assistance**

  Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.
O0500: Restorative Nursing Programs (cont.)

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

- **O0500D, Bed Mobility**
  Code activities provided to improve or maintain the resident’s self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

- **O0500E, Transfer**
  Code activities provided to improve or maintain the resident’s self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

- **O0500F, Walking**
  Code activities provided to improve or maintain the resident’s self-performance in walking, with or without assistive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

- **O0500G, Dressing and/or Grooming**
  Code activities provided to improve or maintain the resident’s self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

- **O0500H, Eating and/or Swallowing**
  Code activities provided to improve or maintain the resident’s self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident’s ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

- **O0500I, Amputation/Prosthesis Care**
  Code activities provided 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. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.
O0500: Restorative Nursing Programs (cont.)

- **O0500J, Communication**
  
  Code activities provided to improve or maintain the resident’s self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.

**Coding Tips and Special Populations**

- For range of motion (passive): 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.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the resident’s medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident’s skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program 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 were engaged in applying and monitoring the device.
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- 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 be individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.
O0500: Restorative Nursing Programs (cont.)

Examples

1. Mr. V. has lost range of motion in his right arm, wrist, and hand due to a cerebrovascular accident (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 three times per day. The nurse’s aides and Mr. V.’s wife have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in 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 (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse’s aides report that there is less resistance in Mr. V.’s affected extremity when bathing and dressing him.

   **Coding:** Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be **coded 7**.
   **Rationale:** Because this was the number of days these restorative nursing techniques were provided.

2. Mrs. R.’s right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, her physician diagnosed her with right shoulder impingement syndrome. Mrs. R. was given exercises to perform on a daily basis to help improve her right shoulder ROM. After initial training in these exercises by the physical therapist, Mrs. R. and the nursing staff were provided with instructions on how to cue and sometimes actively assist Mrs. R. when she cannot make the full ROM required by the exercises on her own. Her exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in Mrs. R.’s medical record. The nursing staff cued and sometimes actively assisted Mrs. R. two times daily over the past 7 days.

   **Coding:** **Range of motion (active)** item (O0500B), would be **coded 7**.
   **Rationale:** Because this was the number of days restorative nursing training and skill practice for active ROM were provided.
O0500: Restorative Nursing Programs (cont.)

3. 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 bed rails, and a transfer board. The plan was documented in Mrs. K.’s medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse’s notes that in the 5 days Mrs. K. has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, her endurance and strength have improved, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing restorative intervention has been decreasing, so that for the past 5 days, the average time is 45 minutes.

   **Coding:** Both Bed Mobility item (O0500D), Transfer item (O0500E), would be **coded 5.**
   **Rationale:** Because this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.

4. Mrs. D. is receiving training and skill practice in walking using a quad cane. 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 walk with her quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

   **Coding:** Walking item (O0500F), would be **coded 7.**
   **Rationale:** Because this was the number of days that restorative nursing skill and practice training for walking was provided.

5. 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 ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability 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 hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide Mrs. J. as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. It takes approximately 20 minutes per day for Mrs. J. to complete this task (dressing and undressing).

   **Coding:** Dressing or Grooming item (O0500G), would be **coded 7.**
   **Rationale:** Because this was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.
O0500: Restorative Nursing Programs (cont.)

6. 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.

**Coding:** Eating and/or Swallowing item (O0500H), would be **coded 0**.

**Rationale:** Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

7. Mrs. E. has Amyotrophic Lateral Sclerosis. She no longer has the ability to speak or even to nod her head “yes” or “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 been in use over the past 2 weeks and has proven very successful. 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 using the communication board had been completed 2 weeks ago and Mrs. E. is able to use the board to communicate successfully, she no longer receives skill and practice training in communication.

**Coding:** Communication item (O0500J), would be **coded 0**.

**Rationale:** Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

O0600: Physician Examinations

<table>
<thead>
<tr>
<th>O0600. Physician Examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Days:</td>
</tr>
<tr>
<td>Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?</td>
</tr>
</tbody>
</table>

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State’s requirements for completing this item.

**Item Rationale**

**Health-related Quality of Life**

- Health status that requires frequent physician examinations can adversely affect an individual’s sense of well-being and functional status and can limit social activities.

**Planning for Care**

- Frequency of physician examinations can be an indication of medical complexity and stability of the resident’s health status.
O0600: Physician Examinations (cont.)

Steps for Assessment

1. Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.

Coding Instructions

- Record the number of days that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).
- If the State does not require the completion of this item, use the standard “no information” code (a dash, “-”).

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician’s office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident’s acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- 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 examination as long as documentation of the physician’s evaluation is included in the medical 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.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.
- Does not include visits made by Medicine Men.
O0700: Physician Orders

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State’s requirements for completing this item.

Item Rationale

**Health-related Quality of Life**

- Health status that requires frequent physician order changes can adversely affect an individual’s sense of well-being and functional status and can limit social activities.

**Planning for Care**

- Frequency of physician order changes can be an indication of medical complexity and stability of the resident’s health status.

Steps for Assessment

1. Review the physician order sheets in the medical record.
2. Determine the number of days during the 14-day look-back period that a physician or other authorized practitioner allowable by State law changed the resident’s orders.

Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident’s orders.
- If the State does not require the completion of this item, use the standard “no information” code (a dash, “-”).

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law.
- 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 for 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.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
O0700: Physician Orders (cont.)

- Do not count orders prior to the date of admission or re-entry.
- 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.
- When a PRN (as needed) 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.
- A Medicare Certification/Recertification 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), 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 classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.
<table>
<thead>
<tr>
<th>✓</th>
<th>Indicators of Dehydration</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Dehydration CAA triggered, indicating signs or symptoms of dehydration are present (J1550C)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Recent decrease in urine volume or more concentrated urine than usual (I and O) (clinical record)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Recent decrease in eating habits – skipping meals or leaving food uneaten, weight loss (K0300)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Nausea, vomiting (J1550B), diarrhea, or blood loss</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Receiving intravenous drugs (O0100H)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Receiving diuretics or drugs that may cause electrolyte imbalance (medication administration record)(N0410G)</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Functional Status</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>□</td>
<td>• Recent decline in ADL status (Section G0110) (may be related to delirium) (C1310)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Increased risk for falls (J1700) (may be related to delirium) (See Falls CAA)</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Medications (that may contribute to delirium)</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>□</td>
<td>• New medication(s) or dosage increase(s)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Drugs with anticholinergic properties (for example, some antipsychotics (N0410A), antidepressants (N0410C), antiparkinsonian drugs, antihistamines)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Opioids (N0410H)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Benzodiazepines, especially long-acting agents (N0410B)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Analgesics, cardiac and GI medications, anti-inflammatory drugs</td>
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<tr>
<td>□</td>
<td>• Recent abrupt discontinuation, omission, or decrease in dose of a short or long acting benzodiazepines (N0410B)</td>
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<tr>
<td>□</td>
<td>• Drug interactions (pharmacist review may be required)</td>
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<tr>
<td>□</td>
<td>• Resident taking more than one drug from a particular class of drugs</td>
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<tr>
<td>□</td>
<td>• Possible drug toxicity, especially if the person is dehydrated (J1550C) or has renal insufficiency (I1500). Check serum drug levels</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Associated or progressive signs and symptoms</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
<td>□</td>
<td>• Sleep disturbances (for example, up and awake at night/asleep during the day) (D0200C, D0500C)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Agitation and inappropriate movements (for example, unsafe climbing out of bed or chair, pulling out tubes) (E0500)</td>
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</tr>
<tr>
<td>□</td>
<td>• Hypoactivity (for example, low or lack of motor activity, lethargy or sluggish responses) (D0200D, D0500D)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Perceptual disturbances such as hallucinations (E0100A) and delusions (E0100B)</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Other Considerations</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>□</td>
<td>Psychosocial</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Recent change in mood; sad or anxious (for example, crying, social withdrawal) (D0200, D0500)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Recent change in social situation (for example, isolation, recent loss of family member or friend)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Use of restraints (P0100, clinical record)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Physical or environmental factors</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Hearing or vision impairment (B0200, B1000) - may have an impact on ability to process information (directions, reminders, environmental cues)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Lack of frequent reorientation, reassurance, reminders to help make sense of things</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Recent change in environment (for example, a room or unit change, new admission, or return from hospital) (A1700)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Interference with resident’s ability to get enough sleep (for example, light, noise, frequent disruptions)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Noisy or chaotic environment (for example, calling out, loud music, constant commotion, frequent caregiver changes)</td>
<td></td>
</tr>
</tbody>
</table>
2. Cognitive Loss/Dementia

<table>
<thead>
<tr>
<th>✓</th>
<th>Mood and behavior</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Mood State (D0300, D0600) CAA triggered. Analysis of Findings indicates possible impact on cognition – important to consider when drawing conclusions about cognitive loss</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Behavioral Symptoms (E0200) CAA triggered: Analysis of Findings points to cause(s), contributing factors, etc. – important to consider when drawing conclusions about cognitive loss</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Medical problems that can impact cognition</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Constipation (H0600), fecal impaction, diarrhea</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Diabetes (I2900)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Thyroid Disorder (I3400)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Congestive heart failure (I0600)/other cardiac diseases (I0300, I0400)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Respiratory problems (I6200, I6300, I2000, I2200, I8000)/decreased oxygen saturation</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Cancer (I0100)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Liver disease (I1100, I2400, I8000, clinical record)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Renal failure (I1500)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Psychiatric or mood disorder (I5700-I6100)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Electrolyte imbalance (clinical record)</td>
<td></td>
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<tr>
<td>□</td>
<td>Poor nutrition (I5600) or hydration status (J1550C) (clinical record)</td>
<td></td>
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<tr>
<td>□</td>
<td>End of life (Hospice O0100K and clinical record)</td>
<td></td>
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<tr>
<td>□</td>
<td>Alcoholism (I8000)</td>
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<tr>
<td>□</td>
<td>Failure to thrive (I8000)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Pain and its relationship to cognitive loss and behavior</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>Indications that pain is present (J0100, J0300, J0400, J0500, J0600, J0700, J0800, J0850)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>Pain CAA triggered. Determine relationship between pain and cognitive status via observation and assessment.</td>
<td></td>
</tr>
<tr>
<td>Functional limitations related to vision problems (from clinical record, resident and staff interviews, direct observation)</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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</tbody>
</table>
- Peripheral vision or other visual problem that impedes ability to eat, walk, or interact with others (B1000 = 3, 4)  
- Ability to recognize staff limited by vision problem (B1000 = 3, 4)  
- Difficulty negotiating the environment due to vision problem (B1000 = 3, 4)  
- Balance problems (G0300) exacerbated by vision problem (B1000, B1200)  
- Participation in self-care limited by vision problem (B1000)  
- Difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problem (B1000 = 2, 3, 4)  
- Increased risk for falls due to vision problems or due to bifocals or trifocals (B1200 = 1) |

<table>
<thead>
<tr>
<th>Supporting Documentation</th>
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<tbody>
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</table>
- Is resident’s environment adapted to his or her unique needs, such as availability of large print books, high wattage reading lamp, night light, etc.?  
- Are there aspects the facility’s environment that should be altered to enhance vision, such as low-glare floors, low glare tables and surfaces, large print signs marking rooms, etc.? |

<table>
<thead>
<tr>
<th>Medications that can impair vision (consultant pharmacist review of medication regimen can be very helpful)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
- Opioids (N0410H)  
- Antipsychotics (N0410A)  
- Antidepressants (N0410C)  
- Anticholinergics  
- Hypnotics (N0410D)  
- Other |

<table>
<thead>
<tr>
<th>Use of visual appliances (B1200)</th>
<th>Supporting Documentation</th>
</tr>
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<tbody>
<tr>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
- Reading glasses  
- Distance glasses  
- Contact lenses  
- Magnifying glass |
### 4. COMMUNICATION

**Review of Indicators of Communication**

<table>
<thead>
<tr>
<th>Diseases and conditions that may be related to communication problems</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Medications (consultant pharmacist review of medication regimen can be very helpful)</th>
<th>Supporting Documentation</th>
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<tbody>
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<td>✓</td>
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<tr>
<td>Medications that can contribute to functional decline</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>• Psychoactive medications (N0410A-D)</td>
<td>(Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
</tr>
<tr>
<td>• Opioids (N0410H)</td>
<td></td>
</tr>
<tr>
<td>• Other medications – ask consultant pharmacist to review medication regimen to identify these medications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limiting factors resulting in need for assistance with any of the ADLs (observation, interview, clinical record)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental errors such as sequencing problems, incomplete performance, or anxiety limitations</td>
<td></td>
</tr>
<tr>
<td>• Physical limitations such as weakness (G0110A–J.1 = 2,3, 4) (G0110 A-J.2 = 2, 3), limited range of motion (G0400A = 1, 2, G0400B = 1, 2), poor coordination, poor balance (G0300A-E =2), visual impairment (B1000 = 1-4), or pain (J0300 = 1, J0700 =1)</td>
<td></td>
</tr>
<tr>
<td>• Facility conditions such as policies, rules, or physical layout</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problems resident is at risk for because of functional decline (from observation, assessment, clinical record)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Falls (J1700)</td>
<td></td>
</tr>
<tr>
<td>• Weight loss (K0300)</td>
<td></td>
</tr>
<tr>
<td>• Unidentified pain (J0700)</td>
<td></td>
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<tr>
<td>• Social isolation</td>
<td></td>
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<tr>
<td>• Restraint use (P0100)</td>
<td></td>
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<tr>
<td>• Depression(D0100)</td>
<td></td>
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<tr>
<td>• Complications of immobility, such as  — Pressure ulcer/injury (M0210)</td>
<td></td>
</tr>
<tr>
<td>— Muscular atrophy</td>
<td></td>
</tr>
<tr>
<td>— Contractures (G0400 A, B = 1, 2)</td>
<td></td>
</tr>
<tr>
<td>— Incontinence (H0300, H0400)</td>
<td></td>
</tr>
<tr>
<td>— Urinary (I2300) and respiratory infections</td>
<td></td>
</tr>
<tr>
<td>Diseases and conditions</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>□ • Benign prostatic hypertrophy (I1400)</td>
<td>□ • Congestive Heart Failure (CHF), pulmonary edema (I0600)</td>
</tr>
<tr>
<td>□ • Cerebrovascular Accident (CVA) (I4500)</td>
<td>□ • Transient Ischemic Attack (TIA) (I4500)</td>
</tr>
<tr>
<td>□ • Diabetes (I2900)</td>
<td>□ • Depression (I5800)</td>
</tr>
<tr>
<td>□ • Parkinson’s disease (I5300)</td>
<td>□ • Prostate cancer (I0100)</td>
</tr>
<tr>
<td>□ □ Type of incontinence</td>
<td>□ □ Supporting Documentation</td>
</tr>
<tr>
<td>□ • Stress (occurs with coughing, sneezing, laughing, lifting heavy objects, etc.)</td>
<td>□ • Urge (overactive or spastic bladder)</td>
</tr>
<tr>
<td>□ □ □ Mixed (stress incontinence with urgency)</td>
<td>□ • Overflow (due to blocked urethra or weak bladder muscles)</td>
</tr>
<tr>
<td>□ □ □ Transient (temporary/occasional related to a potentially improvable/reversible cause)</td>
<td>□ • Functional (can’t get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating)</td>
</tr>
<tr>
<td>□ □ □ Functional (can’t get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating)</td>
<td>□ □ Medications (from medication administration record and preadmission records if new admission; review by consultant pharmacist)</td>
</tr>
<tr>
<td>□ □ □ • Diuretics(N0410G) – can cause urge incontinence</td>
<td>□ □ □ • Sedative hypnotics (N0410B, N0410D)</td>
</tr>
<tr>
<td>□ □ □ □ • Anticholinergics – can lead to overflow incontinence</td>
<td>□ □ □ □ • Anticholinergics – can lead to overflow incontinence</td>
</tr>
<tr>
<td>□ □ □ □ □ — Parkinson’s medications (except Sinemet and Deprenyl)</td>
<td>□ □ □ □ □ — Parkinson’s medications (except Sinemet and Deprenyl)</td>
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<tr>
<td>□ □ □ □ □ — Disopyramide</td>
<td>□ □ □ □ □ — Disopyramide</td>
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<tr>
<td>□ □ □ □ □ — Antispasmodics</td>
<td>□ □ □ □ □ — Antispasmodics</td>
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<td>□ □ □ □ □ — Antihistamines</td>
<td>□ □ □ □ □ — Antihistamines</td>
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<tr>
<td>□ □ □ □ □ — Antipsychotics (N0410A)</td>
<td>□ □ □ □ □ — Antipsychotics (N0410A)</td>
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<tr>
<td>□ □ □ □ □ — Antidepressants (N0410C)</td>
<td>□ □ □ □ □ — Antidepressants (N0410C)</td>
</tr>
<tr>
<td>□ □ □ □ □ — Opioids (N0410H)</td>
<td>□ □ □ □ □ — Opioids (N0410H)</td>
</tr>
<tr>
<td>□ □ □ □ • Drugs that stimulate or block sympathetic nervous system</td>
<td>□ □ □ • Calcium channel blockers</td>
</tr>
<tr>
<td>□ □ □ □ • Calcium channel blockers</td>
<td>□ □ □ • Calcium channel blockers</td>
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<tr>
<td>Medications (from medication administration record and preadmission records if new admission)</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
<td>✓</td>
<td><strong>Antibiotics (N0410F)</strong></td>
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<tr>
<td></td>
<td>• Anticholinergics</td>
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<tr>
<td></td>
<td>• Antihypertensives</td>
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<td></td>
<td>• Anticonvulsants</td>
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<tr>
<td></td>
<td>• Antipsychotics (N0410A)</td>
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<td></td>
<td>• Cardiac medications</td>
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<td></td>
<td>• Cimetidine</td>
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<td></td>
<td>• Clonidine</td>
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<td>• Chemotherapeutic agents</td>
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<td></td>
<td>• Digitalis</td>
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<td></td>
<td>• Other</td>
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<td>• Glaucma medications</td>
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<td></td>
<td>• Guanethidine</td>
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<td>• Immuno-suppressive medications</td>
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<td></td>
<td>• Methyldopa</td>
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<td></td>
<td>• <strong>Opioids (N0410H)</strong></td>
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<td></td>
<td>• Nitrates</td>
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<td></td>
<td>• Propranolol</td>
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<td>• Reserpine</td>
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<td>• Steroids</td>
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<td>• Stimulants</td>
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<tr>
<td>✓</td>
<td><strong>Laboratory tests</strong></td>
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<td></td>
<td>• Serum calcium</td>
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<td>• Thyroid function</td>
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<td>• Blood glucose</td>
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<td>• Potassium</td>
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<td>• Porphyria</td>
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</table>
## 9. Behavioral Symptoms

### Review of Indicators of Behavioral Symptoms

<table>
<thead>
<tr>
<th>Seriousness of the behavioral symptoms (E0300, E0800, E0900, E1100)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Resident is immediate threat to self – IMMEDIATE INTERVENTION REQUIRED (D0200I.1=1, D0500I.1=1, E0500A=1, E1000A = 1)</td>
</tr>
<tr>
<td>□</td>
<td>• Resident is immediate threat to others – IMMEDIATE INTERVENTION REQUIRED (E0600A)</td>
</tr>
<tr>
<td>□</td>
<td>• Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A=1, 2, or 3)</td>
</tr>
<tr>
<td>□</td>
<td>• Verbal behaviors directed toward others (e.g., threatening, screaming at, or cursing at others) (E0200B=1, 2, or 3)</td>
</tr>
<tr>
<td>□</td>
<td>• Other behavior symptoms not directed toward others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C=1, 2, or 3)</td>
</tr>
<tr>
<td>□</td>
<td>• Behavior significantly interferes with the resident’s care (E0500B=1)</td>
</tr>
<tr>
<td>□</td>
<td>• Behavior significantly interferes with the resident’s participation in activities or social interaction (E0500C=1)</td>
</tr>
<tr>
<td>□</td>
<td>• Behavior significantly intrudes on the privacy or activity of others (E0600B=1, E1000B=1)</td>
</tr>
<tr>
<td>□</td>
<td>• Behavior significantly disrupts care or living environment (E0600C=1)</td>
</tr>
<tr>
<td>□</td>
<td>• Resident rejects care that is necessary to achieve his or her goals for health and well-being (E0800=1, 2, or 3)</td>
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<tr>
<td>□</td>
<td>• Resident’s behavior status, care rejection, or wandering has worsened since last assessment (E1100=2)</td>
</tr>
<tr>
<td>✓</td>
<td>Nature of the behavioral disturbance (resident interview, if possible; staff observations)</td>
</tr>
<tr>
<td>□</td>
<td>• Provoked or unprovoked</td>
</tr>
<tr>
<td>Seriousness of the behavioral symptoms (E0300, E0800, E0900, E1100)</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
<td>✓</td>
<td>• Offensive or defensive</td>
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<td></td>
<td>• Purposeful</td>
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<td>• Occurs during specific activities, such as bath or transfers</td>
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<td>• Pattern, such as certain times of the day, or varies over time</td>
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<td></td>
<td>• Others in the vicinity are involved</td>
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<td></td>
<td>• Reaction to a particular action, such as being physically moved</td>
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<td></td>
<td>• Resident appears to startle easily</td>
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</tbody>
</table>
## Medication side effects that can cause behavioral symptoms (from medication records)

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<thead>
<tr>
<th></th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
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<tbody>
<tr>
<td>✓</td>
<td>• New medication</td>
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<td>• Change in dosage</td>
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<tr>
<td>□</td>
<td>• Antiparkinsonian drugs - may cause hypersexuality, socially inappropriate behavior</td>
</tr>
<tr>
<td>□</td>
<td>• Sedatives, centrally active antihypertensives, some cardiac drugs, anticholinergic agents can cause paranoid delusions, delirium</td>
</tr>
<tr>
<td>□</td>
<td>• Bronchodilators or other respiratory drugs, which can increase agitation and cause difficulty sleeping</td>
</tr>
<tr>
<td>□</td>
<td>• Caffeine</td>
</tr>
<tr>
<td>□</td>
<td>• Nicotine</td>
</tr>
<tr>
<td>□</td>
<td>• Medications that impair impulse control, such as benzodiazepines, sedatives, alcohol (or any product containing alcohol, such as some cough medicine)</td>
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</tbody>
</table>

## Illness or conditions that can cause behavior problems

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<thead>
<tr>
<th></th>
<th>Supporting Documentation</th>
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<tbody>
<tr>
<td>✓</td>
<td>• Long-standing mental health problem associated with the behavioral disturbances, such as schizophrenia, bipolar disorder, depression, anxiety disorder, post-traumatic stress disorder (I5700 – I6100)</td>
</tr>
<tr>
<td>□</td>
<td>• New or acute physical health problem or flare-up of a known chronic condition (I8000)</td>
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<tr>
<td>□</td>
<td>• Delusions (E0100B)</td>
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<tr>
<td>□</td>
<td>• Hallucinations (E0100A)</td>
</tr>
<tr>
<td>□</td>
<td>• Paranoia (from record)</td>
</tr>
<tr>
<td>□</td>
<td>• Constipation (H0600)</td>
</tr>
<tr>
<td>□</td>
<td>• Congestive heart failure (I0600)</td>
</tr>
<tr>
<td>□</td>
<td>• Infection (I1700 – I2500)</td>
</tr>
<tr>
<td>□</td>
<td>• Head injury (I5500, clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Diabetes (I2900)</td>
</tr>
<tr>
<td>□</td>
<td>• Pain (J0300, J0800)</td>
</tr>
<tr>
<td>□</td>
<td>• Fever (J1550A, clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Dehydration (J1550C, clinical record; see Dehydration CAA)</td>
</tr>
<tr>
<td>Factors that can cause or exacerbate the behavior (from observation, interview, record)</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
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</tr>
<tr>
<td>☑</td>
<td>□ * Frustration due to problem communicating discomfort or unmet need</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Frustration, agitation due to need to urinate or have bowel movement</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Fear due to not recognizing caregiver</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Fear due to not recognizing the environment or misinterpreting the environment or actions of others</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Major unresolved sources of interpersonal conflict between the resident and family members, other residents, or staff (see Psychosocial Well-Being CAA)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Recent change, such as new admission (A1700) or a new unit, assignment of new care staff, or withdrawal from a treatment program</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Departure from normal routines</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Sleep disturbance (D0500C = 1)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Noisy, crowded area</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Dimly lit area</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Sensory impairment, such as hearing or vision problem (B0200, B1000)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Restraints (P0100)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Alarm Use (P0200)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Fatigue (D0500D = 1)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Need for repositioning (M1200C)</td>
</tr>
<tr>
<td>☑</td>
<td>Cognitive status problems (also see Cognitive Loss CAT/CAA)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Delirium (C1310), clinical record (Delirium CAT)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Dementia (I4800)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Recent cognitive loss (clinical record, interviews with family, etc.)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Alzheimer’s disease (I4200)</td>
</tr>
<tr>
<td>☐</td>
<td>□ * Effects of cerebrovascular accident (I4500)</td>
</tr>
<tr>
<td>✓</td>
<td>Other Considerations</td>
</tr>
<tr>
<td>---</td>
<td>----------------------</td>
</tr>
<tr>
<td>□</td>
<td>• May be communicating discomfort, personal needs, preferences, fears, feeling ill</td>
</tr>
<tr>
<td>□</td>
<td>• Persons exhibiting long-standing problem behaviors related to psychiatric conditions may place others in danger of physical assault, intimidation, or embarrassment and place themselves at increased risk of being stigmatized, isolated, abused, and neglected by loved ones or care givers</td>
</tr>
<tr>
<td>□</td>
<td>• The actions and responses of family members and caregivers can aggravate or even cause behavioral outbursts</td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

### Analysis of Findings
Review indicators and supporting documentation, and draw conclusions.
Document:
- Description of the problem;
- Causes and contributing factors; and
- Risk factors related to the care area.

### Care Plan Considerations
Care Plan Y/N
Document reason(s) care plan will/will not be developed.

---

Referral(s) to another discipline(s) is warranted (to whom and why):

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

- Yes
- No

Signature/Title: ____________________________ Date: ____________________________
10. ACTIVITIES

Review of Indicators of Activities

<table>
<thead>
<tr>
<th>✓</th>
<th>Activity preferences prior to admission (from interviews and clinical record)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Passive</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Active</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Outside the home</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Inside the home</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Centered almost entirely on family activities</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Centered almost entirely on non-family activities</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Group (F0500E) activities</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Solitary activities</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Involved in community service, volunteer activities</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Athletic</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Non-athletic</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Current activity pursuits (from interviews and clinical record)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Resident identifies leisure activities of interest</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Self-directed or done with others and/or planned by others</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Activities resident pursues when visitors are present</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Scheduled programs in which resident participates</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Activities of interest not currently available or offered to the resident</td>
<td></td>
</tr>
<tr>
<td><strong>Health issues</strong> that result in reduced activity participation</td>
<td><strong>Supporting Documentation</strong> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>□ • Indicators of depression or anxiety (D0200, D0300, D0500, D0600)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Use of psychoactive medications (N0410A-N0410D)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Functional/mobility (G0110) or balance (G0300) problems; physical disability (G0300, G0400)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Cognitive deficits (C0500, C0700-C1000), including stamina, ability to express self (B0700), understand others (B0800), make decisions (C1000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Unstable acute/chronic health problem (clinical record, O0100, J0100, J1100, J0700, J1400, J1550, I8000, M1040, M1200)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Chronic health conditions, such as incontinence (H0300, H0400) or pain (J0300)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Embarrassment or unease due to presence of equipment (O0100D, E, F), such as tubes, oxygen tank (O0100C), or colostomy bag (H0100) (observation, clinical record)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Receives numerous treatments (O0100, O0400) that limit available time/energy (clinical record)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Performs tasks slowly due to reduced energy reserves (observation, clinical record)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>✔ <strong>Environmental or staffing issues</strong> that hinder participation</td>
<td><strong>Supporting Documentation</strong></td>
<td></td>
</tr>
<tr>
<td>□ • Physical barriers that prevent the resident from gaining access to the space where the activity is held (observation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Need for additional staff responsible for social activities (observation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Lack of staff time to involve residents in current activity programs (observation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ • Resident’s fragile nature results in feelings of intimidation by staff responsible for the activity (from observation, interviews, clinical record)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 10. Activities

<table>
<thead>
<tr>
<th></th>
<th><strong>Unique skills or knowledge</strong> the resident has that he or she could pass on to others (from interviews and clinical record)</th>
<th><strong>Supporting Documentation</strong> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>• Games</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complex tasks such as knitting, or computer skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Topic that might interest others</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td><strong>Issues</strong> that result in reduced activity participation</td>
<td><strong>Supporting Documentation</strong></td>
</tr>
<tr>
<td></td>
<td>• Resident is new to facility or has been in facility long enough to become bored with status quo (interview, clinical record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Psychosocial well-being issues, such as shyness, initiative, and social involvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Socially inappropriate behavior (E0200)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Indicators of psychosis (E0100A–E0100B)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feelings of being unwelcome, due to issues such as those already involved in an activity drawing boundaries that are difficult to cross (observation, interview, clinical record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Limited opportunities for resident to get to know others through activities such as shared dining, afternoon refreshments, monthly birthday parties, reminiscence groups (observation, facility activity calendar)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Available activities do not correspond to resident’s values, attitudes, expectations (interview, clinical record) (F0500, F0800)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Long history of unease in joining with others (interview, clinical record)</td>
<td></td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

### Analysis of Findings

<table>
<thead>
<tr>
<th>Description of the problem;</th>
<th>Causes and contributing factors; and</th>
<th>Risk factors related to the care area.</th>
</tr>
</thead>
</table>

### Care Plan Considerations

<table>
<thead>
<tr>
<th>Care Plan Y/N</th>
<th>Document reason(s) care plan will/ will not be developed.</th>
</tr>
</thead>
</table>

Referral(s) to another discipline(s) is warranted (to whom and why): __________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

- [ ] Yes
- [ ] No

Signature/Title: __________________________ Date: __________________________
## 11. FALL(S)

### Review of Indicators of Fall Risk

<table>
<thead>
<tr>
<th>✓</th>
<th>History of falling (J1700, J1800, J1900)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Time of day, exact hour of the fall(s)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Location of the fall(s), such as bedroom, bathroom, hallway, stairs, outside, etc.</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Related to specific medication</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Proximity to most recent meal</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Responding to bowel or bladder urgency</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Doing usual/unusual activity</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Standing still or walking</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Reaching up or reaching down</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Identify the conclusions about the root cause(s), contributing factors related to previous falls</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Physical performance limitations: balance, gait, strength, muscle endurance (G0300A-G0300E)</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Difficulty maintaining sitting balance</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Need to rock body or push off on arms of chair when standing up from chair</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Difficulty maintaining standing position</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Impaired balance during transitions (G0300A-G0300E)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Gait problem, such as unsteady gait, even with mobility aid or personal assistance, slow gait, takes small steps, takes rapid steps, or lurching gait</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• One leg appears shorter than the other</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Musculoskeletal problem, such as kyphosis, weak hip flexors from extended bed rest, or shortening of a leg</td>
<td></td>
</tr>
<tr>
<td>Medications (from medication record)</td>
<td>Internal risk factors (from diagnosis list and clinical indicators)</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>• Antipsychotics (N0410A)</td>
<td>• Circulatory/Heart</td>
<td></td>
</tr>
<tr>
<td>• Antianxiety agents (N0410B)</td>
<td>— Anemia (I0200)</td>
<td></td>
</tr>
<tr>
<td>• Antidepressants (N0410C)</td>
<td>— Cardiac Dysrhythmias (I0300)</td>
<td></td>
</tr>
<tr>
<td>• Hypnotics (N0410D)</td>
<td>— Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400)</td>
<td></td>
</tr>
<tr>
<td>• Cardiovascular medications</td>
<td>— Congestive Heart Failure (CHF) pulmonary edema (I0600)</td>
<td></td>
</tr>
<tr>
<td>• Diuretics (N0410G)</td>
<td>— Cerebrovascular Accident (CVA) (I4500)</td>
<td></td>
</tr>
<tr>
<td>• Opioids (N0410H)</td>
<td>— Transient Ischemic Attack (TIA) (I4500)</td>
<td></td>
</tr>
<tr>
<td>• Neuroleptics</td>
<td>— Postural/Orthostatic hypotension (I0800)</td>
<td></td>
</tr>
<tr>
<td>• Other medications that cause lethargy or confusion</td>
<td>Supporting Documentation</td>
<td></td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Internal risk factors (from diagnosis list and clinical indicators) (continued)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
</table>
| ✔ | • Neuromuscular/functional  
  — Cerebral palsy (I4400)  
  — Loss of arm or leg movement (G0400)  
  — Decline in functional status (G0110)  
  — Incontinence (H0300, H0400)  
  — Hemiplegia/Hemiparesis (I4900)  
  — Parkinson’s disease (I5300)  
  — Seizure disorder (I5400)  
  — Paraplegia (I5000)  
  — Multiple sclerosis (I5200)  
  — Traumatic brain injury (I5500)  
  — Syncope  
  — Chronic or acute condition resulting in instability  
  — Peripheral neuropathy  
  — Muscle weakness |
| | • Orthopedic  
  — Joint pain  
  — Arthritis (I3700)  
  — Osteoporosis (I3800)  
  — Hip fracture (I3900)  
  — Missing limb(s) (G0600D) |
| | • Perceptual  
  — Visual impairment (B1000)  
  — Hearing impairment (B0200)  
  — Dizziness/vertigo |
| | • Psychiatric or cognitive  
  — Impulsivity or poor safety awareness  
  — Delirium (C1310)  
  — Wandering (E0900)  
  — Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.  
  — Cognitive impairment (C0500, C0700- C1000)  
  — Alzheimer’s disease (I4200)  
  — Other dementia (I4800)  
  — Anxiety disorder (I5700)  
  — Depression (I5800)  
  — Manic depression (I5900)  
  — Schizophrenia (I6000) |

(continued)
<table>
<thead>
<tr>
<th><strong>Internal risk factors</strong> (from diagnosis list and clinical indicators) (continued)</th>
<th><strong>Supporting Documentation</strong> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>![ ]</td>
<td>• Infection (I1700 – I2500)</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Low levels of physical activity</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Pain (J0300)</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Headache</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Fatigue, weakness</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Vitamin D deficiency</td>
</tr>
<tr>
<td>![ ]</td>
<td><strong>Laboratory tests</strong></td>
</tr>
<tr>
<td>![ ]</td>
<td>• Hypo- or hyperglycemia</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Electrolyte imbalance</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Dehydration (J1550C)</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Hemoglobin and hematocrit</td>
</tr>
<tr>
<td>![ ]</td>
<td><strong>Environmental factors</strong> (from review of facility environment)</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Poor lighting</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Glare</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Patterned carpet</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Poorly arranged furniture</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Uneven surfaces</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Slippery floors</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Obstructed walkway</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Poor fitting or slippery shoes</td>
</tr>
<tr>
<td>![ ]</td>
<td>• Proximity to aggressive resident</td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  - Description of the problem;  
  - Causes and contributing factors; and  
  - Risk factors related to the care area. | Care Plan Y/N |
|                      | Document reason(s) care plan will/will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): ____________________________
______________________________________________________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes       ☐ No

Signature/Title: ____________________________ Date: ____________________________
## 12. NUTRITIONAL STATUS

### Review of Indicators of Nutritional Status

<table>
<thead>
<tr>
<th>✓</th>
<th><strong>Current eating pattern</strong> – resident leaves significant proportion of meals, snacks, and supplements daily for even a few days</th>
<th><strong>Supporting Documentation</strong> (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
</table>
| □ | • Food offered or available is not consistent with the resident’s food choices/needs  
  — Food preferences not consistently honored  
  — Resident has allergies or food intolerance (for example, needs lactose-free)  
  — Food not congruent with religious or cultural needs  
  — Resident complains about food quality (for example, not like what spouse used to prepare, food lacks flavor)  
  — Resident doesn’t eat processed foods  
  — Food doesn’t meet other special diet requirements | |
<p>| □ | • Pattern re: food left uneaten (for example, usually leaves the meat or vegetables) | |
| □ | • Intervals between meals may be too long or too short | |
| □ | • Unwilling to accept food supplements or to eat more than three meals per day | |</p>
<table>
<thead>
<tr>
<th>✓</th>
<th>Functional problems that affect ability to eat</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>• Swallowing problem (K0100)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Arthritis (I3700)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Contractures (G0400)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Functional limitation in range of motion (G0400)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Partial or total loss of arm movement (G0400A)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Hemiplegia/hemiparesis (I4900)(G0400 A and B = 1)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Quadriplegia/paraplegia (I5100/I5000) (G0400 A and/or B = 2)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Inability to perform ADLs without significant physical assistance (G0110)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Inability to sit up (G0300)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Missing limb(s) (G0600D)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Vision problems (B1000)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Decreased ability to smell or taste food</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Need for special diet or altered consistency which might not appeal to resident</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Recent decline in Activities of Daily Living (ADLs) (G0110-G0600)</td>
<td></td>
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<tr>
<td>✓</td>
<td>Cognitive, mental status, and behavior problems that can interfere with eating</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>☐</td>
<td>• Review Cognitive Loss CAA</td>
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</tr>
<tr>
<td>☐</td>
<td>• Alzheimer’s Disease (I4200)</td>
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<tr>
<td>☐</td>
<td>• Other dementia (I4800)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Intellectual disability/developmental disability (A1550)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Paranoid fear that food is poisoned</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Requires frequent/constant cueing</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Disruptive behaviors (E0200)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Indicators of psychosis (E0100)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Wandering (E0900)</td>
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</tr>
<tr>
<td>☐</td>
<td>• Pacing (E0200)</td>
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<tr>
<td>☐</td>
<td>• Throwing food (E0200C)</td>
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</tr>
<tr>
<td>☐</td>
<td>• Resisting care (E0800)</td>
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<tr>
<td>☐</td>
<td>• Very slow eating</td>
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<tr>
<td>☐</td>
<td>• Short attention span</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Poor memory (C0500, C0700-C0900)</td>
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</tr>
<tr>
<td>☐</td>
<td>• Anxiety problems (I5700)</td>
<td></td>
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</table>
### Communication problems
- Review Communication CAA
- Comatose (B0100)
- Difficulty making self understood (B0700)
- Difficulty understanding others (B0800)
- Aphasia (I4300)

### Dental/oral problems
- See Dental Care CAA
- Broken or fractured teeth (L0200D)
- Toothache (L0200F)
- Bleeding gums (L0200E)
- Loose dentures, dentures causing sores (L0200A)
- Lip or mouth lesions (for example, cold sores, fever blisters, oral abscess) (L0200C)
- Mouth pain (L0200F)
- Dry mouth

### Other diseases and conditions
- Anemia (I0200)
- Arthritis (I3700)
- Burns (M1040F)
- Cancer (I0100)
- Cardiovascular disease (I0300-I0900)
- Cerebrovascular accident (I4500)
- Constipation (H0600)
- Delirium (C1310)
- Depression (I5800)
- Diabetes (I2900)
- Diarrhea
- Gastrointestinal problem (I1100-I1300)
- Hospice care (O0100K)
- Liver disease (I8000)
- Pain (J0300)
- Parkinson’s disease (I5300)
- Pressure ulcers (M0300)

Supporting Documentation

(Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)

(continued)
<table>
<thead>
<tr>
<th>✓</th>
<th>Other diseases and conditions that can affect appetite or nutritional needs (continued)</th>
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<tbody>
<tr>
<td>□</td>
<td>• Radiation therapy (O0100B)</td>
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<td>□</td>
<td>• Recent acute illness (I8000)</td>
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<tr>
<td>□</td>
<td>• Recent surgical procedure (I8000, M1200F)</td>
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</tr>
<tr>
<td>□</td>
<td>• Renal disease (I1500)</td>
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</tr>
<tr>
<td>□</td>
<td>• Respiratory disease (I6200)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Thyroid problem (I3400)</td>
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</tr>
<tr>
<td>□</td>
<td>• Weight loss (K0300)</td>
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<td>□</td>
<td>• Weight gain (K0310)</td>
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<tr>
<td>□</td>
<td>• Electrolytes</td>
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<td>□</td>
<td>• Pre-albumin level</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Plasma transferrin level</td>
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<tr>
<td>□</td>
<td>• Others</td>
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<tr>
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<tr>
<td>□</td>
<td>• Antipsychotics (N0410A)</td>
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<tr>
<td>□</td>
<td>• Chemotherapy (O0100A)</td>
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</tr>
<tr>
<td>□</td>
<td>• Cardiac drugs</td>
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<tr>
<td>□</td>
<td>• Diuretics (N0410G)</td>
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</tr>
<tr>
<td>□</td>
<td>• Anti-inflammatory drug</td>
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<tr>
<td>□</td>
<td>• Anti-Parkinson’s drugs</td>
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</tr>
<tr>
<td>□</td>
<td>• Laxatives</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Antacids</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Start of a new drug</td>
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<table>
<thead>
<tr>
<th>✓</th>
<th>Environmental factors (from direct observation and clinical record)</th>
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<tbody>
<tr>
<td>□</td>
<td>• Sufficient eating assistance</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Availability of adaptive equipment</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Dining environment fosters pleasant social experience</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Appropriate lighting</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Sufficient personal space during meals</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Proper positioning in wheelchair/chair for dining</td>
<td></td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
- Description of the problem;  
- Causes and contributing factors; and  
- Risk factors related to the care area. | Care Plan Y/N  
Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): ______________________  
______________________________________________________________________________  

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

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<tr>
<th>Yes</th>
<th>No</th>
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Signature/Title: ___________________________ Date: ___________________________
### 13. FEEDING TUBE(S)

#### Review of Indicators of Feeding Tubes

<table>
<thead>
<tr>
<th>✓</th>
<th>Reason for tube feeding</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>• Unable to swallow or to eat food and unlikely to eat within a few days due to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Physical problems in chewing or swallowing (for example, stroke or Parkinson’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>disease) (L0200F, K0100D)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Mental problems (I5700 – I6100) (for example, Alzheimer’s (I4200), Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dementia (I4800), depression (I5800))</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Normal caloric intake is substantially impaired due to endotracheal tube or a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>tracheostomy (O0100E)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Prevention of meal-induced hypoxemia (insufficient oxygen to blood), in resident</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with COPD (I6200) or other pulmonary problems that interfere with eating (I6200)</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Complications of tube feeding</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>☐</td>
<td>• Diagnostic conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Delirium (C1310)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Repetitive physical movements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Anxiety (I5700, clinical record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Depression (I5800)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Lung aspiration, pneumonia (I2000, clinical record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Infection at insertion site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Shortness of breath (J1100)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Bleeding around insertion site</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Constipation (H0600)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Abdominal distension or abdominal pain</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Diarrhea or cramping</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Nausea, vomiting (J1550B)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Tube dislodgement, blockage, leakage</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Bowel perforation</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Dehydration (J1550C) or fluid overload</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Self-extubation</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>• Use of physical restraints (P0100)</td>
<td></td>
</tr>
</tbody>
</table>
### Psychosocial issues related to tube feeding

- **Supporting Documentation**
  - (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□  • Signs of depression ((D0300, D0600, I5800); see Mood State CAA)</td>
<td></td>
</tr>
<tr>
<td>□  • Ways to socially engage the resident with a feeding tube</td>
<td></td>
</tr>
<tr>
<td>□  • Emotional and social support from social workers, other members of the healthcare team</td>
<td></td>
</tr>
</tbody>
</table>

### Periodic evaluations and consultations

- **Supporting Documentation**
  - (K0300, K0310)

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□  • Weight check at least monthly</td>
<td></td>
</tr>
<tr>
<td>□  • Lab tests to monitor electrolytes, serum albumin, hematocrit</td>
<td></td>
</tr>
<tr>
<td>□  • Periodic evaluations by nutritionist or dietitian</td>
<td></td>
</tr>
<tr>
<td>□  • Periodic evaluation of possibility of resuming oral feeding</td>
<td></td>
</tr>
<tr>
<td>□  • Regular changing and replacement of PEG tubes and J-tubes, per physician order and facility protocol (K0510B1, K0510B2)</td>
<td></td>
</tr>
</tbody>
</table>

### Factors that may impede removal of feeding tube

- **Supporting Documentation**
  - (K0300, K0310)

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>□  • Comatose (B0100)</td>
<td></td>
</tr>
<tr>
<td>□  • Failure to eat and resists assistance in eating (E0800)</td>
<td></td>
</tr>
<tr>
<td>□  • Cerebrovascular accident (I4500)</td>
<td></td>
</tr>
<tr>
<td>□  • Gastric ulcers, gastric bleeding, or other stomach disorder (I1200, I1300)</td>
<td></td>
</tr>
<tr>
<td>□  • Chewing problems unresolvable (L0200F)</td>
<td></td>
</tr>
<tr>
<td>□  • Swallowing problems unresolvable (K0100)</td>
<td></td>
</tr>
<tr>
<td>□  • Mouth pain (L0200F)</td>
<td></td>
</tr>
<tr>
<td>□  • Anorexia (I8000)</td>
<td></td>
</tr>
<tr>
<td>□  • Lab values indicating compromised nutritional status</td>
<td></td>
</tr>
<tr>
<td>□  • Significant weight loss (K0300)</td>
<td></td>
</tr>
<tr>
<td>□  • Significant weight gain (K0310)</td>
<td></td>
</tr>
<tr>
<td>□  • Prolonged illness</td>
<td></td>
</tr>
<tr>
<td>□  • Neurological disorder (I4200 – I5500)</td>
<td></td>
</tr>
<tr>
<td>□  • Cancer or side effects of cancer treatment (I0100, clinical record)</td>
<td></td>
</tr>
<tr>
<td>□  • Advanced dementia (I4800)</td>
<td></td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  - Description of the problem;  
  - Causes and contributing factors; and  
  - Risk factors related to the care area. | Care Plan Y/N  
  Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): ______________________  
______________________________________________________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):  
□ Yes    □ No

Signature/Title:___________________________________ Date:______________________
## 14. DEHYDRATION/FLUID MAINTENANCE

### Review of Indicators of Dehydration/Fluid Maintenance

<table>
<thead>
<tr>
<th>✓</th>
<th>Symptoms of dehydration</th>
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<tbody>
<tr>
<td>✗</td>
<td>Dizziness on sitting or standing</td>
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<tr>
<td>✗</td>
<td>Confusion or change in mental status (delirium) (C1310, V0100D)</td>
</tr>
<tr>
<td>✗</td>
<td>Lethargy (C1310D)</td>
</tr>
<tr>
<td>✗</td>
<td>Recent decrease in urine volume or more concentrated urine than usual</td>
</tr>
<tr>
<td>✗</td>
<td>Decreased skin turgor, dry mucous membranes (J1550)</td>
</tr>
<tr>
<td>✗</td>
<td>Newly present constipation (H0600), fecal impaction</td>
</tr>
<tr>
<td>✗</td>
<td>Fever (J1550A)</td>
</tr>
<tr>
<td>✗</td>
<td>Functional decline (G0110)</td>
</tr>
<tr>
<td>✗</td>
<td>Increased risk for falls (J1700)</td>
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<tr>
<td>✗</td>
<td>Fluid and electrolyte disturbance</td>
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<table>
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<tr>
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<td>Hematocrit</td>
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<td>Potassium chloride</td>
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<td>✗</td>
<td>Sodium</td>
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<tr>
<td>✗</td>
<td>Albumin</td>
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<td>Blood urea nitrogen</td>
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<td>Urine specific gravity</td>
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<td>(from clinical record)</td>
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<td>Hemoglobin</td>
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<td>Potassium chloride</td>
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<tr>
<td>Sodium</td>
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<tr>
<td>Albumin</td>
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<td>Blood urea nitrogen</td>
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<tr>
<td>Urine specific gravity</td>
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### Cognitive, communication, and mental status issues that can interfere with intake

<table>
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<th>Supporting Documentation</th>
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<td>(Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
<td>□</td>
<td>• Depression (I5800, D0300, D0600) or anxiety (I5700)</td>
</tr>
<tr>
<td>□</td>
<td>• Behavioral disturbance that interferes with intake (E0200, clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Recent change in mental status (C1310)</td>
</tr>
<tr>
<td>□</td>
<td>• Alzheimer’s or other dementia that interferes with eating due to short attention span, resisting assistance, slow eating/drinking, etc. (I4200, I4800)</td>
</tr>
<tr>
<td>□</td>
<td>• Difficulty making self understood (B0700)</td>
</tr>
<tr>
<td>□</td>
<td>• Difficulty understanding others (B0800)</td>
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### Diseases and conditions that predispose to limitations in maintaining normal fluid balance

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<tr>
<td>□</td>
<td>• Infection (I1700 – I2500)</td>
</tr>
<tr>
<td>□</td>
<td>• Fever (J1550A)</td>
</tr>
<tr>
<td>□</td>
<td>• Diabetes (I2900)</td>
</tr>
<tr>
<td>□</td>
<td>• Congestive heart failure (I0600)</td>
</tr>
<tr>
<td>□</td>
<td>• Swallow problem (K0100)</td>
</tr>
<tr>
<td>□</td>
<td>• Malnutrition (I5600)</td>
</tr>
<tr>
<td>□</td>
<td>• Renal disease (I1500)</td>
</tr>
<tr>
<td>□</td>
<td>• Weight loss (K0300)</td>
</tr>
<tr>
<td>□</td>
<td>• Weight gain (K0310)</td>
</tr>
<tr>
<td>□</td>
<td>• New cerebrovascular accident (clinical record, I4500)</td>
</tr>
<tr>
<td>□</td>
<td>• Unstable acute or chronic condition (clinical record, I8000)</td>
</tr>
<tr>
<td>□</td>
<td>• Nausea or vomiting (J1550B)</td>
</tr>
<tr>
<td>□</td>
<td>• Diarrhea (clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Excessive sweating (clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Recent surgery (clinical record, I8000)</td>
</tr>
<tr>
<td>□</td>
<td>• Recent decline in activities of daily living (G0110), including body control or hand control problems, inability to sit up (G0300), etc. (observation, interview, clinical record)</td>
</tr>
<tr>
<td>□</td>
<td>• Parkinson’s or other neurological disease that requires unusually long time to eat (I4200 – I5500)</td>
</tr>
<tr>
<td>□</td>
<td>• Abdominal pain, with or without diarrhea, nausea, or vomiting (clinical record, J1550B)</td>
</tr>
</tbody>
</table>

(continued)
**Diseases and conditions** that predispose to limitations in maintaining normal fluid balance (continued)

<table>
<thead>
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<th></th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>• Newly taking a diuretic or recent increase in diuretic dose (N0410G) (medication records)</td>
</tr>
<tr>
<td></td>
<td>• Takes excessive doses of a laxative (interview, clinical record)</td>
</tr>
<tr>
<td></td>
<td>• Hot weather (increases risk for elderly in absence of increased fluid intake)</td>
</tr>
</tbody>
</table>

**Oral intake** (from observation and clinical record)

<table>
<thead>
<tr>
<th></th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>• Recent change in oral intake</td>
</tr>
<tr>
<td></td>
<td>• Skips meals or consumes less than 25 percent of meals</td>
</tr>
<tr>
<td></td>
<td>• Fluid restriction</td>
</tr>
<tr>
<td></td>
<td>• Newly prescribed diet</td>
</tr>
<tr>
<td></td>
<td>• Decreased perception of thirst</td>
</tr>
<tr>
<td></td>
<td>• Limited fluid-drinking opportunities</td>
</tr>
<tr>
<td></td>
<td>• Fluid intake limited to try to control incontinence</td>
</tr>
<tr>
<td></td>
<td>• Dependence on staff for fluid intake</td>
</tr>
<tr>
<td></td>
<td>• Excessive output compared to fluid intake</td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Queotes/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  - Description of the problem;  
  - Causes and contributing factors; and  
  - Risk factors related to the care area. | Care Plan Y/N  
  Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why):

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

- [ ] Yes  
- [ ] No

Signature/Title: ____________________________ Date: ____________________________
## 15. DENTAL CARE

### Review of Indicators of Oral/Dental Condition/Problem

<table>
<thead>
<tr>
<th>Cognitive problems that contribute to oral/dental problems</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Needs reminders to clean teeth</td>
<td></td>
</tr>
<tr>
<td>☐ Cannot remember steps to complete oral hygiene</td>
<td></td>
</tr>
<tr>
<td>☐ Decreased ability to understand others (B0800) or to perform tasks following demonstration</td>
<td></td>
</tr>
<tr>
<td>☐ Cognitive deficit (C0500, C0700 – C1000)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional impairment limiting ability to perform personal hygiene</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Loss of voluntary arm movement (G0400A)</td>
<td></td>
</tr>
<tr>
<td>☐ Impaired hand dexterity (G0400A)</td>
<td></td>
</tr>
<tr>
<td>☐ Functional limitation in upper extremity range of motion (G0400A)</td>
<td></td>
</tr>
<tr>
<td>☐ Decreased mobility (G0110)</td>
<td></td>
</tr>
<tr>
<td>☐ Resists assistance with activities of daily living (E0800)</td>
<td></td>
</tr>
<tr>
<td>☐ Lacks motivation or knowledge regarding adequate oral hygiene, dental care</td>
<td></td>
</tr>
<tr>
<td>☐ Requires adaptive equipment for oral hygiene</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dry mouth causing buildup of oral bacteria</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Dehydration (see Dehydration/Fluid Maintenance CAA)</td>
<td></td>
</tr>
<tr>
<td>☐ Medications (from MDS and medication administration record)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>--- Antipsychotics (N0410A)</td>
</tr>
<tr>
<td></td>
<td>--- Antidepressants (N0410C)</td>
</tr>
<tr>
<td></td>
<td>--- Antianxiety agents (N0410B)</td>
</tr>
<tr>
<td></td>
<td>--- Sedatives/hypnotics (N0410D)</td>
</tr>
<tr>
<td></td>
<td>--- Diuretics (N0410G)</td>
</tr>
<tr>
<td></td>
<td>--- Antihypertensives</td>
</tr>
<tr>
<td></td>
<td>--- Antiparkinsons medications</td>
</tr>
<tr>
<td></td>
<td>--- Opioids (N0410H)</td>
</tr>
<tr>
<td></td>
<td>--- Anticonvulsants</td>
</tr>
<tr>
<td></td>
<td>--- Antihistamines</td>
</tr>
<tr>
<td></td>
<td>--- Decongestants</td>
</tr>
<tr>
<td></td>
<td>--- Antiemetics</td>
</tr>
<tr>
<td>☐ Antineoplastics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diseases and conditions that may be related to poor oral hygiene, oral infection</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>✓</td>
<td>• Recurrent pneumonia related to aspiration of saliva contaminated due to poor oral hygiene (I2000)</td>
</tr>
<tr>
<td></td>
<td>• Unstable diabetes related to oral infection (I2900)</td>
</tr>
<tr>
<td></td>
<td>• Endocarditis related to oral infection (I8000)</td>
</tr>
<tr>
<td></td>
<td>• Sores in mouth related to poor-fitting dentures (L0200C)</td>
</tr>
<tr>
<td></td>
<td>• Poor nutrition (I5600) (See Nutrition CAA)</td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review indicators and supporting documentation, and draw conclusions. Document:</td>
<td>Document reason(s) care plan will/ will</td>
</tr>
<tr>
<td>• Description of the problem;</td>
<td>not be developed.</td>
</tr>
<tr>
<td>• Causes and contributing factors; and</td>
<td></td>
</tr>
<tr>
<td>• Risk factors related to the care area.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Referral(s) to another discipline(s) is warranted (to whom and why): ______________________
______________________________________________________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes  ☐ No

Signature/Title: ____________________________ Date: ____________________________
## 16. PRESSURE ULCER/INJURY

### Review of Indicators of Pressure Ulcer/Injury

<table>
<thead>
<tr>
<th>![ ]</th>
<th>Existing pressure ulcer/injury (M0210)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
</table>
| ![ ] | • Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin  
  — Note if eschar or slough is present (M0300F)  
  — Assess for signs of infection, such as the presence of a foul odor, increasing pain, surrounding skin is reddened (erythema) or warm, or there is a presence of purulent drainage  
  — Note whether granulation tissue (required for healing) is present and the wound is healing as expected | |
| ![ ] | • If the ulcer/injury does not show signs of healing despite treatment, consider complicating factors  
  — Elevated bacterial level in the absence of clinical infection  
  — Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed  
  — Underlying osteomyelitis (bone infection) | |
| ![ ] | Extrinsic risk factors | Supporting Documentation |
| ![ ] | • Pressure  
  — Requires staff assistance to move sufficiently to relieve pressure over any one site  
  — Confined to a bed or chair all or most of the time  
  — Needs special mattress or seat cushion to reduce or relieve pressure (M1200A, M1200B)  
  — Requires regular schedule of turning (M1200C) | |
| ![ ] | • Friction and shear  
  — Slides down in the bed  
  — Moved by sliding rather than lifting | |
| ![ ] | • Maceration  
  — Persistently wet, especially from fecal incontinence, wound drainage, or perspiration  
  — Moisture associated skin damage (M1040H) | |

(continued)
<table>
<thead>
<tr>
<th>✓</th>
<th>Intrinsic risk factors</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Immobility (G0110)</td>
<td></td>
</tr>
</tbody>
</table>
| □ | • Altered mental status  
   — Delirium limits mobility (see Delirium CAA)  
   — Cognitive loss (C0500, C0700-C1000) limits mobility (see Cognitive Loss CAA) | |
| □ | • Incontinence (H0300, H0400, M1040H) (see Incontinence CAA) | |
| □ | • Poor nutrition *(I5600)* (see Nutrition CAA) | |
| ✓ | Medications that increase risk for pressure ulcer/injury development | Supporting Documentation |
| □ | • Antipsychotics (N0410A) | |
| □ | • Antianxiety agents (N0410B) | |
| □ | • Antidepressants (N0410C) | |
| □ | • Hypnotics (N0410D) | |
| □ | • Steroids | |
| □ | • Opioids *(N0410H)* | |
| ✓ | Diagnoses and conditions that present complications or increase risk for pressure ulcer/injury | Supporting Documentation |
| □ | • Delirium (C1310) | |
| □ | • Comatose (B0100) | |
| □ | • Cancer (I0100) | |
| □ | • Peripheral Vascular Disease (I0900) | |
| □ | • Diabetes (I2900) | |
| □ | • Alzheimer’s disease (I4200) | |
| □ | • Cerebrovascular Accident (I4500) | |
| □ | • Other dementia (I4800) | |
| □ | • Hemiplegia/hemiparesis (I4900) | |
| □ | • Paraplegia (I5000), Quadriplegia (I5100) | |
| □ | • Multiple sclerosis (I5200) | |
| □ | • Depression (D0300, D0600, I5800) | |
| □ | • Edema | |
| □ | • Severe pulmonary disease (I6200) | |
| □ | • Sepsis (I2100) | |
| □ | • Terminal illness *(J1400, O0100K)* | |
# CMS’s RAI Version 3.0 Manual

## Appendix C: CAA Resources

### 16. Pressure Ulcer/Injury

<table>
<thead>
<tr>
<th>Diagnoses and conditions that present complications or increase risk for pressure ulcer/injury (continued)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>• Chronic or end-stage renal (I1500), liver, or heart disease (I0400, I0600)</td>
</tr>
<tr>
<td>☐</td>
<td>• Pain (J0300, J0800)</td>
</tr>
<tr>
<td>☐</td>
<td>• Dehydration (J1530C, I8000)</td>
</tr>
<tr>
<td>☐</td>
<td>• Shortness of breath (J1100)</td>
</tr>
<tr>
<td>☐</td>
<td>• Recent weight loss (K0300)</td>
</tr>
<tr>
<td>☐</td>
<td>• Recent weight gain (K0310)</td>
</tr>
<tr>
<td>☐</td>
<td>• Malnutrition (I5600)</td>
</tr>
<tr>
<td>☐</td>
<td>• Decreased sensory perception</td>
</tr>
<tr>
<td>☐</td>
<td>• Recent decline in Activities of Daily Living (ADLs) (G0110-G0600)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatments and other factors that cause complications or increase risk</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>• Newly admitted or readmitted (A1700)</td>
</tr>
<tr>
<td>☐</td>
<td>• History of healed pressure ulcer/injury</td>
</tr>
<tr>
<td>☐</td>
<td>• Chemotherapy (O0100A)</td>
</tr>
<tr>
<td>☐</td>
<td>• Radiation therapy (O0100B)</td>
</tr>
<tr>
<td>☐</td>
<td>• Ventilator or respirator (O0100F)</td>
</tr>
<tr>
<td>☐</td>
<td>• Renal dialysis (O0100J)</td>
</tr>
<tr>
<td>☐</td>
<td>• Functional limitation in range of motion (G0400)</td>
</tr>
<tr>
<td>☐</td>
<td>• Head of bed elevated most or all of the time</td>
</tr>
<tr>
<td>☐</td>
<td>• Physical restraints (P0100)</td>
</tr>
<tr>
<td>☐</td>
<td>• Devices that can cause pressure, such as oxygen (O0100C) or indwelling catheter (H0100A) tubing, TED hose, casts, or splints</td>
</tr>
</tbody>
</table>
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
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</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
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Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): ______________________  
________________________________________________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):  
☐ Yes  ☐ No

Signature/Title: ___________________________ Date: ___________________________
## 17. PSYCHOTROPIC MEDICATION USE

### Review of Indicators of Psychotropic Drug Use

<table>
<thead>
<tr>
<th>✓</th>
<th>Class(es) of medication this resident is taking</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Antipsychotic (N0410A, N0450A)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Antianxiety (N0410B)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Antidepressant (N0410C)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Sedative/Hypnotic (N0410D)</td>
<td>□</td>
</tr>
<tr>
<td>✓</td>
<td>Unnecessary drug evaluation (from clinical record)</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>□</td>
<td>• Excessive dose, including duplicate medications</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Excessive duration and/or without gradual dose reductions (N0450B, N0450C)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Inadequate monitoring for effectiveness and/or adverse consequences</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Inadequate or inappropriate indications for use</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• In presence of adverse consequences of the drug</td>
<td>□</td>
</tr>
<tr>
<td>✓</td>
<td>Treatable/reversible reasons for use of psychotropic drug</td>
<td>Supporting Documentation</td>
</tr>
<tr>
<td>□</td>
<td>• Environmental stressors such as excessive heat, noise, overcrowding, etc. (observation, clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Psychosocial stressors such as abuse, taunting, not following resident’s customary routine, etc. (observation, clinical record) (F0300 – F0800)</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>• Treatable medical conditions, such as heart disease (I0200 – I0900), diabetes (I2900), or respiratory disease (from medical evaluation) (I6200, I6300)</td>
<td>□</td>
</tr>
</tbody>
</table>
### Adverse consequences of Antidepressants exhibited by this resident

<table>
<thead>
<tr>
<th>Condition</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worsening of depression and/or suicidal behavior or thinking (D0350, D0650, V0100E, V0100F, clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Delirium unrelated to medical illness or severe depression (C1310, clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Hallucinations (E0100A)</td>
<td>□</td>
</tr>
<tr>
<td>Dizziness (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Nausea (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Diarrhea (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Anxiety (I5700, clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Nervousness, fidgety or restless (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Insomnia (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Somnolence (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Weight gain (K0310, clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Anorexia or increased appetite (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Increased risk for falls (clinical record), falls (J1700-J1900)</td>
<td>□</td>
</tr>
<tr>
<td>Seizures (I5400)</td>
<td>□</td>
</tr>
<tr>
<td>Hypertensive crisis if combined with certain foods, cheese, wine (MAO inhibitors)</td>
<td>□</td>
</tr>
<tr>
<td>Anticholinergic (tricyclics), such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Postural hypotension (tricyclics) (I0800, clinical record)</td>
<td>□</td>
</tr>
</tbody>
</table>

### Adverse consequences of Antipsychotics exhibited by this resident

<table>
<thead>
<tr>
<th>Condition</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergic effects, such as constipation, dry mouth, blurred vision, urinary retention, etc. (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Increase in total cholesterol and triglycerides (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Akathisia (inability to sit still) (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>Parkinsonism (any combination of tremors, postural unsteadiness, muscle rigidity, pill-rolling of hands, shuffling gait, etc.) (clinical record)</td>
<td>□</td>
</tr>
<tr>
<td>✓</td>
<td>Adverse consequences of ANTIHYPERTENSIVE exhibited by this resident</td>
</tr>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Adverse consequences of ANXIOLYTICS exhibited by this resident</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>• Sedation manifested by short-term memory loss (C0500, C0700), decline in cognitive abilities, slurred speech (B0600), drowsiness, little/no activity involvement (clinical record)</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>• Delirium unrelated to medical illness or severe depression (C1310, clinical record)</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>• Hallucinations (E0100A)</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>• Depression (D0300, D0600, I5800)</td>
</tr>
<tr>
<td></td>
<td>□</td>
<td>• Disturbances of balance, gait, positioning ability (G0300, G0110C, G0110D, G0110A, clinical record)</td>
</tr>
</tbody>
</table>
## Adverse consequences of SEDATIVES/HYPNOTICS exhibited by this resident

- May increase the metabolism of many medications (for example, anticonvulsants, antipsychotics), which may lead to decreased effectiveness and subsequent worsening of symptoms or decreased control of underlying illness (clinical record)
- Hypotension (I0800, clinical record)
- Dizziness, lightheadedness (clinical record)
- “Hangover” effect (interview, clinical record)
- Drowsiness (observation, clinical record)
- Confusion, delirium unrelated to acute illness or severe depression (C1310, clinical record)
- Mental depression (I5800, I5900)
- Unusual excitement (clinical record)
- Nervousness (clinical record)
- Headache (interview, clinical record)
- Insomnia (clinical record)
- Nightmares (interview, clinical record)
- Hallucinations (E0100A)
- Falls (J1700-J1900)

### Drug-related discomfort requiring treatment and/or prevention

- Dehydration (J1550C, I8000)
- Reduced dietary bulk (from observation of food intake)
- Lack of exercise (observation, clinical record)
- Constipation/fecal impaction (H0600, clinical record)
- Urinary retention (clinical record)
- Dry mouth (interview, clinical record)

### Overall status change for relationship to psychotropic drug use (from clinical record)

- Major differences in a.m./p.m. performance
- Decline in cognition/communication (V0100D)
- Decline in mood (V0100E, V0100F)
- Decline in behavior (E1100)
- Decline in Activities of Daily Living (ADLs) (G0110)
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
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</thead>
</table>
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• Risk factors related to the care area. | Care Plan Y/N  
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_____________________________________________________________________________________

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☐ Yes ☐ No

Signature/Title:___________________________________ Date:_________________________
### 18. PHYSICAL RESTRAINTS

#### Review of Indicators of Physical Restraints

<table>
<thead>
<tr>
<th>✓</th>
<th>Evaluation of current restraint use (based on chart documentation, including care plan)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAA)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Evidence of informed consent not evident on chart</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Medical symptom not identified for treatment via restraints</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Used for staff convenience</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Used for discipline purposes</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Multiple restraints in use</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Non-restraint interventions not attempted prior to restraining</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Less restrictive devices not attempted</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• No regular schedule for removing restraints</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• No schedule for frequency by hour of the day for checking on resident’s well-being</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• No plan for reducing/eliminating restraints</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th>Medical conditions/treatments that may lead to restraint use</th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Indwelling catheter (H0100A), external catheter (H0100B), or ostomy (H0100C)</td>
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<tr>
<td>□</td>
<td>• Parenteral/IV feeding (K0510A1, K0510A2)</td>
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<tr>
<td>□</td>
<td>• Feeding tube (K0510B1, K0510B2)</td>
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<tr>
<td>□</td>
<td>• Pressure ulcer/injury (M0210) or pressure ulcer/injury care (M1200E)</td>
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</tr>
<tr>
<td>□</td>
<td>• Other skin ulcers, wounds, skin problems (M1040) or wound care (M1200F-M1200I)</td>
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<td>□</td>
<td>• Oxygen therapy (O0100C)</td>
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<td>□</td>
<td>• Tracheostomy (O0100E, clinical record)</td>
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<td>□</td>
<td>• Ventilator or respirator (O0100F)</td>
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<td>□</td>
<td>• IV medications (O0100H)</td>
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<td>□</td>
<td>• Transfusions (O0100I)</td>
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<tr>
<td>□</td>
<td>• Functional decline, decreased mobility (clinical record)</td>
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<tr>
<td>□</td>
<td>• Alarm use (P0200)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Other medical problem or equipment associated with restraint use (clinical record)</td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Cognitive impairment/behavioral symptoms that may lead to restraint use (also see Cognitive Loss and Behavior CAAs)</td>
<td>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</td>
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<tr>
<td>☐</td>
<td>• Inattention, easily distracted (C1310B)</td>
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<tr>
<td>☐</td>
<td>• Disorganized thinking (C1310C)</td>
<td></td>
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<tr>
<td>☐</td>
<td>• Fidgety, restless</td>
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<tr>
<td>☐</td>
<td>• Agitation behavior (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.</td>
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<tr>
<td>☐</td>
<td>• Confusion (C0100, C0600)</td>
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<tr>
<td>☐</td>
<td>• Psychosis (E0100A, E0100B)</td>
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<tr>
<td>☐</td>
<td>• Physical symptoms directed toward others (E0200A)</td>
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<tr>
<td>☐</td>
<td>• Verbal behavioral symptoms directed toward others (E0200B)</td>
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<tr>
<td>☐</td>
<td>• Rejection of care (E0800)</td>
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<td>☐</td>
<td>• Wandering (E0900)</td>
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<tr>
<td>☐</td>
<td>• Delirium (C1310), including side effects of medications (clinical record)</td>
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<tr>
<td>☐</td>
<td>• Alzheimer’s disease (I4200) or other dementia (I4800)</td>
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<tr>
<td>☐</td>
<td>• Traumatic brain injury (I5500)</td>
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<td>☐</td>
<td>• Psychiatric disorder (I5700-I6100)</td>
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<tr>
<td>✓</td>
<td>Risk for falls that may lead to restraint use (also see Falls CAA)</td>
<td>Supporting Documentation</td>
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<td>☐</td>
<td>• Poor safety awareness, impulsivity (clinical record)</td>
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<td>☐</td>
<td>• Urinary urgency (clinical record)</td>
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<td>☐</td>
<td>• Incontinence of bowel and/or bladder (H0300, H0400)</td>
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<td>☐</td>
<td>• Side effect of medication, such as dizziness, postural/orthostatic hypotension (I0800), sedation, etc. (clinical record)</td>
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<td>☐</td>
<td>• Insomnia, fatigue (D0200D, D0500D)</td>
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<td>☐</td>
<td>• Need for assistance with mobility (G0110)</td>
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<td>☐</td>
<td>• Balance problem (G0300)</td>
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<tr>
<td>☐</td>
<td>• Postural/orthostatic hypotension (I0800, clinical record)</td>
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<td>☐</td>
<td>• Hip or other fracture (I3900, I4000)</td>
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<td>☐</td>
<td>• Hemiplegia/hemiparesis (I4900), paraplegia (I5000), quadriplegia (I5100)</td>
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<td>☐</td>
<td>• Other neurological disorder (for example, Cerebral Palsy (I4400), Multiple Sclerosis (I5200), Parkinson’s Disease (I5300))</td>
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<tr>
<td>☐</td>
<td>• Respiratory problems (J1100, J16200, J16300, clinical record)</td>
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<tr>
<td>☐</td>
<td>• History of falls (J1700 – J1900)</td>
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</table>
### Adverse reaction to restraint use

<table>
<thead>
<tr>
<th></th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>• Skin breakdown (Section M)</td>
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<tr>
<td></td>
<td>• Incontinence or increased incontinence (H0300, H0400, clinical record)</td>
</tr>
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<td></td>
<td>• Moisture associated skin damage (M1040H)</td>
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<td></td>
<td>• Constipation (H0600)</td>
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<td></td>
<td>• Increased agitation behavior (E0200, clinical record) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.</td>
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<td>• Depression, withdrawal, diminished dignity, social isolation (I5800, I5900, clinical record)</td>
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<td></td>
<td>• Loss of muscle mass, contractures, lessened mobility (G0110, G0300, G0400) and stamina (clinical record)</td>
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<td></td>
<td>• Infections, such as UTI or pneumonia (I1700 – I2500)</td>
</tr>
<tr>
<td></td>
<td>• Frequent attempts to get out of the restraints (P0100), falls (J1700 – J1900, clinical record)</td>
</tr>
</tbody>
</table>
Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  - Description of the problem;  
  - Causes and contributing factors; and  
  - Risk factors related to the care area. | Document reason(s) care plan will/ will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why): ____________________
______________________________________________________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes       ☐ No

Signature/Title:___________________________________ Date:_________________________
# 19. PAIN

## Review of Indicators of Pain

<table>
<thead>
<tr>
<th>√</th>
<th>Diseases and conditions that may cause pain (diagnosis OR signs/symptoms present)</th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Cancer (I0100)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Circulatory/heart — Angina, Myocardial Infarction (MI), Atherosclerotic Heart Disease (ASHD) (I0400) — Deep Vein Thrombosis (I0500) — Peripheral Vascular Disease (I0900)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Skin/Wound — Pressure ulcer/injury (section M) — Other ulcers, wounds, incision, skin problems (M1040) — Moisture associated skin damage (M1040H)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Infections — Urinary tract infection (I2300) — Pneumonia (I2000)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Neurological (I4200 – I5500) — Head trauma (clinical record) — Headache — Neuropathy — Post-stroke syndrome</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Gastrointestinal — Gastroesophageal Reflux Disease/Ulcer (I1200) — Ulcerative Colitis/Crohn’s Disease/Inflammatory Bowel Disease (I1300) — Constipation (H0600, clinical record, resident interview)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Hospice care (O0100K)</td>
<td></td>
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<tr>
<td>□</td>
<td>• Terminal condition (J1400)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Musculoskeletal — Arthritis (I3700) — Osteoporosis (I3800) — Hip fracture (I3900) — Other fracture (I4000) — Back problems (I8000) — Amputation (O0500) — Other (I8000)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Dental problems (section L) (L0200)</td>
<td></td>
</tr>
</tbody>
</table>
### Characteristics of the pain

- **Location**
- **Type** (constant, intermittent, varies over time, etc.)
- **What makes it better**
- **What makes it worse**
- **Words that describe it** (for example, aching, soreness, dull, throbbing, crushing)
  - Burning, pins and needles, shooting, numbness (neuropathic)
  - Cramping, crushing, throbbing, stabbing (musculoskeletal)
  - Cramping, tightness (visceral)

### Frequency and intensity of the pain (J0400, J0600, J0850)

- **How often it occurs**
- **Time or situation of onset**
- **How long it lasts**

### Non-verbal indicators of pain (particularly important if resident is stoic)

- **Facial expression** (frowning, grimacing, etc.) (J0800A, J0800C)
- **Vocal behaviors** (signing, moaning, groaning, crying, etc.) (J0800A, J0800B)
- **Body position** (guarding, distorted posture, restricted limb movement, etc.) (J0800D)
- **Restlessness**

### Pain effect on function

- **Disturbs sleep** (J0500A)
- **Decreases appetite** (clinical record)
- **Adversely affects mood** (D0200, D0500, clinical record)
- **Limits day-to-day activities** (J0500B) (social events, eating in dining room, etc.)
- **Limits independence with at least some Activities of Daily Living (ADLs)** (G0110)
<table>
<thead>
<tr>
<th>✓</th>
<th><strong>Associated signs and symptoms</strong></th>
<th>Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Agitation or new or increased behavior problems (E0200) – describe the specific verbal or motor activity- e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc.</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Delirium (C1310)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Withdrawal</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✓</th>
<th><strong>Other Considerations</strong></th>
<th>Supporting Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>• Improper positioning (M1200C)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Contractures (G0400)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Immobility (G0110)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Use of restraints (P0100)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Recent change in pain (characteristics, frequency, intensity, etc.) (J0400, J0600)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Insufficient pain relief (from resident/staff interview, clinical record, direct observation) (J0100 – J0850)</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>• Pain relief occurs, but duration is not sufficient, resulting in breakthrough pain (J0100 – J0850)</td>
<td></td>
</tr>
</tbody>
</table>
## Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review indicators and supporting documentation, and draw conclusions. Document:</td>
<td>Document reason(s) care plan will/will not be developed.</td>
</tr>
<tr>
<td>• Description of the problem;</td>
<td></td>
</tr>
<tr>
<td>• Causes and contributing factors; and</td>
<td></td>
</tr>
<tr>
<td>• Risk factors related to the care area.</td>
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</table>

Referral(s) to another discipline(s) is warranted (to whom and why): ________________________________

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
☐ Yes       ☐ No

Signature/Title:___________________________________ Date:_________________________
### 20. RETURN TO COMMUNITY REFERRAL

#### Review of Return to Community Referral

<table>
<thead>
<tr>
<th>☑️ Steps in the Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B).</td>
</tr>
<tr>
<td>□ 2. Discuss with the individual and his or her family to identify potential barriers to transition planning. The care planning/discharge planning team should have additional discussions with the individual and family to develop information that will support the individual’s smooth transition to community living. (Q0100)</td>
</tr>
</tbody>
</table>
| □ 3. Other factors to consider regarding the individual’s discharge assessment and planning for community supports include:  
  - Cognitive skills for decision making (C1000) and Cognitive deficits (C0500, C0700-C1000)  
  - Functional/mobility (G0110) or balance (G0300) problems  
  - Need for assistive devices and/or home modifications if considering a discharge home |
| □ 4. Inform the discharge planning team and other facility staff of the individual’s choice. |
| □ 5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual’s overall goals of care and discharge planning from previous items responses (Q0300 and Q0400). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility? (Q0300, Q0400) |
| □ 6. Initiate contact with the State-designated local contact agency within approximately 10 business days, and document (Q0600). Follow-up is expected in a “reasonable” amount of time, 10 business days is a recommendation and not a requirement. |
| □ 7. If the local contact agency does not contact the individual by telephone or in person within approximately 10 business days, make another follow-up call to the designated local contact agency as necessary. The level and type of response needed by a particular individual is determined on a resident-by-resident basis, so timeframes for response may vary depending on the needs of the resident and the supports available within the community. |
| □ 8. Communicate and collaborate with the State-designated local contact agency on the discharge process. Identify and address challenges and barriers facing the individual in their discharge process. Develop solutions to these challenges in the discharge/transition plan. |
| □ 9. Communicate findings and concerns with the facility discharge planning team, the individual’s support circle, the individual’s physician and the local contact agency in order to facilitate discharge/transition planning. |
### Input from resident and/or family/representative regarding the care area.
(Questions/Comments/Concerns/Preferences/Suggestions)

<table>
<thead>
<tr>
<th>Analysis of Findings</th>
<th>Care Plan Considerations</th>
</tr>
</thead>
</table>
| Review indicators and supporting documentation, and draw conclusions. Document:  
  • Description of the problem;  
  • Causes and contributing factors; and  
  • Risk factors related to the care area. | Care Plan Y/N  
  Document reason(s) care plan will/will not be developed. |

Referral(s) to another discipline(s) is warranted (to whom and why):

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

☐ Yes   ☐ No

Signature/Title: ___________________ Date: ___________________
CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

NOTE: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

- Advancing Excellence in America’s Nursing Homes Resources: https://www.nhqualitycampaign.org/;
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: http://www.ahrq.gov/professionals/clinicians-providers/index.html;
- Alzheimer’s Association Resources: http://www.alz.org/professionals_and_researchers_14899.asp;
- American Pain Society: http://americanpainsociety.org/;
- American Society of Consultant Pharmacists Practice Resources: https://www.ascp.com/page/prc;
- Association for Professionals in Infection Control and Epidemiology Practice Resources: http://www.apic.org/Resources/Overview;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/longtermcare/prevention/index.html;
- Emerging Solutions in Pain Tools: http://www.emergingsolutionsinpain.com/;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools: https://consultgeri.org/tools;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: https://consultgeri.org/;
CARE AREA GENERAL RESOURCES (cont.)

- Quality Improvement Organizations: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagemenu=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793;
- University of Missouri’s Geriatric Examination Tool Kit: http://geriatric toolkit.missouri.edu/; and
<table>
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<tr>
<th>Chapter</th>
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<td>• Terresita Gayden</td>
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<td>• Michael Harrup</td>
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<td>• Brandy Barnette, MBA, RN, CCM</td>
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<td>• Ellen M. Berry, PT</td>
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<td>• Sara Brice-Payne, MS, BSN, RN</td>
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| 3       | B0700   | B-7  | 1. Assess using the resident’s preferred language or method of communication.  
2. Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.  
3. Observe his or her interactions with others in different settings and circumstances.  
4. Consult with the primary nurse assistants (over all shifts), if available, and the resident’s family, and speech-language pathologist. |
| 3       | B0700   | B-7  | **Coding Tips and Special Populations**  
- This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents’ ability to make self understood during the entire 7-day look-back period.  
- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated. |
| 3       | B0800   | B-8  | **Steps for Assessment**  
1. Assess in the resident’s preferred language or preferred method of communication. |
| 3       | B0700 – B1200 | B-7 – B-12 | Page length changed due to revised content on B-7. |
### 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 if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.

3. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

### Coding Instructions

*Record whether the cognitive interview should be attempted with the resident.*

**Code 0, no:** if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally, or in writing, or using another method, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.

**Code 1, yes:** if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

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<tr>
<td>This information identifies if the interview will be attempted.</td>
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<tbody>
<tr>
<td>3</td>
<td>C0100</td>
<td>C-1</td>
<td>This information identifies if the interview will be attempted.</td>
</tr>
<tr>
<td>3</td>
<td>C0100</td>
<td>C-1</td>
<td>Steps for Assessment</td>
</tr>
<tr>
<td>3</td>
<td>C0100</td>
<td>C-1–C-2</td>
<td>Coding Instructions</td>
</tr>
<tr>
<td>3</td>
<td>C0100–C1310</td>
<td>C-1–C-33</td>
<td>Page length changed due to revised content on C-1–C-2.</td>
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<td>3</td>
<td>C0100</td>
<td>C-2</td>
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**Coding Tips**

- 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 needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Staff Assessment of Mental Status**, instead of C0200-C0500, **Brief Interview for Mental Status**.

- Includes residents who use American Sign Language (ASL).

- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.

- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.

- There is one exception to completing the Staff Assessment for Mental Status items (C0700–C1000) in place of the resident interview. This exception is specific to a stand-alone, unscheduled 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) were 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.
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</thead>
<tbody>
<tr>
<td>3</td>
<td>D0100</td>
<td>D-1</td>
<td>This item helps to determine whether or not a resident or staff mood interview should be conducted.</td>
</tr>
<tr>
<td>3</td>
<td>D0100–D0650</td>
<td>D-1–D-17</td>
<td>Page length changed due to revised content on D-1–D-3.</td>
</tr>
<tr>
<td>3</td>
<td>D0100</td>
<td>D-2</td>
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**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 the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

3. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

**Coding Instructions**

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

- **Code 1, yes:** if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9©).
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</table>
| 3       | D0100   | D-2–D-3 | • 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 needs an interpreter, every effort should be made to have an interpreter present for the PHQ-9© interview. If it is absolutely not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0650.  
  • Includes residents who use American Sign Language (ASL).  
  • If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.  
  • Do not complete the Staff Assessment of Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.  
  • There is one exception to completing the Staff Assessment of Resident Mood items (D0500) in place of the resident interview. This exception is specific to a stand-alone, unscheduled 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 standalone End of Therapy OMRA (EOT), or a standalone 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) were 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. |
<p>| 3       | D0300   | D-9  | Updated graphic |</p>
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<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>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.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>2. Determine whether or not resident is rarely/never understood verbally, in writing, or using another method, and if family member/significant other is available. If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>3. If resident is rarely/never understood and a family member or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>4. Conduct the interview during the observation period.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>5. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-1–F-2</td>
<td>6. The resident interview should be conducted if the resident can respond:</td>
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<td></td>
<td>• verbally,</td>
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<td></td>
<td></td>
<td></td>
<td>• by pointing to their answers on the cue card, OR</td>
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<tr>
<td></td>
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<td></td>
<td>• by writing out their answers</td>
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<td>3</td>
<td>F0300</td>
<td>F-1–F-17</td>
<td>Page length changed due to revised content on F-1–F-2.</td>
</tr>
<tr>
<td>3</td>
<td>F0300</td>
<td>F-2</td>
<td>Record whether the resident preference interview should be attempted.</td>
</tr>
</tbody>
</table>

- **Code 0, no:** if the interview should not be attempted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences). |

- **Code 1, yes:** if the resident interview should be conducted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview. Continue to F0400 (Interview for Daily Preferences) and F0500 (Interview for Activity Preferences).
### 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 needs an interpreter, every effort should be made to have an interpreter present for the MDS clinical interview. If it is not possible for a needed interpreter to be present on the day of the interview, **code F0300 = 0** to indicate interview not attempted, and complete the Staff Assessment of Daily and Activity Preferences (F0800) instead of the interview with the resident (F0400 and F0500).
- If the resident interview was not conducted within the look-back period of the ARD, item F0300 must be coded 1, Yes, and the standard “no information” code (a dash “–”) entered in the resident interview items.
- Do not complete the Staff Assessment of Daily and Activity Preferences items (F0700–F0800) if the resident interview should have been conducted, but was not done.

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<tr>
<td>3</td>
<td>G0110</td>
<td>G-8</td>
<td>a. Convert episodes of Total Dependence (4) to Extensive Assistance (3). If this change makes 3 episodes at Extensive Assistance (3), code as Extensive Assistance (3).</td>
</tr>
<tr>
<td>3</td>
<td>G0110</td>
<td>G-8</td>
<td>Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level? (Item 3a and 3b Rule of 3)</td>
</tr>
<tr>
<td>3</td>
<td>G0110</td>
<td>G-8</td>
<td>Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3c Rule of 3)</td>
</tr>
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Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

Intent: This section assesses includes items about functional abilities and goals. It includes items focused on prior functioning, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

Section GG - Functional Abilities and Goals - Admission (Start of SNF PPS Stay)

<table>
<thead>
<tr>
<th>Coding</th>
<th>Description</th>
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<tbody>
<tr>
<td>3. Independent</td>
<td>Resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.</td>
</tr>
<tr>
<td>2. Needed Some Help</td>
<td>Resident needed partial assistance from another person to complete the activities.</td>
</tr>
<tr>
<td>1. Dependent</td>
<td>A helper completed the activities for the resident.</td>
</tr>
<tr>
<td>0. Unknown</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>

Item Rationale

• Knowledge of the resident’s functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or his or her family about, or review the resident’s medical records describing, the resident’s prior functioning with everyday activities.

Coding Instructions

• **Code 3, Independent:** if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.

• **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.

• **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more
Track Changes  
from Chapter 3 Section GG v1.15  
to Chapter 3 Section GG v1.16  

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<td>helpers was required for the resident to complete the activities.</td>
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<td></td>
<td>• <strong>Code 8, Unknown:</strong> if the resident’s usual ability prior to the current illness, exacerbation, or injury is unknown.</td>
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<td></td>
<td>• <strong>Code 9, Not Applicable:</strong> if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.</td>
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<td></td>
<td><strong>Coding Tips</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Record the resident’s usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.</td>
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<td>• If no information about the resident’s ability is available after attempts to interview the resident or his or her family and after reviewing the resident’s medical record, code as 8, Unknown.</td>
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<td><strong>Examples for Coding Prior Functioning: Everyday Activities</strong></td>
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<td>3. <strong>Self-Care:</strong> Ms. R was admitted to an acute care facility after sustaining a right hip fracture and subsequently admitted to the SNF for rehabilitation. Prior to the hip fracture, Ms. R was independent in eating, bathing, dressing, and using the toilet. Ms. R used a raised toilet seat because of arthritis in both knee joints. Both she and her family indicated that there were no safety concerns when she performed these everyday activities in her home.</td>
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<td><strong>Coding:</strong> GG0100A, Self Care, would be coded 3, Independent.</td>
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<td><strong>Rationale:</strong> Prior to her hip fracture, the resident completed the self-care tasks of eating, bathing, dressing, and using the toilet safely without any assistance from a helper. The resident may use an assistive device, such as a raised toilet seat, and still be coded as independent.</td>
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<td>4. <strong>Self-Care:</strong> Mr. T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, Mr. T was independent in eating and using the toilet; however, Mr. T required assistance for bathing and putting on and taking</td>
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off his shoes and socks. The assistance needed was due to severe arthritis lumbar pain upon bending, which limited his ability to access his feet.

**Coding:** GG0100A, Self Care, would be coded 2, Needed Some Help.

**Rationale:** Mr. T needed partial assistance from a helper to complete the activities of bathing and dressing. While Mr. T did not need help for all self-care activities, he did need some help. Code 2 is used to indicate that Mr. T needed some help for self-care.

5. **Self-Care:** Mr. R was diagnosed with a progressive neurologic condition five years ago. He lives in a long-term nursing facility and was recently hospitalized for surgery and has now been admitted to the SNF for skilled services. According to Mr. R’s wife, prior to the surgery, Mr. R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

**Coding:** GG0100A, Self Care, would be coded 1, Dependent.

**Rationale:** Mr. R’s wife has reported that Mr. R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.

6. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder. Mr. F is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission. The staff has not been successful in contacting either Mr. F’s family or his friends. Mr. F’s prior self-care abilities are unknown.

**Coding:** GG0100A, Self Care, would be coded 8, Unknown.

**Rationale:** Attempts to seek information regarding Mr. F’s prior functioning were made; however, no information was available. This item is coded 8, Unknown.

7. **Indoor Mobility (Ambulation):** Mr. C was admitted to an acute care hospital after experiencing a stroke. Prior to admission, he used a cane to walk from room to room. In the morning, Mr. C’s wife would provide steadying assistance to Mr. C when he walked from room to room.
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<td>because of joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day when walking from room to room.</td>
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<td><strong>Coding:</strong> GG0110B, Indoor Mobility (Ambulation), would be coded 2, Needed Some Help.</td>
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<td><strong>Rationale:</strong> The resident needed some assistance (steadying assistance) from his wife to complete the activity of walking in the home.</td>
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8. **Indoor Mobility (Ambulation):** Approximately three months ago, Mr. K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Mr. K has been living at home with his wife and developed aspiration pneumonia. After this most recent hospitalization, he was admitted to the SNF for aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking.

**Coding:** GG0100B, Indoor Mobility (Ambulation), would be coded 2, Needed Some Help.

**Rationale:** While the resident experienced a cardiac event three months ago, he recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident’s prior functioning would be based on the time immediately before his most recent condition exacerbation that required acute care.

9. **Indoor Mobility (Ambulation):** Mrs. L had a stroke one year ago that resulted in her using a wheelchair to self-mobilize, as she was unable to walk. Mrs. L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

**Coding:** GG0100B, Indoor Mobility (Ambulation), would be coded 9, Not Applicable.

**Rationale:** The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

10. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by his recent admission to the SNF for rehabilitation, Mr. V experienced severe knee pain upon
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<td>ascending and particularly descending his internal and external stairs at home. Mr. V required assistance from his wife when using the stairs to steady him in the event his left knee would buckle. Mr. V’s wife was interviewed about her husband’s functioning prior to admission, and the therapist noted Mr. V’s prior functional level information in his medical record.</td>
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<td></td>
<td><strong>Coding:</strong> GG0100C, Stairs, would be coded 2, Needed Some Help.</td>
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<tr>
<td></td>
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<td></td>
<td><strong>Rationale:</strong> Prior to admission, Mr. V required some help in order to manage internal and external stairs.</td>
</tr>
<tr>
<td>11.</td>
<td>Stairs</td>
<td></td>
<td>Mrs. E lived alone prior to her hospitalization for sepsis and has early stage multiple sclerosis. She has now been admitted to a SNF for rehabilitation as a result of deconditioning. Mrs. E reports that she used a straight cane to ascend and descend her indoor stairs at home and small staircases within her community. Mrs. E reports that she did not require any human assistance with the activity of using stairs prior to her admission.</td>
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<td></td>
<td></td>
<td><strong>Coding:</strong> GG0100C, Stairs, would be coded 3, Independent.</td>
</tr>
<tr>
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<td><strong>Rationale:</strong> Mrs. E reported that prior to admission, she was independent in using her internal stairs and the use of small staircases in her community.</td>
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<tr>
<td>12.</td>
<td>Stairs</td>
<td></td>
<td>Mr. P has continued to show signs and symptoms of possible delirium since admission to the SNF. SNF staff have not received any response to their phone messages to Mr. P’s family members requesting a return call. Mr. P has not received any visitors since his admission. The medical record from his prior facility does not indicate Mr. P’s prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.</td>
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<td></td>
<td><strong>Coding:</strong> GG0100C, Stairs, would be coded 8, Unknown.</td>
</tr>
<tr>
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<td></td>
<td><strong>Rationale:</strong> Attempts were made to seek information regarding Mr. P’s prior functioning; however, no information was available.</td>
</tr>
<tr>
<td>13.</td>
<td>Functional Cognition</td>
<td></td>
<td>Mr. K has mild dementia and recently sustained a fall resulting in complex multiple</td>
</tr>
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<td>fractures requiring multiple surgeries. Mr. K has been admitted to the SNF for rehabilitation. Mr. K’s caregiver reports that when living at home, Mr. K needed reminders to take his medications on time, manage his money, and plan tasks, especially when he was fatigued.</td>
</tr>
<tr>
<td>Rationale:</td>
<td>Mr. K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.</td>
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<tr>
<td>14. Functional Cognition:</td>
<td>Ms. L recently sustained a brain injury from a fall at home. Prior to her recent hospitalization, she had been living in an apartment by herself. Ms. L’s cognition is currently impaired, and her self-report has been determined to be an unreliable source for the information required to code this activity. Ms. L’s cousin, who had visited her frequently prior to her recent hospitalization, indicated that Ms. L did not require any help with taking her prescribed medications, planning her daily activities, and managing money when shopping.</td>
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<tr>
<td>Rationale:</td>
<td>Ms. L’s cousin, who frequently visited Ms. L prior to her sustaining a brain injury, reported that Ms. L was independent in taking her prescribed medications, planning her daily activities, and managing money when shopping, indicating her independence in using memory and problem-solving skills.</td>
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<tr>
<td>15. Functional Cognition:</td>
<td>Mrs. R had a stroke. Since hospitalization and continuing during her SNF stay, she has had a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R’s prior functional status. Her medical records do not include information about her functional cognition prior to the stroke.</td>
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</tr>
<tr>
<td>Coding:</td>
<td>GG0100D, Functional Cognition, would be coded 8, Unknown.</td>
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<tr>
<td>Rationale:</td>
<td>Attempts to seek information regarding Mrs. R’s prior functioning were made; however, no information was available.</td>
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</table>
GG0110. Prior Device Use

<table>
<thead>
<tr>
<th>GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury</th>
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<tbody>
<tr>
<td>Check all that apply</td>
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<tr>
<td>☐ A. Manual wheelchair</td>
</tr>
<tr>
<td>☐ B. Motorized wheelchair and/or scooter</td>
</tr>
<tr>
<td>☐ C. Mechanical lift</td>
</tr>
<tr>
<td>☐ D. Walker</td>
</tr>
<tr>
<td>☐ E. Orthotics/Prosthetics</td>
</tr>
<tr>
<td>☐ F. None of the above</td>
</tr>
</tbody>
</table>

**Item Rationale**

- Knowledge of the resident’s use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

**Steps for Assessment**

1. Ask the resident or his or her family or review the resident’s medical records describing the resident’s use of prior devices and aids.

**Coding Instructions**

- **Check all devices that apply.**
- **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

**Coding Tips**

- For GG0110D, Prior Device Use - Walker: “Walker” refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

**Example for Coding Prior Device Use**

Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. She is unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. She uses a motorized wheelchair to mobilize.

**Coding:** GG0110B, Motorized wheelchair and/or scooter, would be checked.
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<tr>
<td>3</td>
<td>GG0100–GG0170</td>
<td>GG-1–GG-64</td>
<td>Page length changed due to revised content on pages GG-1–GG-64</td>
</tr>
</tbody>
</table>

**Rationale:** Mrs. M used a motorized wheelchair prior to the current illness/injury.

**GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)**

<table>
<thead>
<tr>
<th>GG0130: Self-Care (Assessment period is the last 3 days of the SNF PPS stay ending on A240C). Complete only if A0310G or A0310H = 1 and A240C minus A2400B is greater than 2 and A2100 is not = 03. Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.</th>
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<tbody>
<tr>
<td><strong>Coding:</strong> Safety and Quality of Performance – F: helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. Activities may be completed with or without assistive devices.</td>
</tr>
<tr>
<td>06. Independent: resident completes the activity by him/herself with no assistance from a helper.</td>
</tr>
<tr>
<td>05. Setup or clean-up assistance: helper sets up or cleans up resident complete activity, helper assists only prior to or following the activity.</td>
</tr>
<tr>
<td>04. Supervision or touching assistance: helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.</td>
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<tr>
<td>03. Partial/moderate assistance: helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</td>
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<tr>
<td>02. Substantial/maximal assistance: helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</td>
</tr>
<tr>
<td>01. Dependent: helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.</td>
</tr>
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</table>

If activity was not attempted, code reason:

77. Resident refused
79. Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
80. Not attempted due to environmental limitations (e.g., lack of equipment, weather conditions)
88. Not attempted due to medical condition or safety concerns

**Discharge Performance**

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<th><strong>Enter Code in Box:</strong></th>
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<tr>
<td>A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.</td>
</tr>
<tr>
<td>B. Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth. Manage/denture cleaning and rinsing with use of equipment.</td>
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<tr>
<td>C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement if managing an ostomy, include wiping the opening but not managing equipment.</td>
</tr>
<tr>
<td>D. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.</td>
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<tr>
<td>F. Upper body dressing: The ability to dress and undress above the waist, including fasteners, if applicable.</td>
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<tr>
<td>G. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.</td>
</tr>
<tr>
<td>H. Putting on/taking off footwear: The ability to put on and take off shoes and or shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.</td>
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Updated graphic
Table of Changes

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<td>GG-9</td>
<td>GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)</td>
</tr>
</tbody>
</table>

**Steps for Assessment**

1. Licensed clinicians may assess the resident’s self-care status performance based on direct observation, as well as the resident’s self-report, family and reports, and direct from qualified clinicians, care staff reports, or family documented in the resident’s medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the...
date in A2400B, which is the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.

3. For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, “helper” does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, only consider facility staff when scoring according to the amount of assistance provided.

4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

5. Section GG coding on admission should reflect the person’s baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident’s admission.

6. The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

7. If the resident performs the activity more than once
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<td>during the assessment period and the resident’s performance varies, coding in Section GG should be based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident’s Self-Care performance varies during the assessment period, report the resident’s usual performance, not the resident’s most independent performance and not the resident’s most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the resident’s usual performance.</td>
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<td>3</td>
<td>GG0130</td>
<td>GG-10</td>
<td>• <strong>Code 10, Not attempted due to environmental limitations:</strong> if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.</td>
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**DEFINITION**

**USUAL PERFORMANCE**
A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status. If the resident’s admission or discharge functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worst performance, but rather record the resident’s usual performance.

**QUALIFIED CLINICIAN**
Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

October 2018
### Chapter 3 Section GG

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<td><strong>Assessment Period</strong></td>
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<td>• <strong>Admission:</strong> The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.</td>
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<td>o For the 5-Day PPS assessment, code the resident’s functional status based on a clinical assessment of the resident’s performance that occurs soon after the resident’s admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day three. The admission function scores are to reflect the resident’s admission baseline status and are to be based on an assessment. The scores should reflect the resident’s status prior to any benefit from interventions.</td>
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<td>The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident’s true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.</td>
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<td>GG0130</td>
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<td><strong>Coding Tips: Admission or Discharge Performance Coding Tips</strong></td>
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<td><strong>General Coding Tips</strong></td>
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<td>• When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.</td>
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<td>• When coding the resident’s usual performance, use the 6-point scale or one of the 3 “activity was not attempted” codes to specify the reason why an activity was not attempted.</td>
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</table>
When coding the resident’s usual performance, “effort” refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

Residents with cognitive impairments/limitations may need physical and/or verbal assistance when coding for the resident’s Discharge Goal(s), use the same 6-point scale. Instructions about coding Discharge Goals are provided below under Discharge Goal(s): Coding Tips.

On discharge, use the same 6-point scale or “completing an activity was not attempted codes that are used for the admission assessment to identify the resident’s usual performance. Code based on the Discharge assessment.

Do not record the staff’s assessment of the resident’s potential capability need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).

If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity; code as 09 if the activity is not applicable for the resident (the activity did not perform this activity occur at the time of the assessment and prior to the current illness, injury, or exacerbation, or injury); code as 10 if the resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.

If two or more helpers are required to assist the resident into completing the activity, code as 01, Dependent.
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<td>• To clarify your own understanding of the resident’s performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.</td>
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<td>• Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods). If the resident eats finger foods with his/her hands independently, for example, the resident would be coded as 06, Independent.</td>
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<td>• Coding A dash (&quot;-&quot;) in these items indicates “No information.” CMS expects dash use for SNF-QRP items to be a rare occurrence. Use of dashes for these items may result in a reduction in the annual payment update. Do not use a dash if the reason the item was not assessed was that because the resident refused (code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88) use these codes instead of a dash (&quot;-&quot;). Please note that a dash may be used for GG0130 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale. Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash (&quot;-&quot;) for Discharge Goals is provided below under Discharge Goal(s): Coding Tips.</td>
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<td>• For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.</td>
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</table>
• Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record. This assessment can be conducted by appropriate health care personnel as defined by facility policy and in accordance with State and Federal regulations.

• Completion of the Self-Care items is not required if the resident has an unplanned discharge to an acute-care hospital, or if the SNF PPS Part A Stay is less than 3 days.

**Coding Tips for Coding the Resident’s Usual Performance**

- When coding the resident’s usual performance and discharge goal(s), use the six-point scale, or use one of the 4 “activity was not attempted” codes to specify the reason why an activity was not attempted.

- When coding the resident’s usual performance, “effort” refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

- Do not record the resident’s best performance, and do not record the resident’s worst performance, but rather record the resident’s usual performance during the assessment period.

- Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity.

- If the resident performs the activity more than once during the assessment period and the resident’s performance varies, coding in Section GG should be based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident’s Self-Care performance varies during the assessment period, report
the resident’s usual performance, not the resident’s most independent performance and not the resident’s most dependent performance. A provider may need to use the entire three-day assessment period to obtain the resident’s usual performance.

**Coding Tips for GG0130A, Eating**

- Resident receives tube feedings or total parenteral nutrition (TPN):
  - If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or TPN because of a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding the Eating item.
  - If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code GG0130A as 09, Not applicable. Assistance with tube feedings or TPN is not considered when coding the Eating item.
  - If the resident eats and drinks by mouth, and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code the Eating item based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding the Eating item.

- If the resident eats finger foods using his or her hands, then code the Eating item based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.

### Coding Tip for GG0130B, Oral hygiene

If a resident does not perform oral hygiene during therapy, determine the resident’s abilities based on performance on the nursing care unit.

5. **Oral hygiene:** Mr. G has Parkinson’s disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies...
toothpaste to his toothbrush. Mr. G requires assistance to
guide the toothbrush into his mouth and to steady his elbow
while he brushes his teeth. Mr. G usually starts by brushing
his upper and lower front teeth. Tooth brushing and the certified
nursing assistant usually completes the activity by performing
more than half of this activity by brushing the rest of his teeth.

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<tr>
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<td>GG0130</td>
<td>GG-18</td>
<td>Coding Tips for GG0130C, Toileting hygiene</td>
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<td>- Toileting hygiene includes the tasks of managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then assess the resident’s need for assistance to manage lower-body clothing and perineal hygiene.</td>
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<td>- Toileting hygiene (managing clothing and perineal cleansing) can take place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident’s need for assistance in managing clothing and perineal cleansing.</td>
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<td>If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident when moving his or her bowels.</td>
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<tr>
<td>3</td>
<td>GG0130</td>
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<td>6. Toileting hygiene: Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a hospital gown and underwear during the day. Ms. Q uses a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity owing to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perianal hygiene as Ms. Q needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.</td>
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<td><strong>Coding:</strong> GG0130C, Toileting hygiene, would be coded 02, Substantial/maximal assistance.</td>
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<td><strong>Rationale:</strong> The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.</td>
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**Coding Tips for GG0130E, Shower/bathe self**

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident’s back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.

- Assessment of Shower/bathe self can take place in a shower or bath, at a sink, or at the bedside (i.e., sponge bath).

- If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.

- If the resident cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity.

**Examples for GG0130E, Shower/bathe self**

1. **Shower/bathe self:** Mr. J sits on a tub bench as he washes, rinses, and dries himself. A certified nursing assistant stays with him to ensure his safety, as Mr. J has had instances of losing his sitting balance. The certified nursing assistant also provides lifting assistance as Mr. J gets onto and off of the tub bench.

   **Coding:** GG0130E, Shower/bathe self, would be coded 04, Supervision or touching assistance.

   **Rationale:** The helper provides supervision as Mr. J washes, rinses, and dries himself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** Mrs. E has a severe and progressive
neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench with partial/moderate assistance. Mrs. E showers while sitting on a tub bench and washes her arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of her body, as a result of Mrs. E’s fatigue, to complete the activity. Mrs. E uses a long-handled shower to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E’s entire body.

**Coding:** GG0130E, Shower/bathe self, would be coded 02, Substantial/maximal assistance.

**Rationale:** The helper assists Mrs. E with more than half of the task of showering, which includes bathing, rinsing, and drying her body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** Mr. Y has limited mobility resulting from his multiple and complex medical conditions. He prefers to sponge-bathe at his bedside. Mr. Y washes, rinses, and dries his face, chest, and abdomen. A helper assists with washing, rinsing, and drying Mr. Y’s arms/hands, upper legs, lower legs, buttocks, and back.

**Coding:** GG0130E, Shower/bathe self, would be coded 02, Substantial/maximal assistance.

**Rationale:** The helper completed more than half the activity. Bathing may occur at the bedside. When coding this activity, do not include assistance provided with washing, rinsing, or drying the person’s back.

**Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear**

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident’s clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic
## Change

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<td>bandage/elastic stocking/orthotic/prosthetic as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.</td>
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<td>The following items are considered a piece of clothing when coding the dressing items:</td>
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<td>Upper body dressing examples: thoracic-lumbar-sacrum orthotic (TLSO), abdominal binder, back brace, elastic stockings, stump sock/shrinker, upper body support device, neck support, hand or arm prostatic.</td>
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<td>Lower body dressing examples: knee brace, elastic bandage, elastic stockings, stump sock/shrinker, lower-limb prostatic.</td>
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<td>Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).</td>
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<td>Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.</td>
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<td>Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.</td>
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<td>Footwear dressing items used for coding include socks, shoes, boots, and running shoes.</td>
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<td>For residents with bilateral lower extremity amputations with or without use of prosthetics, the activity of putting on-taking off footwear may not occur. For example, the socks and shoes may be attached to the prostatic associated with the upper or lower leg.</td>
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<td>If the resident performed the activity of putting on-taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.</td>
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<td>o</td>
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<td>If the resident did not perform the activity of putting on-taking off footwear immediately prior to the current illness, exacerbation, or injury because the</td>
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resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable.

- For residents with a single lower extremity amputation with or without use of a prosthetic, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthetic and the intact limb:
  - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. Upper body dressing: Mrs. Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress her upper body. During the day, she requires a certified nursing assistant only to place her clothing next to her bedside. Mrs. Y can now use compensatory strategies to put on her bra and top without any assistance. At night she removes her top and bra independently and puts the clothes on the nightstand, and the certified nursing assistant puts them away in her dresser.

   Coding: GG0130F, Upper body dressing, would be coded 05, Setup or clean-up assistance.

   Rationale: Mrs. Y dresses and undresses her upper body and requires a helper only to retrieve her clothing, that is, setting up the clothing for her use. The description refers to Mrs. Y as “independent” (when removing clothes), but she needs setup assistance, so she is not independent with regard to the entire activity of upper body dressing.

2. Upper body dressing: Mrs. Z wears a bra and a
sweatshirt most days while in the SNF. Mrs. Z requires assistance from a certified nursing assistant to initiate the threading of her arms into her bra. Mrs. Z completes the placement of the bra over her chest. The helper hooks and unhooks the bra clasps. Mrs. Z pulls the sweatshirt over her arms, head, and trunk and slides the bra off, once it has been unclasped by the helper.

**Coding:** GG0130F, Upper body dressing, would be coded 03, Partial/moderate assistance.

**Rationale:** The helper provides assistance with threading Mrs. Z’s arms into upper body garments and hooking and unhooking bra clasps, but Mrs. Z performs more than half of the effort.

3. **Upper body dressing:** Mr. K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one-third of his left sleeve of his shirt with much time and effort and is unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Mr. K.

**Coding:** GG0130F, Upper body dressing, would be coded 02, Substantial/maximal assistance.

**Rationale:** Mr. K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

**Examples for GG0130G, Lower body dressing**

1. **Lower body dressing:** Mr. D is required to follow hip precautions as a result of recent hip surgery. He requires a helper to retrieve his clothing from the closet. Mr. D uses his adaptive equipment to assist in threading his legs into his pants. Because of balance issues, Mr. D needs the helper to steady him when standing to manage pulling on or pulling down his pants/undergarments. Mr. D also needs some assistance to put on and take off his socks and shoes.
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<td><strong>Coding:</strong> GG0130G, Lower body dressing, would be coded 04, Supervision or touching assistance.</td>
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<td><strong>Rationale:</strong> A helper steadies Mr. D when he is standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.</td>
</tr>
<tr>
<td>2.</td>
<td>Lower body dressing: Mrs. M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. She has been issued a knee brace, to be worn during the day. Mrs. M threads her legs into her garments, and pulls up and down her clothing to and from just below her hips. Only a little assistance from a helper is needed to pull up her garments over her hips. Mrs. M requires the helper to fasten her knee brace because of grasp and fine motor weakness.</td>
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<td><strong>Coding:</strong> GG0130G, Lower body dressing, would be coded 03, Partial/moderate assistance.</td>
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<td><strong>Rationale:</strong> A helper provides only a little assistance when Mrs. M is putting on her lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace she wears is considered when determining the help needed when coding lower body dressing.</td>
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<td>3.</td>
<td>Lower body dressing: Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks.</td>
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<td><strong>Coding:</strong> GG0130G, Lower body dressing, would be coded 03, Partial/moderate assistance.</td>
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|         | **Rationale:** A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). *The helper lifts, holds, or supports Mrs. R’s trunk or limbs, but provides less than half the effort for the task of lower body dressing.* In contrast,
**Examples for GG0130H, Putting on/taking off footwear**

1. **Putting on/taking off footwear:** Mr. M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. He has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an ankle-foot orthosis that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks, and shoes within easy reach of his bed. While sitting on the bed, he needs to bend over to put on and take off his AFO, socks, and shoes, and he occasionally loses his sitting balance, requiring staff to place their hands on him to maintain his balance while performing this task.

   **Coding:** GG0130H, Putting on/taking off footwear, would be coded 04, Supervision or touching assistance.

   **Rationale:** Mr. M puts on and takes off his AFO, socks, and shoes by himself; however, because of occasional loss of balance, he needs a helper to provide touching assistance when he is bending over.

2. **Putting on/taking off footwear:** Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes.

   **Coding:** GG0130H, Putting on/taking off footwear, would be coded 03, Partial/moderate assistance.
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<td>3</td>
<td>GG0130</td>
<td>GG-27–GG-29</td>
<td><strong>Rationale:</strong> A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.</td>
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**Discharge Goal(s): Coding Tips**

Use the 6-point scale Discharge goal(s) are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident’s discharge goal(s). Do not use using the six-point scale. Use of the “activity was not attempted” codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash (-) to indicate is permissible for any remaining self-care or mobility goals that a specific activity is not a Discharge Goal. Of note, at least one Discharge Goal must be indicated for either Self Care or Mobility. were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.

- Licensed, qualified clinicians can establish a resident’s discharge goal(s) at the time of admission based on the 5-Day PPS resident’s prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the professional’s standard of practice, expected treatments, the resident’s motivation to improve, anticipated length of stay, and the resident’s discharge plan. Goals should be established as part of the resident’s care plan.

- For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.

| | | | |
| | | | |
Goals may be determined based on the resident’s admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family concerning discharge goals, anticipated length of stay, and the clinician’s consideration of expected treatments, and resident motivation to improve.

If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the Admission assessment, a discharge goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

Discharge Goal: Coding Examples

Example 1: Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code

If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.

Example 2: Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain her admission functional performance level. The qualified clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident’s admission performance code.

Oral Hygiene 5-Day PPS Assessment Admission Performance and Discharge Goal: In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident’s 5-Day PPS admission performance code is coded and the
Discharge Goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson’s disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes Mrs. E’s 5-Day PPS admission performance and discusses her usual performance with qualified clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E’s limb). The qualified clinician codes Mrs. E’s 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding her limb.

**Oral Hygiene 5-Day PPS Assessment Admission Performance and Discharge Goal:** The qualified clinician anticipates Mrs. E’s discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E’s progressive and degenerative condition, the qualified clinician and resident feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a Discharge Goal.

**Example 3:** Discharge Goal Code Is Lower than 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident’s 5-Day PPS assessment admission performance code.

**Toileting Hygiene:** Mrs. T’s participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The resident’s *Discharge Goal* code will be lower than the 5-Day PPS *Admission Performance* code.

**Toileting Hygiene 5-Day PPS Assessment Admission Performance:** Mrs. T has a progressive neurological
Track Changes  
from Chapter 3 Section GG v1.15  
to Chapter 3 Section GG v1.16

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| 3       | GG0170  | GG-30–GG-33 | illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. T’s toileting hygiene.  

**Toileting Hygiene Discharge Goal:** By discharge, it is expected that Mrs. T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The qualified clinician codes her Discharge Goal as 02, Substantial/maximal assistance.  

GG0170: Mobility (3-day assessment period)  
Admission (Start of Medicare Part A Stay) |
### Track Changes from Chapter 3 Section GG v1.15 to Chapter 3 Section GG v1.16

#### GG0170. Mobility

Assessment period is days 1 through 3 of the SNF PPS stay starting with A2400B.

Complete only if A0310B=01

Code the resident’s usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident’s end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

**Codings**

- **Safety and Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
- **Activities may be completed with or without assistant devices.**

**00.** Independent - Resident completes the activity by him/herself with no assistance from a helper.

**02.** Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts or supports trunk or limbs, but provides less than half the effort.

**03.** Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or supports trunk or limbs and provides more than half the effort.

**06.** Required - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

**07.** Resident refused

**08.** Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

**09.** Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)

**10.** Not attempted due to medical condition or safety concerns

#### Table

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<th>1. Admission Performance</th>
<th>2. Discharge Goal</th>
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<tbody>
<tr>
<td>A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.</td>
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<tr>
<td>B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.</td>
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<tr>
<td>C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.</td>
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<td>D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</td>
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<tr>
<td>E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).</td>
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<td>F. Toilet transfer: The ability to get on and off a toilet or commode.</td>
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<tr>
<td>G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open close door or fasten seat belt.</td>
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<td>I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170A, 1 step (out)</td>
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<td>J. Walk 5 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.</td>
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<tr>
<td>K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.</td>
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**Updated graphic**
Track Changes from Chapter 3 Section GG v1.15 to Chapter 3 Section GG v1.16

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<td>GG017.0</td>
<td>Mobility: Assessment period is days 1 through 3 of the SNF PPS stay starting with A2400(0) - Continued (Complete only if A2310B = 0)</td>
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Code the resident’s usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident’s end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 11 is permissible to code end of SNF PPS stay (discharge) goals.

**Coding:**

- **Safety and Quality of Performance:** If helper assistance is required because resident’s performance is unsafe or of poor quality, score according to amount of assistance provided.
- **Activities:** Activities may be completed with or without assistive devices.
  - 06. Independent: Resident completes the activity by him/herself with no assistance from a helper.
  - 05. Setup or clean-up assistance: Helper sets up or cleans up resident completes activity. Helper assists only prior to or following the activity.
  - 04. Supervision or teaching assistance: Helper provides verbal cues and/or touching/stabilizing and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
  - 03. Partial moderate assistance: Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
  - 02. Substantial/maximal assistance: Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
  - 01. Dependent: Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

- 07. Resident refused
- 09. Not attempted: Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints).
- 08. Not attempted due to medical condition or safety concerns

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- **L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor) such as turf or gravel.
  - M. 1 step (curb): The ability to go up and down a curb and/or up and down one step.
  - N. 4 steps: The ability to go up and down 4 steps with or without a rail.
  - O. 12 steps: The ability to go up and down 12 steps with or without a rail.
  - P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

- **Q1. Does the resident use a wheelchair and/or scooter?**
  - 0. No ➔ Skip to GG017.0: Wheelchair
  - 1. Yes ➔ Continued to GG017.0: Wheelchair

- **R. Wheel 50 feet with two turns:** Once seated in wheelchair/scraper, the ability to wheel at least 50 feet and make two turns.

- **S. Wheel 150 feet:** Once seated in wheelchair/scraper, the ability to wheel at least 150 feet in a corridor or similar space.

- **SS1. Indicate the type of wheelchair or scooter used:**
  - 1. Manual
  - 2. Motorized

**Updated graphic**
**GG0170: Mobility (3-day assessment period) Discharge (End of Medicare Part A Stay)**

**Coding:**
- Safety and Quality of Performance - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
- Activities may be completed with or without assistance devices.
- Independent: Resident completes the activity by him/herself with no assistance from a helper.
- Setup or clean-up assistance: Helper sets up or cleans up resident completes activity. Helper assists only prior to or following the activity.
- Supervision or touching assistance: Helper provides verbal cues and or touching/steadying and or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- Partial/moderate assistance: Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- Substantial/maximal assistance: Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Dependent: Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
- 07. Resident refused
- 08. Not applicable: Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 10. Not attempted due to environmental limitations (e.g., bed of equipment, weather constraints)
- 50. Not attempted due to medical condition or safety concerns

### Discharge Performance

#### Enter Codes In Box:

A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.

E. Chair to chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

F. Toilet transfer: The ability to get on and off a toilet or commode.

G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/ close door or fasten seat belt.

H. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.

If discharge performance is coded 07, 09, 10, or 50 — Skip to GG0170M, 1 step (out).

I. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.

J. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

**Updated graphic**
Updated graphic

**Item Rationale**

- Residents in **During a Medicare Part A SNF stay**, residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

**Steps for Assessment**

1. Assess the resident’s mobility status/performance based on direct observation, as well as the resident’s self-report and the reports of family, direct care staff, and qualified clinicians. CMS anticipates that a multidisciplinary team of qualified clinicians is involved.
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<td><strong>in assessing the resident during the three-day assessment period.</strong> For Section GG on admission, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, which is the <strong>most recent Medicare stay.</strong> On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).</td>
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<td><strong>2.</strong> Residents should be allowed to perform activities as independently as possible, as long as they are safe.</td>
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<td><strong>3.</strong> For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.</td>
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<td><strong>4.</strong> Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.</td>
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<td><strong>5.</strong> Section GG coding on admission should reflect the person’s baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident’s admission.</td>
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<td><strong>6.</strong> The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.</td>
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<td><strong>7.</strong> If the resident performs the activity more than once during the assessment period and the resident’s performance varies, coding in Section GG should be based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance</td>
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for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident’s Mobility performance varies during the assessment period, report the resident’s usual performance, not the resident’s most independent performance and not the resident’s most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the resident’s usual performance.

Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

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<td>3</td>
<td>GG0170</td>
<td>GG-35</td>
<td><strong>Code 10, Not attempted due to environmental limitations:</strong> if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.</td>
</tr>
<tr>
<td>3</td>
<td>GG0170</td>
<td>GG-36</td>
<td><strong>Admission or Discharge Performance Coding Tips</strong></td>
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<td>• <strong>Admission:</strong> The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.</td>
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<td>o For the 5-Day PPS assessment, code the resident’s functional status based on a clinical assessment of the resident’s performance that occurs soon after the resident’s admission. This functional assessment must be completed within the first three days (three calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and including the following two days, ending at 11:59 PM on day three. The admission function scores are to reflect the resident’s admission baseline status and are to be based on an assessment. The scores should reflect the resident’s status prior to any benefit from interventions. The</td>
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Table: Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

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<td>3</td>
<td>GG0170</td>
<td>GG-36–GG-39</td>
<td>Assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident’s true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.</td>
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**Admission and Discharge Performance Coding Tips**

**General Coding Tips**

1. When reviewing the resident’s medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns (item GG0170J), determine the level, type, and amount of assistance required to walk 50 feet while making 2 turns as the resident walks 50 feet.

2. When coding the resident’s usual performance, use the 6-point scale or one of the 3 “activity was not attempted” codes to specify the reason why an activity was not attempted.

3. When coding the resident’s usual performance, “effort” refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

4. At admission, when coding the resident’s Discharge Goal(s), use the same 6-point scale. Instructions above related to coding Discharge Goals for the Mobility items (GG0170) are the same as those for coding Discharge Goals for the Self-Care items (GG0130).

5. On discharge, use the same 6-point scale or “activity was not attempted” codes that are used for the admission assessment to identify the resident’s usual performance on the Discharge assessment.

6. Do not record the staff’s assessment of the resident’s
7. If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire three-day assessment period, code the reason the activity was not attempted. For example, enter code 07, Resident refused, if the resident refused to attempt the activity during the entire assessment period; enter code 09, Not applicable, if the activity is not applicable for the resident (because the resident did not perform this activity did not occur during the assessment period, and prior to the current illness, exacerbation, or injury); enter code 10, Not attempted due to environmental limitations, if the resident was not able to attempt the activity due to environmental limitations; or enter code 88, Not attempted due to medical condition or safety concerns, if the resident was not able to attempt the activity due to a medical condition or safety concerns.

8. An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.

9. If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.

10. To clarify your own understanding and observations about a resident’s performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.

11. The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person’s ability level and can include use of an assistive device (for example, cane or wheelchair).

12. Coding A dash (“-“) in these items (“-“) indicates “No information.” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may ...
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<td>result in a reduction in annual payment update. Do not use a <strong>dash</strong> if the reason the item was not assessed was that the resident refused (code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash (“””). A dash may be used for GG0170 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale. Using the dash in this allowed instance does not affect APU determination. Further information about use of a dash (“””) for Discharge Goals is provided above under Discharge Goal(s): Coding Tips.</td>
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<td>13. <strong>For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function</strong>, a minimum of one Self-Care or Mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.</td>
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<td>14. <strong>Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.</strong></td>
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<td><strong>Tips for Coding the Resident’s Usual Performance</strong></td>
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<td>15. When coding the resident’s usual performance and the resident’s discharge goal(s), use the six-point scale, or one of the four “activity was not attempted” codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.</td>
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|         |         |      | 16. When coding the resident’s usual performance, “effort” refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance,
17. Do not record the resident’s best performance, and do not record the resident’s worst performance, but rather record the resident’s usual performance during the assessment period.

18. Code based on the resident’s performance. Do not record the staff’s assessment of the resident’s potential capability to perform the activity.

19. If the resident performs the activity more than once during the assessment period and the resident’s performance varies, coding in Section GG is based on the resident’s “usual performance,” which is identified as the resident’s usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire three-day assessment period to obtain the resident’s usual performance.

### Examples and Coding Tips for Admission or Discharge Performance

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days. Some examples do not have coding tips.

#### Examples for GG0170A, Roll left and right

20. **Roll left and right:** Mrs. R has a history of skin breakdown. A nurse instructs her to turn onto her right side, providing step-by-step instructions to use the bedrail, bend her left leg, and then roll onto her right side. Mrs. R attempts to roll with the use of the bedrail, but indicates she cannot perform the task. The nurse then rolls her onto her right side. Next, Mrs. R is instructed to return to lying on her back, which she successfully completes. Mrs. R then requires physical assistance from the nurse to roll onto her left side and to return to lying on her back to complete the activity.

**Coding:** GG0170A, Roll left and right, would be coded 02, Substantial/maximal assistance.
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<td><strong>Rationale:</strong> The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right.</td>
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<td><strong>21. Roll left and right:</strong> A physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. K completes the activity without physical assistance from the physical therapist. <strong>Coding:</strong> GG0170A, Roll left and right, would be coded <strong>04, Supervision or touching assistance.</strong></td>
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<td><strong>Rationale:</strong> The physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back, and then again as he performs the same activities with respect to his left side. The physical therapist does not provide any physical assistance. <strong>Coding:</strong> GG0170A, Roll left and right, would be coded <strong>01, Dependent.</strong></td>
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<td><strong>Rationale:</strong> Two certified nursing assistants are needed to help Mr. Z roll onto his left and right side and back while in bed.</td>
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<td><strong>23. Roll left and right:</strong> Mr. M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician’s order allows him to roll onto his left hip as tolerated. A certified nursing assistant assists Mr. M in rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. M needs physical assistance from the certified nursing assistant to initiate his rolling right because of his left arm weakness when grasping the right bedrail to assist in rolling. Mr. M returns to lying on his back without assistance and uses his right arm to grasp the left bedrail to slowly roll onto his left hip and then return to lying on his back.</td>
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### Coding: GG0170A, Roll left and right, would be coded **03, Partial/moderate assistance.**

**Rationale:** The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

### Examples for GG0170B, Sit to lying

1. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H’s right leg. Mrs. H uses her arms to position her upper body and lowers herself to a lying position flat on her back. Overall, Mrs. H performs more than half of the effort.

2. **Sit to lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

   **Coding:** GG0170B would be coded 02, Substantial/maximal assistance.

   **Rationale:** The helper provided more than half the effort for the resident to complete the activity of sit to lying.

3. **Sit to lying:** Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

   **Coding:** GG0170B would be coded 01, Dependent.

   **Rationale:** The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.
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| 3       | GG0170  | GG-41| 4. **Sit to lying:** Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.  
**Coding:** GG0170B would be coded 04, Supervision or touching assistance.  
**Rationale:** A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.  
5. **Sit to lying:** Mrs. G suffered a traumatic brain injury three months prior to admission. She requires the certified nursing assistant to steady her movements from sitting on the side of the bed to lying flat on the bed. Mrs. G requires steadying (touching) assistance throughout the completion of this activity.  
**Coding:** GG0170B would be coded 04, Supervision or touching assistance.  
**Rationale:** A helper provides steadying assistance in order for the resident to complete the activity of sit to lying flat on her bed.  
6. **Sit to lying:** Mrs. E suffered a pelvic fracture during a motor vehicle accident. Mrs. E requires the certified nursing assistant to lift and position her left leg when she transfers from sitting at the edge of the bed to lying flat on the bed due to severe pain in her left pelvic area. Mrs. E uses her arms to position and lower her upper body to lying flat on the bed. Overall, Mrs. E performs more than half of the effort. |

**Coding Tips for GG0170C, Lying to sitting on side of bed**

- The activity includes resident transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The resident’s ability to perform each of the tasks within this activity and how much support the resident requires to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is...
considered a “lying” position for a particular resident.

• If the resident’s feet do not reach the floor upon lying to sitting, the qualified clinician will determine if a bed height adjustment or a footstool is required to accommodate foot placement on the floor/footstool.

• Back support refers to an object or person providing support for the resident’s back.

• If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

2. Lying to sitting on side of bed: Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides additional lifting assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the occupational therapist performs more than half of the effort.

Coding: GG0170C would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

Coding Tips for GG0170C, Lying to sitting on side of bed

- Item GG0170C, Lying to sitting on side of bed, indicates that the resident transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support. The clinician is to assess the resident’s ability to perform each of the tasks within this activity and determine how much support the resident requires to complete the activity.

- For item GG0170C, Lying to sitting on the side of bed, clinical judgment should be used to determine what is considered a “lying” position for that resident.
### Track Changes
**from Chapter 3 Section GG v1.15**
**to Chapter 3 Section GG v1.16**

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<td>- If the resident’s feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a foot stool is required to accommodate foot placement on the floor/footstool.</td>
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<td>- Back support refers to an object or person providing support of the resident’s back.</td>
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<td>3</td>
<td>GG0170</td>
<td>GG-44</td>
<td><strong>Coding Tips for GG0170E, Chair/bed-to-chair transfer</strong></td>
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<td>- Item GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.</td>
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<td>3</td>
<td>GG0170</td>
<td>GG-45</td>
<td>- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.</td>
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### 4. Chair/bed-to-chair transfer
Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides **limited** trunk support with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance. **Overall, the therapist provides less than half of the effort.**

**Coding:** GG0170E would be coded 03, Partial/moderate assistance.

**Rationale:** The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.
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<td>3</td>
<td>GG0170</td>
<td>GG-29</td>
<td>5. <strong>Chair/bed-to-chair transfer:</strong> Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, but assists with the transfer. The physical therapist assists him in side scooting by lifting his trunk in a rocking motion as Mr. U scoots across the transfer board and into the wheelchair. Overall, the therapist provides more than half of the effort. <strong>Coding:</strong> GG0170E would be coded 02, Substantial/maximal assistance. <strong>Rationale:</strong> The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.</td>
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| 3       | GG0170  | GG-47| **Coding Tips for GG0170E, Chair/bed-to-chair transfer**

- Item GG0170E, Chair/bed to chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.

- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

**Toilet transfer:** The therapist supports Mrs. M’s trunk with a gait belt by providing weight-bearing as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer. **Coding:** GG0170F would be coded 03, Partial/moderate assistance. |
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<td><strong>Rationale:</strong> The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.</td>
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<td><strong>Toilet transfer:</strong> Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The certified nursing assistant provides weight-bearing assistance as she slowly rotates and lowers Ms. W onto the bedside commode. Ms. W contributes less than half of the effort to transfer onto the toilet.</td>
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**Examples for GG0170H1, Does the resident walk?**

1. **Car transfer:** Mrs. W uses a wheelchair and ambulates for only short distances. She requires lifting assistance from a physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the therapist. She lifts her legs into the car with support from the therapist.

   **Coding:** GG0170G, Car transfer, would be coded 02, Substantial/maximal assistance.

   **Rationale:** Although Mrs. W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer Mrs. W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During her rehabilitation stay Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Mrs. N requires verbal reminders for safety and light touching assistance. The therapist instructs her on strategic hand placement while Mrs. N transitions to sitting in the car’s passenger seat. The therapist opens and closes the door.
Coding: GG0170G, Car transfer, would be coded 04, Supervision or touching assistance.

Rationale: The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

Coding Tips for Walking Items

- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.

- When coding GG0170 walking items, do not consider the resident’s mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Mrs. C has resolving sepsis and has not walked in three weeks because of her medical condition. A physical therapist determines that it is unsafe for Mrs. C to use a walker, and the resident only walks using the parallel bars. On day 3 of the Admission assessment period, Mrs. C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

   **Coding:** GG0170I, Walk 10 feet, would be coded 88, Not attempted due to medical condition or safety concerns.

   **Rationale:** When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident is unable to walk without the use of parallel bars because of his or her medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns. Since GG0170I, Walk 10 feet, is coded 88, follow the skip pattern to GG0170Q1 (admission) or GG0170Q3 (planned discharge), Does the resident use a wheelchair and/or scooter?

2. **Walk 10 feet:** Mr. L had bilateral amputations three years ago, and prior to the current admission he used a
wheelchair and did not walk. Currently Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L’s care plan includes fitting and use of bilateral lower extremity prostheses.

**Coding:** GG0170I, Walk 10 feet, would be coded 09, Not applicable.

**Rationale:** When assessing a resident for GG0170I, Walk 10 feet, consider the resident’s status prior to the current episode of care and current three-day assessment status. Use code 09, Not applicable, because Mr. L did not walk prior to the current episode of care and did not walk during the three-day assessment period. Mr. L’s care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the resident’s care plan.

3. **Walk 10 feet:** Mrs. C has Parkinson’s disease and walks with a walker. A physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C’s foot, during the activity of walking 10 feet.

**Coding:** GG0170I, Walk 10 feet, would be coded 02, Substantial/maximal assistance.

**Rationale:** A helper provides more than half the effort as the resident completes the activity.

4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson’s disease. A therapy assistant secures Mr. O’s arms onto his platform walker’s arm supports to manage the tremors. The therapy assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last 5 feet of the 10-foot walk.

**Coding:** GG0170I, Walk 10 feet, would be coded 03, Partial/moderate assistance.

**Rationale:** The helper provides less than half the effort required for the resident to complete the activity, Walk 10 feet.

5. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned
Track Changes
from Chapter 3 Section GG v1.15
to Chapter 3 Section GG v1.16

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<td>GG0170</td>
<td>GG-51</td>
<td>3. Walk 50 feet with two turns: Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the certified nursing assistant supports her trunk providing weight-bearing assistance and provides less than half the effort. Coding: GG0170J would be coded 03, Partial/moderate assistance.</td>
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her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker while walking. The nurse places his hand on Mrs. U’s back to steady her toward the last half of her 10-foot walk.

**Coding:** GG0170I, Walk 10 feet, would be coded 04, Supervision or touching assistance.

**Rationale:** A helper provides touching assistance in order for the resident to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

1. **Does the resident walk?** Mr. Z currently does not walk, but a walking goal is clinically indicated.

   **Coding:** GG0170H1, Does the resident walk? would be coded 1, No, and walking goal is clinically indicated. Discharge goal(s) for items J, Walk 50 feet with two turns and K, Walk 150 feet may be coded.

   **Rationale:** Resident does not currently walk. By indicating the resident does not walk, the admission performance walking items are skipped. However, a walking goal is clinically indicated and walking goals may be coded.

2. **Does the resident walk?** Ms. Y currently walks with great difficulty due to her progressive neurological disease. It is not expected that Ms. Y will continue to walk. Ms. Y also uses a wheelchair so both GG0170H1, Does the resident walk? and GG0170Q1, Does the resident use a wheelchair/scooter? will be coded Yes.

   **Coding:** GG0170H1, Does the resident walk? would be coded 2, Yes, and each walking admission performance activity for items J, Walk 50 feet with two turns and K, Walk 150 feet would then be coded.

   **Rationale:** The resident currently walks and admission performance codes are entered for each walking item.
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<td></td>
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<td><strong>Rationale:</strong> The helper provides trunk support as the resident walks more than 50 feet and makes two turns.</td>
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<tr>
<td>4.</td>
<td><strong>Walk 50 feet with two turns:</strong> Mr. T walks 50 feet with the therapist providing trunk support and the therapy assistant providing supervision. Mr. T walks the 50 feet with two turns.</td>
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<td><strong>Coding:</strong> GG0170J would be coded 01, Dependent. <strong>Rationale:</strong> Mr. T requires two helpers to complete the activity.</td>
</tr>
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<td>5.</td>
<td><strong>Walk 50 feet with two turns:</strong> Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides more than half of the effort for about 30 to 35 feet.</td>
<td></td>
<td><strong>Rationale:</strong> Mr. T requires two helpers to complete the activity.</td>
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<tr>
<td>3</td>
<td>GG0170</td>
<td>GG-51</td>
<td>2. <strong>Walk 150 feet:</strong> Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance. <strong>Coding:</strong> GG0170K, Walk 150 feet, would be coded 88, Activity not attempted due to medical condition or safety concerns, and the resident’s ability to walk a shorter distance would be coded in item GG0170I. The resident did not complete the activity, and a helper cannot complete the activity for the resident.</td>
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<tr>
<td>3</td>
<td>GG0170</td>
<td>GG-51</td>
<td>3. <strong>Walk 150 feet:</strong> Mrs. T has an unsteady gait due to balance impairment. Mrs. T walks the length of the hallway using her quad cane in her right hand. The physical therapist supports her trunk, helping her to maintain her balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance. <strong>Coding:</strong> GG0170K would be coded 03, Partial/moderate assistance.</td>
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<td><strong>Rationale:</strong> The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.</td>
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<td>4.</td>
<td>Walk 150 feet: Mr. W, who has Parkinson’s disease, walks the length of the hallway using his rolling walker. The physical therapist provides trunk support and advances Mr. W’s right leg in longer strides with each step. The therapist occasionally prevents Mr. W from falling as he loses his balance during the activity. The therapist provides more than half the effort for the activity.</td>
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<td>Coding: GG0170K would be coded 02, Substantial/maximal assistance. <strong>Rationale:</strong> The helper provides more than half the effort for the resident to complete the activity walk 150 feet.</td>
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<tr>
<td>3</td>
<td>GG0170</td>
<td>GG-52–GG-54</td>
<td><strong>Example for GG0170L, Walking 10 feet on uneven surfaces</strong></td>
</tr>
<tr>
<td>1.</td>
<td>Walking 10 feet on uneven surfaces: Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During her SNF stay, a physical therapist takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the therapist’s weight-bearing assistance less than half the time during walking in order to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.</td>
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<td>Coding: GG0170L, Walking 10 feet on uneven surfaces, would be coded 03, Partial/moderate assistance. <strong>Rationale:</strong> Mrs. N requires a helper to provide weight-bearing assistance several times to prevent her from falling as she walks 10 feet on uneven surfaces. The helper contributes less than half the effort required for Mrs. N to walk 10 feet on uneven surfaces.</td>
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<td><strong>Example for GG0170M, 1 step (curb)</strong></td>
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<td>1.</td>
<td>1 step (curb): Mrs. Z has had a stroke; she must be able to step up and down one step to enter and exit her home. A physical therapist provides standby assistance as she uses her quad cane to support her balance in stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step.</td>
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</table>
**Coding**: GG0170M, 1 step (curb), would be coded 04, Supervision or touching assistance.

**Rationale**: A helper provides touching assistance as Mrs. Z completes the activity of stepping up and down one step.

**Example for GG0170N, 4 steps**

1. **4 steps**: Mr. J has lower body weakness, and a physical therapist provides steadying assistance when he ascends 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Mr. J holds the stair railing.

   **Coding**: GG0170N, 4 steps, would be coded 03, Partial/moderate assistance.

   **Rationale**: A helper provides touching assistance as Mr. J ascends 4 steps. The helper provides trunk support (more than touching assistance) when he descends the 4 steps.

**Example for GG0170O, 12 steps**

1. **12 steps**: Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y’s home has 12 stairs, with a railing, and she needs to use these stairs to enter and exit her home. Her physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.

   **Coding**: GG0170O, 12 steps, would be coded 03, Partial/moderate assistance.

   **Rationale**: The helper provides less than half the required effort in providing the necessary support for Ms. Y as she ascends and descends 12 stairs.

**Examples for GG0170P, Picking up object**
1. **Picking up object:** Mr. P has a neurologic condition that has resulted in balance problems. He wants to be as independent as possible. Mr. P lives with his wife and will soon be discharged from the SNF. He tends to drop objects and has been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind Mr. P of safety strategies when he bends to pick up objects from the floor, and she needs to steady him to prevent him from falling.

**Coding:** GG0170P, Picking up object, would be coded 04, Supervision or touching assistance.

**Rationale:** A helper is needed to provide verbal cues and touching or steadying assistance when Mr. P picks up an object because of his coordination issues.

- **Picking up object:** Ms. C has recently undergone a hip replacement. When she drops items she uses a long-handled reacher that she had been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket she requires a certified nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher.

**Coding:** GG0170P, Picking up object, would be coded 05, Setup or clean-up assistance.

**Rationale:** The helper provides set-up assistance so that Ms. C can use her long-handled reacher.

**Coding Tips for GG0170R and GG0170S, Wheelchair Items**

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair prior to admission. Use clinical judgment to determine whether a resident’s use of a wheelchair is for self-mobilization as a result of the resident’s medical condition or safety.

- Do not code wheelchair mobility if the resident uses a wheelchair only when transported between locations within the facility or for staff convenience (e.g., because the resident walks slowly). Only code wheelchair mobility based on an assessment of the resident’s ability to mobilize in the wheelchair.
If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.

Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are expected to use a wheelchair during their stay in the SNF, even if the resident is also expected to ambulate during the stay or by discharge.

The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments.

If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.

Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.

### Example for GG0170Q1, Does the resident use a wheelchair/scooter?

1. **Does the resident use a wheelchair/scooter?** On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD. Item GG0170Q1, Does the resident use a wheelchair/scooter? will be coded 1, Yes.

**Coding:** GG0170Q1, Does the resident use a wheelchair/scooter? would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the
type of wheelchair Mr. T uses for GG0170RR1 and RR2 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

**Rationale:** The resident currently uses a wheelchair. Coding all admission assessment wheelchair items the resident’s performance and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The therapy assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The therapy assistant backs up Mr. R’s wheelchair for him so that he may continue mobilizing/wheeling himself. Overall, Mr. R provides more than half of the effort.

**Coding:** GG0170R would be coded 03, Partial/moderate assistance.

**Rationale:** The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. R used a motorized wheelchair during the 3-day assessment period.

**Coding:** GG0170RR would be coded 2, Motorized.

**Rationale:** Mr. R used a motorized wheelchair during the 3-day assessment period.

5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The therapy assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.

**Coding:** GG0170R would be coded 04, Supervision or touching assistance.
6. **Indicate the type of wheelchair/scooter used:** In the above example Mr. V used a manual wheelchair during the 3-day assessment period.

   **Coding:** GG0170RR would be coded 1, Manual.

   **Rationale:** Mr. V used a manual wheelchair during the 3-day assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into her room and then turning into her bathroom.

**Coding Tips for GG0170R and GG0170S, Wheelchair Items**

- The intention of the wheelchair items is to assess the resident’s use of a wheelchair for self-mobilization at admission and discharge when appropriate. The clinician uses clinical judgment to determine if the resident’s use of a wheelchair is appropriate for self-mobilization due to the resident’s medical condition or safety.

- Do not code wheelchair mobility if the resident only uses a wheelchair when transported between locations within the facility. Only code wheelchair mobility based on an assessment of the resident’s ability to mobilize in the wheelchair.

- If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge items—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter—as 0, No. Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions.

- Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair during the
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<td>GG0170</td>
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<td>stay, even if the resident is anticipated to ambulate during the stay or by discharge.</td>
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<td>o The responses for gateway admission and discharge walking items (GG0170H1 and GG0170H3) and the gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the admission and discharge assessments.</td>
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**Discharge Goals: Coding Tips**

**Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.**

- For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident’s discharge goal(s) using the six-point scale. Use of “activity not attempted” codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.

- Licensed qualified clinicians can establish a resident’s discharge goal(s) at the time of admission based on the resident’s prior medical condition, Admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the profession’s practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident’s discharge plan. Goals should be established as part of the resident’s care plan.

- If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.
I0020: Indicate the resident’s primary medical condition category

**Item Rationale**

**Health-related Quality of Life**

- Disease processes can have a significant adverse effect on residents’ functional improvement.

**Planning for Care**

- This item identifies the primary medical condition category that resulted in the resident’s admission to the facility and that influences the resident’s functional outcomes.

**Steps for Assessment**

1. Review the documentation in the medical record to identify the resident’s primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
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<td>I-1–I-3</td>
<td><strong>Coding Instructions</strong></td>
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*Complete only if A0310B = 01*

- Enter the code that represents the primary medical condition that resulted in the resident’s admission. If codes 1–13 do not apply, use code 14, “Other Medical Condition,” and proceed to I0020A.

- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
  - **Code 01, Stroke**, if the resident’s primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
  
  - **Code 02, Non-Traumatic Brain Dysfunction**, if the resident’s primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer’s disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, anoxic brain damage.

  - **Code 03, Traumatic Brain Dysfunction**, if the resident’s primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

  - **Code 04, Non-Traumatic Spinal Cord Dysfunction**, if the resident’s primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

  - **Code 05, Traumatic Spinal Cord Dysfunction**, if the resident’s primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.

  - **Code 06, Progressive Neurological Conditions**, if the resident’s primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson’s disease.
<table>
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<tr>
<th>Code</th>
<th>Other Neurological Conditions, if the resident’s primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.</th>
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<tr>
<td>Code 08</td>
<td>Amputation, if the resident’s primary medical condition category is an amputation. An example is acquired absence of limb.</td>
</tr>
<tr>
<td>Code 09</td>
<td>Hip and Knee Replacement, if the resident’s primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.</td>
</tr>
<tr>
<td>Code 10</td>
<td>Fractures and Other Multiple Trauma, if the resident’s primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.</td>
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<tr>
<td>Code 11</td>
<td>Other Orthopedic Conditions, if the resident’s primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.</td>
</tr>
<tr>
<td>Code 12</td>
<td>Debility, Cardiorespiratory Conditions, if the resident’s primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.</td>
</tr>
<tr>
<td>Code 13</td>
<td>Medically Complex Conditions, if the resident’s primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.</td>
</tr>
<tr>
<td>Code 14</td>
<td>Other Medical Condition, if the resident’s primary medical condition category is not one of the listed categories. Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.</td>
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Examples of Primary Medical Condition

1. Ms. K is a 67-year-old female with a history of Alzheimer’s dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of
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</table>
| 3       | 10020   | I-1–I-14 | **Alzheimer’s dementia and diabetes, is documented in Ms. K’s history and physical by the admitting physician.**  
**Coding:** 10020 would be coded **01, Stroke.**  
**Rationale:** The physician’s history and physical documents the diagnosis stroke as the reason for Ms. K’s admission. |
| 2       |         |      | **Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E’s primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.**  
**Coding:** 10020 would be coded **10, Fractures and Other Multiple Trauma.**  
**Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E’s primary medical condition category is **10, Fractures and Other Multiple Trauma.** |
| 3       | 15100   | I-13 | **Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis. The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician’s discharge summary from the acute care hospital and are incorporated into Mrs. H’s medical record.**  
**Coding:** 10020 would be coded **13, Medically Complex Conditions.**  
**Rationale:** The physician’s discharge summary from the acute care hospital documents the need for IV antibiotics due to urosepsis as the reason for Mrs. H’s admission to the facility. |
| 3       |         |      | Page length changed due to revised content on pages I-1–I-3. |

**Item I5100 Quadriplegia**
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<td>- Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.</td>
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<td>- Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.</td>
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<td>- Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.</td>
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</table>
### 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.

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.

### 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...
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.

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### J2000: Prior Surgery

#### Item Rationale

**Health-related Quality of Life**

- A recent history of major surgery during the 100 days prior to admission can affect a resident’s recovery.

**Planning for Care**

- 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.

#### Steps for Assessment

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

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<td>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.</td>
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</table>

**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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<td>reports Mr. A has had no other surgeries since the time of his bowel resection.</td>
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<td><strong>Coding:</strong> J2000 would be coded <strong>0, No.</strong></td>
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<td><strong>Rationale:</strong> 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.</td>
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<td>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.</td>
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<td></td>
<td><strong>Coding:</strong> J2000 would be coded <strong>1, Yes.</strong></td>
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<tr>
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<td><strong>Rationale:</strong> 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.</td>
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<tr>
<td>3</td>
<td>K0510</td>
<td>K-11</td>
<td><strong>Coding Instructions for Column 1</strong></td>
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<td></td>
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<td></td>
<td>• CMS does not require completion of Column 1 for items K0510C and K0510D; however, some States continue to require its completion. It is important to know your State’s requirements for completing these items.</td>
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<td>• Check all nutritional approaches performed prior to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.</td>
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<td>• If the State does not require the completion of Column 1 for items K0510C and K0510D, use the standard “no information” code (a dash, “-”).</td>
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<tr>
<td>3</td>
<td>K0710</td>
<td>K-13</td>
<td><strong>Coding Instructions</strong></td>
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<td>• Select the best response:</td>
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<td>1. 25% or less</td>
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<td>2. 26% to 50%</td>
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<td>3. 51% or more</td>
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<td>• If the State does not require the completion of Column 1 for this item, use the standard “no information” code (a dash, “-”).</td>
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<td>3</td>
<td>K0710</td>
<td>K-14</td>
<td><strong>Coding Instructions</strong></td>
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<td>Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.</td>
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<td></td>
<td>• <strong>Code 1:</strong> 500 cc/day or less</td>
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<td></td>
<td>• <strong>Code 2:</strong> 501 cc/day or more</td>
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<td>• If the State does not require the completion of Column 1 for this item, use the standard “no information” code (a dash, “-”).</td>
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<td>M-1</td>
<td><strong>Intent:</strong> The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident’s risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.</td>
</tr>
<tr>
<td>3</td>
<td>M0100</td>
<td>M-1</td>
<td><strong>M0100: Determination of Pressure Ulcer/Injury Risk</strong></td>
</tr>
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<td>M0100</td>
<td>M-1–M-2</td>
<td><strong>Item Rationale</strong></td>
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**Health-related Quality of Life**

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development.
- The underlying health of a resident’s soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.
- Throughout this section, terminology referring to “healed” versus “unhealed” ulcers refers to whether or not the ulcer is “closed” versus “open.” When considering this, recognize that Stage 1, Suspected Deep Tissue Injury (sDTI), and unstageable pressure ulcers, although “closed,” (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered “healed.”
- Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin...
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<td>overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.</td>
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### DEFINITION

**HEALED PRESSURE ULCER**

Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.

### Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses’ notes, and pressure ulcer/injury risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

### Coding Instructions

*For this item, check all that apply:*

- **Check A if resident has a Stage 1 or greater pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device.** Review descriptions of pressure ulcers/injuries stages and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.

### DEFINITIONS

**PRESSURE ULCER/INJURY RISK FACTOR**

Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care.
and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; microclimate, under nutrition, malnutrition, and hydration deficits; and a healed ulcer.

**PRESSURE ULCER/INJURY RISK TOOLS**

Screening tools that are designed to help identify residents who might develop a pressure ulcer/injury. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©.

- **Check B if a formal assessment has been completed.** An example of an established pressure ulcer risk tool is the Braden Scale for Predicting Pressure Sore Risk©. Other tools may be used.

- **Check C if the resident’s risk for pressure ulcer/injury development is based on clinical assessment.** A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. Examples of risk factors include the following:
  - impaired/decreased mobility and decreased functional ability
  - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
  - drugs, such as steroids, that may affect wound healing;
  - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
  - resident refusal of some aspects of care and treatment;
  - cognitive impairment;
  - urinary and fecal incontinence;
  - under nutrition, malnutrition, and hydration deficits; and
  - healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.

- **Check Z if none of the above apply.**

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<td>M0150: Risk of Pressure Ulcers/Injuries</td>
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Steps for Assessment

4. Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer/injury.
5. If the medical record reveals that the resident currently has a Stage 1 or greater pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers/injuries.
6. Review formal risk assessment tools to determine the resident’s “risk score.”
7. Review the components of the clinical assessment conducted for evidence of pressure ulcer/injury risk.

Coding Instructions

- **Code 0, no:** if the resident is not at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.
- **Code 1, yes:** if the resident is at risk for developing pressure ulcers/injuries based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcer(s)/Injuries

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<td>Health-related Quality of Life</td>
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<td>• Pressure ulcers/injuries and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.</td>
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Planning for Care

- The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 [Pressure Injury Staging System](http://www.npuap.org/2007-pressure-injury-staging-system). |
- An existing pressure ulcer/injury identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
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<td>• For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.</td>
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<td>• Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.</td>
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<td>• The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.</td>
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</table>

### Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any skin ulcers/injuries are present.
   - Key areas for pressure ulcer/injury development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear, or friction, are also at risk for pressure ulcers/injuries.
   - Without a full body skin assessment, a pressure ulcer/injury can be missed.
   - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers/injuries identified, measure and record the deepest anatomical stage.
### Coding Instructions

*Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days.*

- **Code 0, no:** if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to item M1030, Number of Venous and Arterial Ulcers, Items M0300–M0800.

- **Code 1, yes:** if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage item (M0300).

### Coding Tips

- If an ulcer/injury arises from a combination of factors which are primarily caused by pressure, then the area ulcer should be included in this section as a pressure ulcer/injury.

- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue.

- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.

- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

- If a resident with DM has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, code 1 and proceed to code items in M0300–M0900 as appropriate for the pressure ulcer/injury.
• If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident’s ulcer when the ulcer is in this location.

• Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

• If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900).

• If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.

• If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do not code the ulcer/injury on the assessment, but there was no documented pressure ulcer on the prior assessment, code 0.

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<td>M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</td>
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**Steps for completing M0300A–G**

**Step 1: Determine Deepest Anatomical Stage**

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.
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<td>5. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.</td>
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<td>6. Ulcer staging should be based on the ulcer’s deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer’s tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.</td>
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<td>7. Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.</td>
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<td>8. Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or backstaging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing</td>
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**DEFINITIONS**

**EPITHELIAL TISSUE**
New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

**GRANULATION TISSUE**
Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured.
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<td>homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.</td>
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**Step 2: Identify Unstageable Pressure Ulcers**

1. Visualization of the wound bed is necessary for accurate staging.

2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer’s/injury’s anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.

3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at [http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg](http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg).

4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.

5. A pressure injury ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure injury ulcer. It should be coded as unstageable, as illustrated at [http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg](http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg).

6. Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. “Known” refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

**Step 3: Determine “Present on Admission”**

*For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry*
and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

1. Review the medical record for the history of the ulcer/injury.
2. Review for location and stage at the time of admission/entry or reentry.
3. If the pressure ulcer/injury was present on admission/entry or reentry and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage should not be considered as “present on admission.”
4. If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and should not be coded as “present on admission.”
5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, but then becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should not be considered coded as “present on admission.”
6. If a resident who has a pressure ulcer/injury that was originally acquired in the facility is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury should not be coded as “present on admission” because it was present and acquired at the facility prior to the hospitalization.
7. If a resident who has a pressure ulcer/injury that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.
8. If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable as a result of due to slough or eschar during the hospitalization, it should be coded as “present on admission” at that higher stage upon reentry.
9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as not present on admission.
10. If two pressure ulcers merge, that were both “present on admission,” continue to code the merged pressure ulcer as “present on admission.” Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not “present on admission.”

Examples

1. Ms. K is admitted to the facility without a pressure ulcer/injury. During the stay, she develops a stage 2 pressure ulcer. This is a facility acquired pressure ulcer and was not “present on admission.” Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was originally acquired in the nursing home and should not be considered as “present on admission” when she returns from the hospital.

2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as “present on admission” as it was not acquired in the facility. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is still considered “present on admission” because it was originally acquired outside the facility and has not changed.

M0300A: Number of Stage 1 Pressure Injuries/Ulcers

Item Rationale
Health-related Quality of Care

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure ulcer should be one of multiple factors that initiate pressure ulcer prevention interventions.

DEFINITIONS

STAGE 1 PRESSURE INJURY ULCER
An observable, pressure-related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury ulcer may appear with persistent red, blue, or purple hues.

NON-BLANCHABLE
Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue injuries (see definition of suspected “deep tissue injury” on page M-24). The descriptors are similar for these two types of injuries (e.g., temperature [warmth or coolness]; tissue consistency [firm or boggy]).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing.
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<tr>
<td>3</td>
<td>M0300B</td>
<td>M-12</td>
<td>it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site. 5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes as well as surrounding tissue that may be painful, firm, or soft.</td>
</tr>
</tbody>
</table>

**Coding Instructions for M0300A**

- **Enter the number** of Stage 1 pressure injuries ulcers that are currently present.
- **Enter 0** if no Stage 1 pressure injuries ulcers are currently present.

<table>
<thead>
<tr>
<th>3</th>
<th>M0300B</th>
<th>M-12</th>
<th><strong>M0300B: Stage 2 Pressure Ulcers</strong></th>
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<tbody>
<tr>
<td>3</td>
<td>M0300B</td>
<td>M-12</td>
<td><strong>DEFINITION</strong></td>
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<tr>
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<td><strong>STAGE 2 PRESSURE ULCER</strong></td>
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<td></td>
<td>Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or <strong>bruising</strong>. May also present as an intact or open/ ruptured blister.</td>
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<thead>
<tr>
<th>3</th>
<th>M0300B</th>
<th>M-13</th>
<th><strong>Steps for Assessment</strong></th>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).</td>
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<td></td>
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<td>2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.</td>
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<td>3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a suspected deep</td>
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<td>tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.</td>
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<td>4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.</td>
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<td>5. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see instructions on page M-8).</td>
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<td>6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.</td>
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<td>3</td>
<td>M0300B</td>
<td>M-13</td>
<td><strong>M0300B3</strong></td>
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<td></td>
<td>- Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e. the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a “0.” For example, January 2, 2012, should be entered as 01-02-2012.</td>
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<td></td>
<td><strong>Coding Tips</strong></td>
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<td></td>
<td>- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.</td>
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<td></td>
<td>- Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.</td>
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<td></td>
<td></td>
<td></td>
<td>- If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.</td>
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<tr>
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<td></td>
<td>- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here.</td>
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<td></td>
<td>- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.</td>
</tr>
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<td>3</td>
<td>M0300C</td>
<td>M-14</td>
<td><strong>Planning for Care</strong></td>
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<td>- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.</td>
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<td>- An existing pressure ulcer may put residents at risk for further complications or skin injury.</td>
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</table>
If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed.

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

**DEFINITION**

**STAGE 3 PRESSURE ULCER**

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-18).

<table>
<thead>
<tr>
<th>Example</th>
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<tbody>
<tr>
<td>1. A pressure ulcer described as a Stage 2 was noted and documented in the resident’s medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.</td>
</tr>
</tbody>
</table>

**Coding:** The current Stage 3 pressure ulcer would be coded at item M0300C1 as 1, and at item M0300C2 as 0, not present on admission/entry or reentry.

**Rationale:** The designation of “present on admission” requires that the pressure ulcer be at the same location and not have increased in numerical stage or become unstageable due to slough or eschar. This pressure ulcer worsened from a Stage 2 to a Stage 3 after admission. Item M0300C1 is coded as 1 and item M0300C2 is coded as 0 on the current assessment because the ulcer was not a Stage 3 pressure ulcer on admission. This pressure ulcer would also be coded in M0800B as worsened.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.
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<td><strong>Coding:</strong> The pressure ulcer would be coded at item M0300C1 as Code 1, and at item M0300C2 as 1, present on admission/entry or reentry. <strong>Rationale:</strong> Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.</td>
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<tr>
<td>3.</td>
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<td>On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer. <strong>Coding:</strong> The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry. <strong>Rationale:</strong> Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; therefore, M0300B1 and M0300B2 would be coded as 1; the pressure ulcer that increased in numerical stage to a Stage 3 is coded in M0300C1 as 1 and in M0300C2 as 0, not present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry and developed a deeper level of tissue damage in the time since admission.</td>
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<td>4.</td>
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<td>A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed. <strong>Coding:</strong> The Stage 2 pressure ulcer would be coded at item M0300B1 as 1, and at item M0300B2 as 0, not present on admission/entry or reentry; the Stage 3 pressure ulcer would be coded at item M0300C1</td>
</tr>
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</table>
as 1, and at item M0300C2 as 1, present on admission/entry or reentry.

**Rationale:** The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in item M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here, but in item M0900, Healed Pressure Ulcers.

5. A resident is admitted to a nursing facility with a short leg cast to the right lower extremity. He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast. Two weeks after admission to the nursing facility, the cast is removed by the physician. At that time, it is determined that the resident has a Stage 3 pressure ulcer on his right heel from the cast, which remains until the subsequent assessment.

**Coding:** Code M0300C1 as 1, and M0300C2 as 1, present on admission/entry or reentry.

**Rationale:** The resident was admitted with a documented unstageable pressure ulcer/injury due to non-removable dressing/device. The cast was removed, and a Stage 3 pressure ulcer was assessed. Because this is the first time the ulcer has been numerically staged, this stage will be coded as present on admission/entry or reentry.

6. Mrs. P was admitted to the nursing facility with a blood-filled blister on the right heel. After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI. Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside. After debridement, the right heel is staged as a Stage 3 pressure ulcer. On the subsequent assessment, the right heel remains at Stage 3.

**Coding:** Code M0300C1 as 1, and M0300C2 as 1, present on admission/entry or reentry.

**Rationale:** This resident was admitted with an unstageable DTI that subsequently was debrided and could be numerically staged. The first numerical stage was 3, and it remained a Stage 3 for the subsequent assessment; therefore it is coded as present on admission/entry or reentry.
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<td>7.</td>
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<td>Mr. H was admitted with a known pressure ulcer/injury due to a non-removable dressing. Ten days after admission, the surgeon removed the dressing, and a Stage 2 pressure ulcer was identified. Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3. It remained Stage 3 at the time of the next assessment. <strong>Coding:</strong> Code M0300C1 as 1, and M0300C2 as 0, not present on admission/entry reentry. <strong>Rationale:</strong> This resident was admitted with an unstageable pressure ulcer due to non-removable dressing or device. The dressing was removed to reveal a Stage 2 pressure ulcer, and this is the first numerical stage. Subsequent to this first stage, the ulcer worsened to Stage 3 and therefore is not coded as present on admission/entry or reentry.</td>
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<tr>
<td>3</td>
<td>M0300D</td>
<td>M-17</td>
<td>M0300D: Stage 4 Pressure Ulcers</td>
</tr>
<tr>
<td>3</td>
<td>M0300D</td>
<td>M-19</td>
<td>Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS, but should be assessed, monitored, and treated as part of the comprehensive care plan.</td>
</tr>
<tr>
<td>3</td>
<td>M0300E</td>
<td>M-19–M-20</td>
<td>M0300E: Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device</td>
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<td><strong>Item Rationale</strong></td>
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<td><strong>Health-related Quality of Life</strong></td>
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<td>• Although the wound bed cannot be visualized, and hence the pressure ulcer/injury cannot be staged, the pressure ulcer/injury may affect quality of life for residents because it may limit activity and may be painful.</td>
</tr>
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</table>
### Planning for Care

- Although the pressure ulcer/injury itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

### Steps for Assessment

**Documentation of an existing pressure ulcer/injury is needed to complete this item.**

1. Review the medical record for documentation of a pressure ulcer/injury covered by a non-removable dressing/device.
2. Determine the number of documented unstageable pressure ulcers/injuries related to covered by a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing or an orthopedic device that is not to be removed per physician’s order, an orthopedic device, or a cast.
3. Identify the number of these pressure ulcers/injuries that were present on admission/entry or reentry (see page M-8 for assessment process).

### Coding Instructions for M0300E

**M0300E1**

- **Enter the number** of pressure ulcers/injuries that are unstageable related to non-removable dressing/device.

- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar.

**M0300E2**

- **Enter the number** of these unstageable pressure ulcers/injuries related to a non-removable dressing/device that were first noted at the time of admission/entry AND— for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer/injury related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).
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<td><strong>Enter 0</strong> if no unstageable pressure ulcers/injuries related to non-removable dressing/device were first noted at the time of admission/entry or reentry.</td>
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<tr>
<td>3</td>
<td>M0300F</td>
<td>M-20</td>
<td>2. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-8 for assessment process).</td>
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<td></td>
<td><strong>Coding Tips</strong></td>
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<td>• Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.</td>
</tr>
<tr>
<td>3</td>
<td>M0300F</td>
<td>M-21</td>
<td><strong>Examples</strong></td>
</tr>
</tbody>
</table>
|         |              |        | 1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.  
**Coding:** The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.  
**Rationale:** The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission. |
|         |              |        | 2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.  
**Coding:** The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.  
**Rationale:** After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers... |
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<td>for this resident, the pressure ulcer’s dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar.</td>
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<tr>
<td>3.</td>
<td>Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.</td>
<td></td>
<td>Coding: Code at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.</td>
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</table>

| 4.      | Mr. M. was admitted to the nursing facility with eschar tissue covering both the right and left heels, as well as a Stage 2 pressure ulcer on the coccyx. Mr. M’s pressure ulcers were reassessed before the subsequent assessment, and the Stage 2 coccyx pressure ulcer had healed. The left-heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer. The right-heel eschar remained stable and dry (i.e., remained unstageable). | | Coding: Code M0300D1 as 1, and M0300D2 as 1, present on admission/entry or reentry. Code M0300F1 as 1, and M0300F2 as 1, present on admission/entry or reentry. Rationale: Mr. M was admitted with an unstageable pressure injuries due to slough/eschar on each heel. One of the heels was subsequently debrided, and the first numerical stage was Stage 4; thus this is coded as present on admission/entry or reentry. The other heel eschar remained unstageable, and is coded as present on admission/entry or reentry. |
M0300G: Unstageable Pressure Injuries Ulcers Related to Suspected Deep Tissue Injury

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident’s ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of suspected deep tissue injury (sDTI) is imperative.

DEFINITION

SUSPECTED DEEP TISSUE INJURY
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Planning for Care

- Suspected deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here.
3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister does not show signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do not code as a suspected deep tissue injury.

4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.

5. Determine the number of pressure injuries ulcers that are unstageable related to suspected deep tissue injury.

6. Identify the number of these pressure injuries ulcers that were present on admission/entry or reentry (see page M-8 for instructions).

7. Clearly document assessment findings in the resident’s medical record, and track and document appropriate wound care planning and management.

**Coding Instructions for M0300G**

**M0300G1**

- **Enter the number** of unstageable pressure injuries ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.

- **Enter 0** if no unstageable pressure injuries ulcers related to suspected deep tissue injury are present and skip to item M1030, Number of Venous and Arterial Ulcers.

**M0300G2**

- **Enter the number** of these unstageable pressure injuries ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure injury ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).

- **Enter 0** if no unstageable pressure injuries ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or reentry.
### Coding Tips

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here (see definition of Stage 2 pressure ulcer on page M-12).

### M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar

**Item Rationale**

**Health-related Quality of Life**

- Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.

**Planning for Care**

- Evaluating the dimensions of the pressure ulcer is one aspect of the process of monitoring response to treatment.
- Pressure ulcer measurement findings are used to plan interventions that will best prepare the wound bed for healing.

**Steps for Assessment**

*If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, identify the pressure ulcer with the largest surface area.*
(length × width) and record in centimeters. Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1. The Figure (right) illustrates the measurement process.

1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar after the dressing and any exudate are removed.

2. Use a disposable measuring device or a cotton-tipped applicator.

3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar.

4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.

5. Using a similar approach, measure the longest width (perpendicular to the length forming a “+” side to side).

6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest. Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length × width) of each.

7. Considering only the largest Stage 3 or 4 pressure ulcer or pressure ulcer that is unstageable due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.

8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as
two separate pressure ulcers. Stage and measure each pressure ulcer separately.

**Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar**

- **Enter the current longest length** of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- **Enter the widest width** in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.
- **Enter the depth** measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

**Coding Tips**

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.

**M0700: Most Severe Tissue Type for Any Pressure Ulcer**

<table>
<thead>
<tr>
<th>M0700: Most Severe Tissue Type for Any Pressure Ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select the best description of the most severe type of tissue present in any pressure ulcer bed.</td>
</tr>
<tr>
<td>1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.</td>
</tr>
<tr>
<td>2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance.</td>
</tr>
<tr>
<td>3. Slough - yellow or white tissue that adheres to the ulcer bed in stringy or thick clumps, or is mucinous.</td>
</tr>
<tr>
<td>4. Eschar - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.</td>
</tr>
<tr>
<td>5. None of the Above.</td>
</tr>
</tbody>
</table>
**Health-related Quality of Life**

- The presence of a pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Identify tissue type.

**Planning for Care**

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

**Definitions**

**Epithelial Tissue**

New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

**Granulation Tissue**

Red tissue with “cobblestone” or bumpy appearance, bleeds easily when injured.

**Slough Tissue**

Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

**Eschar**

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Eschar is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

**Steps for Assessment**

1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).

**Coding Instructions for M0700**
- **Code 1, Epithelial tissue**: if the wound is superficial and is re-epithelializing.
- **Code 2, Granulation tissue**: if the wound is clean (e.g., free of slough and eschar tissue) and contains granulation tissue.
- **Code 3, Slough**: if there is any amount of slough tissue present and eschar tissue is absent.
- **Code 4, Eschar**: if there is any eschar tissue present.
- **Code 9, None of the above**: if none of the above apply.

## Coding Tips and Special Populations
- Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough or eschar tissue and should be **coded as 1 for this item**.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar and slough) is present, code for eschar.
- Code this item with **Code 9, None of the above**, in the following situations:
  - Stage 1 pressure ulcer
  - Stage 2 pressure ulcer with intact blister
  - Unstageable pressure ulcer related to non-removable dressing/device
  - Unstageable pressure ulcer related to suspected deep-tissue injury

Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.

## Examples
1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

**Coding**: Code **M0700 as 2, Granulation tissue**.
Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.

2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

Coding: Code M0700 as 1, Epithelial tissue.
Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.

3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

Coding: Code M0700 as 4, Eschar.
Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, Eschar.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry

Item Rationale

Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have increased in numerical stage (worsened) since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

Planning for Care

- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure...
### Track Changes
from Chapter 3 Section M v1.15
to Chapter 3 Section M v1.16

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<td>ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.</td>
</tr>
</tbody>
</table>

### DEFINITION

**Worsening in Pressure Ulcer Status**

Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

### Steps for Assessment

*Look-back period for this item is back to the ARD of the prior assessment. If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.*

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS assessment was completed.

### Coding Instructions for M0800

- **Enter the number** of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.
- **Code 0:** if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.

### Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
Specific guidance regarding coding worsening of pressure ulcers:

- If an unstageable pressure ulcer that was present on admission/entry or reentry is subsequently able to be numerically staged, do not consider it to be worsened because this would be the first time that the pressure ulcer was able to be numerically staged. However, if subsequent to this numerical staging, the pressure ulcer further deteriorates and increases in numerical stage, the ulcer would be considered worsened.

- If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.

- If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer’s current numerical stage has increased, consider this pressure ulcer as worsened.

- If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.

- If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item.

- If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident’s overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a
subsequent MDS assessment, it would be considered as worsened and would be coded in this item.

**Examples**

1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage to a Stage 3 pressure ulcer.

   **Coding:** Code M0800A as 0, M0800B as 1, and M0800C as 0.

   **Rationale:** The pressure ulcer was at a lesser numerical stage on the prior assessment.

2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.

   **Coding:** Code M0800A as 0, M0800B as 0, and M0800C as 0.

   **Rationale:** The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it numerically staged as a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.

3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a new Stage 2 pressure ulcer on the left trochanter.

   **Coding:** Code M0800A as 1, M0800B as 1, and M0800C as 1.

   **Rationale:** M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging of both the sacrum and right heel pressure ulcers.

4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the
pressure ulcer is reassessed and determined to still be a Stage 3 pressure ulcer.

**Coding:** Code M0800A as 0, M0800B as 0, and M0800C as 0.

**Rationale:** M0800B would be coded 0 because the numerical stage of the pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.

**M0900: Healed Pressure Ulcers**

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<tr>
<th>M0900: Healed Pressure Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item Rationale</td>
</tr>
<tr>
<td><strong>Health-related Quality of Life</strong></td>
</tr>
<tr>
<td>Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.</td>
</tr>
<tr>
<td><strong>DEFINITION</strong></td>
</tr>
<tr>
<td><strong>HEALED PRESSURE ULCER</strong></td>
</tr>
<tr>
<td>Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.</td>
</tr>
<tr>
<td><strong>Planning for Care</strong></td>
</tr>
<tr>
<td>Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.</td>
</tr>
<tr>
<td>Most Stage 2 pressure ulcers should heal within a reasonable timeframe (e.g., 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.</td>
</tr>
<tr>
<td>Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not</td>
</tr>
</tbody>
</table>
accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

Steps for Assessment

Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have healed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each healed pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

Coding Instructions for M0900A

Complete on all residents (even if M0210 = 0)

- **Enter 0:** if there were no pressure ulcers on the prior assessment and skip to Number of Venous and Arterial Ulcers item (M1030).
- **Enter 1:** if there were pressure ulcers noted on the prior assessment.
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<tr>
<td></td>
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<td></td>
<td><strong>Coding Instructions for M0900B, C, and D</strong></td>
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<tr>
<td></td>
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<td></td>
<td>• <strong>Enter the number</strong> of pressure ulcers that have healed since the last assessment, for each Stage, 2 through 4.</td>
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<td></td>
<td>• <strong>Enter 0:</strong> if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.</td>
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<td></td>
<td><strong>Coding Tips</strong></td>
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<td></td>
<td>• Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.</td>
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<td>• If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do not consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.</td>
</tr>
<tr>
<td>3</td>
<td>M1030</td>
<td>M-27</td>
<td><strong>Coding Instructions</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td><em>Check all that apply in the last 7 days.</em></td>
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<td><em>Pressure ulcers coded in M0210 through M03990 should not be coded here.</em></td>
</tr>
<tr>
<td>3</td>
<td>M1040</td>
<td>M-29</td>
<td><strong>Coding Instructions</strong></td>
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<tr>
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<td></td>
<td><em>Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.</em></td>
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<tr>
<td></td>
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<td></td>
<td><em>Pressure ulcers/injuries coded in items M0200 through M03990 should not be coded here.</em></td>
</tr>
<tr>
<td>3</td>
<td>M1040</td>
<td>M-29</td>
<td><strong>DEFINITIONS</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>DIABETIC FOOT ULCERS</strong></td>
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<td>Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.</td>
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<td><strong>SURGICAL WOUNDS</strong></td>
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<tr>
<td>3</td>
<td>M1040B</td>
<td>M-30</td>
<td>Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.</td>
</tr>
<tr>
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<td><strong>OPEN LESION OTHER THAN ULCERS, RASHES, CUTS</strong></td>
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<tr>
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<td>Most typically skin lesions, ulcers that develop as a result of diseases and conditions such as syphilis and cancer.</td>
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<td><strong>BURNS (SECOND OR THIRD DEGREE)</strong></td>
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<td>Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.</td>
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<td></td>
<td>M1040D</td>
<td>M-30</td>
<td><strong>Coding Tips</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>M1040B Diabetic Foot Ulcers</strong></td>
</tr>
<tr>
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<td></td>
<td>• Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.</td>
</tr>
<tr>
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<td></td>
<td>• Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.</td>
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<tr>
<td></td>
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<td></td>
<td>• Do <strong>not</strong> include pressure ulcers/injuries that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.</td>
</tr>
<tr>
<td>3</td>
<td>M1040D</td>
<td>M-30</td>
<td><strong>M1040D Open Lesion Other than Ulcers, Rashes, Cuts</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Do <strong>not</strong> code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Do <strong>not</strong> code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.</td>
</tr>
</tbody>
</table>
### M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

- Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.

### M1040H Moisture Associated Skin Damage (MASD)

DEFINITION

**Moisture Associated Skin Damage**

Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as maceration and includes incontinence-associated dermatitis, and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.

- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.

- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges.
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<tr>
<td></td>
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<td></td>
<td>Inflammation of the skin may also be present. Necrosis is not found in MASD.</td>
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<td></td>
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<td></td>
<td>• If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.</td>
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<tr>
<td></td>
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<td></td>
<td>• If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.</td>
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<td></td>
<td><strong>Examples</strong></td>
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<td></td>
<td>1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.</td>
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<td></td>
<td><strong>Coding:</strong> This ulcer is <em>not checked at M1040B</em>. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210–M0300).</td>
</tr>
<tr>
<td>3</td>
<td>M1200</td>
<td>M-33</td>
<td><strong>M1200: Skin and Ulcer/Injury Treatments</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Planning for Care</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.</td>
</tr>
<tr>
<td>3</td>
<td>M1200</td>
<td>M-34</td>
<td><strong>M1200</strong> <strong>E,</strong> Pressure ulcer/injury care</td>
</tr>
<tr>
<td>3</td>
<td>M1200A/ M1200B</td>
<td>M-35</td>
<td><strong>Coding Tips</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>M1200A/M1200B Pressure Reducing Devices</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure reducing (redistribution) device should be selected based on the individualized needs of the resident.</td>
</tr>
</tbody>
</table>
### M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers/injuries. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, that is, i.e. adding additional protein, calories, or nutrients, is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and “tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed.” (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer/injury management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

### M1200E Pressure Ulcer/Injury Care

- Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (Items M0300A–G). Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

### M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do not code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M1200E, Pressure Ulcer/Injury Care.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the
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<td>MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.</td>
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<td>• This category may include but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND- AID® bandages, wound closure strips).</td>
</tr>
<tr>
<td>3</td>
<td>M1200H</td>
<td>M-37</td>
<td><strong>M1200H Application of Ointments/Medications Other than to Feet</strong></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Do <strong>not</strong> code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure Ulcer/Injury Care.</td>
</tr>
<tr>
<td>3</td>
<td>M1200I</td>
<td>M-37</td>
<td><strong>M1200I Application of Dressings to the Feet (with or without Topical Medications)</strong></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Includes interventions to treat any foot wound or ulcer other than a pressure ulcer/injury.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Do <strong>not</strong> code application of dressings to pressure ulcers/injuries on the foot; use M1200E, Pressure Ulcer/Injury Care.</td>
</tr>
<tr>
<td>3</td>
<td>M1200</td>
<td>M-38</td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td></td>
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<td>1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing (redistribution) pad on the resident’s wheelchair. The medical record documents delivery of care and notes that the resident is on a two-hour turning/repositioning program that is organized, planned, documented, monitored, and evaluated based on an individualized assessment of her needs. The physician documents that after reviewing the resident’s nutritional intake, healing progress of the resident’s pressure ulcer, dietician’s nutritional assessment, and laboratory results, that the resident has protein-calorie under malnutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients, and</td>
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micronutrients. All mattresses in the nursing home are pressure reducing (redistribution) mattresses.

**Coding:** Check items M1200A, M1200B, M1200C, M1200D, and M1200E.

**Rationale:** Interventions include pressure reducing (redistribution) pad on the wheelchair (M1200A) and pressure reducing (redistribution) mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the past last 7 days the resident has had a three-layer compression-bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure reducing redistributing mattress and pad for the wheelchair.

**Coding:** Check items M1200A, M1200B, and M1200G.

**Rationale:** Treatments include pressure reducing (redistribution) mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression-bandaging system (M1200G).

---

**Example M0300, M0610, M0700 and M0800**

1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S’ quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.

**Admission Assessment:**

**Coding:**

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>- <strong>M0300B3</strong> (Date of the oldest Stage 2 pressure ulcer), code with dashes. <strong>Rationale:</strong> The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.</td>
</tr>
</tbody>
</table>

**Quarterly Assessment #1:**

**Coding:**

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present upon admission/entry or reentry), Code 1.
- **M0300B3** (Date of the oldest Stage 2 pressure ulcer), code with dashes. **Rationale:** On the quarterly assessment the Stage 2 pressure ulcer is still present and date was unknown. Therefore, **M0300B3** is still coded with dashes. |

**Quarterly Assessment #2:**

**Coding:**

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 0 and skip to **M0300C**, Stage 3 pressure ulcers.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 1.
- **M0300C2** (Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry). Code 0.
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<tbody>
<tr>
<td>M0300D1, M0300E1, M0300F1, and M0300G1</td>
<td>Code 0’s and proceed to code M0610 (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M0610A (Pressure ulcer length), Code 03.0, M0610B (Pressure ulcer width), Code 02.4, M0610C (Pressure ulcer depth) Code 00.2.</td>
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<tr>
<td>M0700 (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.</td>
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</tr>
<tr>
<td>M0800 (Worsening in pressure ulcer status since prior assessment—(OBRA or scheduled PPS or Last Admission/Entry or Reentry)—M0800A (Stage 2) Code 0, M0800B (Stage 3) Code 1, M0800C (Stage 4) Code 0.</td>
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**Rationale:**
- M0300B1 is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to M0300C (Stage 3 pressure ulcer).
- M0300C1 is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.
- M0300C2 is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.
- M0300D1, M0300E1, M0300F1, and M0300G1 are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code M0610 with the dimensions of the Stage 3 ulcer.
- M0610A is coded, 03.0 for length, M0610B is coded 02.4 for width, and M0610C is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.
- M0700 is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.
- M0800A is coded as 0, M0800B is coded as 1, and M0800C is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.
### M0306. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Number of Stage 1 Pressure Ulcers</strong>&lt;br&gt;Stage 1: Intact skin with no distinguishable defect of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blistering in dark skin tones only it may appear with persistent blue or purple hues</td>
</tr>
<tr>
<td>2</td>
<td><strong>Number of Stage 2 Pressure Ulcers</strong>&lt;br&gt;Stage 2: Partial-thickness skin damage present as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/tunneled blister</td>
</tr>
<tr>
<td>3</td>
<td><strong>Number of Stage 3 Pressure Ulcers</strong>&lt;br&gt;Stage 3: Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</td>
</tr>
<tr>
<td>4</td>
<td><strong>Number of Stage 4 Pressure Ulcers</strong>&lt;br&gt;Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</td>
</tr>
</tbody>
</table>

### M0308. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued

#### E. Unstageable - Non-removable dressing

- **Number of unstageable pressure ulcers due to non-removable dressing/device**: If 0 → Skip to M0309G. Unstageable - Slough and/or eschar
- **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry**: Enter how many were noted at the time of admission/entry or reentry

#### F. Unstageable - Slough and/or eschar

- **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**: If 0 → Skip to M0309G. Unstageable - Deep Tissue
- **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry**: Enter how many were noted at the time of admission/entry or reentry

#### G. Unstageable - Deep Tissue

- **Number of unstageable pressure ulcers with suspected deep tissue injury**: If 0 → Skip to M0610. Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
- **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry**: Enter how many were noted at the time of admission/entry or reentry

### M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete if M0904C, M0004D1 or M0908F is greater than 0

- **A. Pressure ulcer length**: Longest length from head to toe
- **B. Pressure ulcer width**: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
- **C. Pressure ulcer depth**: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

### M0709. Most Severe Tissue Type for Any Pressure Ulcer

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with deep red, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strips or thick, dry clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin
5. **None of the Above

### MORB. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Sched LPFS) or Last Admission/Entry or Reentry

Complete only if ADI OIE = 0

- **A. Stage 2**: Enter number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled LPFS) or last admission/entry. If no current pressure ulcer at a given stage, enter 0.
### Example M0100-M1200

1. Mrs. P was admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P also has pressure reducing redistribution devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/2010. Upon reentry the 5-day PPS ARD was set at 11/19/2010. In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx, however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth. It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.

#### 5-Day PPS #1:

**Coding:**

- **M0100B** (Formal assessment instrument), Check box.
- **M0100C** (Clinical assessment), Check box.
- **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
- **M0210** (One or more unhealed pressure ulcers/injuries(s) at Stage 1 or higher), Code 0 and skip to item **M1030** (Number of Venous and Arterial Ulcers), **M0900** (Healed pressure ulcers).
- **M0900** (Healed pressure ulcers). Skip to **M1030** since this item is only completed if **A0310E=0**. The 5-Day PPS Assessment is the first assessment since the most
Recent admission/entry or reentry, therefore, **A0310E=1**.

- **M1030** (Number of Venous and Arterial Ulcers), Code 0.
- **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
- **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).

**Rationale:** The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident’s skin was noted to be intact, therefore, item M0210 was coded 0. **M0900** was skipped because the 5-Day PPS is the first assessment. M1030 was coded 0 due to the resident not having any of these conditions. Item M1040Z was checked since none of these problems were noted. Item M1200Z was checked because none of these treatments were provided.

### 14-Day PPS:

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<td>recent admission/entry or reentry, therefore, <strong>A0310E=1</strong>.</td>
</tr>
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<td></td>
<td><strong>M1030</strong> (Number of Venous and Arterial Ulcers), Code 0.</td>
</tr>
<tr>
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<td></td>
<td></td>
<td><strong>M1040</strong> (Other ulcers, wounds and skin problems), Check Z (None of the above).</td>
</tr>
<tr>
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<td></td>
<td></td>
<td><strong>M1200</strong> (Skin and Ulcer Treatments), Check Z (None of the above were provided).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Rationale:</strong> The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident’s skin was noted to be intact, therefore, item M0210 was coded 0. <strong>M0900</strong> was skipped because the 5-Day PPS is the first assessment. M1030 was coded 0 due to the resident not having any of these conditions. Item M1040Z was checked since none of these problems were noted. Item M1200Z was checked because none of these treatments were provided.</td>
</tr>
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</table>
• **M0100A** (Resident has a **pressure ulcer/injury** Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device), Check box.
• **M0100B** (Formal assessment instrument), Check box.
• **M0100C** (Clinical assessment), Check box.
• **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
• **M0210** (One or more unhealed pressure ulcers/injuries at Stage 1 or higher), Code 1.
• **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
• **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
• **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
• **M0300B3** (Date of the oldest Stage 2 pressure ulcer), Enter 11 01 2010.
• **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to item M0300D (Stage 4).
• **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to item M0300E (Unstageable dressing/device).
• **M0300E1** (Unstageable dressing/device), Code 0 and skip to item M0300F (Unstageable slough and/or eschar).
• **M0300F1** (Unstageable slough and/or Eschar), Code 0 and skip to item M0300G (Unstageable deep tissue injury).
• **M0300G1** (Unstageable deep tissue injury), Code 0 and skip to item M1030 (Number of Venous and Arterial Ulcers). M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar).
• **M0610** (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is not completed, as the resident has a Stage 2 pressure ulcer.
• **M0700** (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).
• **M0800** (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), **M0800A**, Code 1; **M0800B**, Code 0; **M0800C**, Code 0. This item is completed because the 14-Day PPS is not the first assessment since the most recent admission/entry or
reentry. Therefore, \( A0310E=0 \). \( M0800A \) is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.

- \( M0900A \) (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is not the first assessment since the most recent admission/entry or reentry. Therefore \( A0310E=0 \). Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to \( M1030 \).

- \( M1030 \) (Number of Venous and Arterial Ulcers), Code 0.

- \( M1040 \) (Other Ulcers, Wounds and Skin Problems), Check Z (None of the above).

- \( M1200A \) (Pressure reducing device for chair), \( M1200B \) (Pressure reducing device for bed), \( M1200C \) (Turning/repositioning program), and \( M1200E \) (Pressure ulcer/injury care) are all checked.

**Rationale:** The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-Day PPS assessment, the resident’s skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14–Day PPS completed, the 14-day PPS would be coded 0 at \( A0310E \). This is because the 14–Day PPS is not the first assessment since the most recent admission/entry or reentry. Since \( A0310E=0 \), items \( M0800 \) (Worsening in pressure ulcer status) and \( M0900 \) (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under \( M0800 \) (Worsening in pressure ulcer status). \( M0900 \) (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However, the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has had preventative measures put in place, with pressure reducing redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items \( M1200A \), \( M1200B \), and \( M1200C \) were all checked.
She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings [with or without topical medications]) would not be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).

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**M0100. Determination of Pressure Ulcer/Injury Risk**
- [ ] A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
- [ ] B. Formal assessment instrument/tools (e.g., Braden, Norton, or other)
- [ ] C. Clinical assessment
- [ ] D. None of the above

**M0150. Risk of Pressure Ulcers/Injuries**
- [ ] Is this resident at risk of developing pressure ulcers/injuries?
- [ ] No
- [ ] Yes

**M0210. Unhealed Pressure Ulcers/Injuries**
- [ ] Does this resident have one or more unhealed pressure ulcers/injuries?
- [ ] No → Skip to M0150. Number of Venous and Arterial Ulcers
- [ ] Yes → Continue to M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

**M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**

- [ ] A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching. In dark skin tones it may appear with persistent blue or purple hue.
- [ ] B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/necrotic/infected blister.
- [ ] C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- [ ] D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

**M0300 continued on next page**

**M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued**

- [ ] E. Unstoppable - Non-removable dressing/device: Known but not stoppage due to non-removable dressing/device
- [ ] F. Unstoppable - Slough and/or eschar: Known but not stoppage due to coverage of wound bed by slough and/or eschar
- [ ] G. Unstoppable - Deep tissue injury: Known but not stoppage due to coverage of wound bed by slough and/or eschar

**M0300 continued on next page**
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<tbody>
<tr>
<td>M0700</td>
<td>Most Severe Tissue Type for Any Pressure Ulcer</td>
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</table>

**Enter Code**

1. **Epithelial tissue** - new skin growing on top layer of skin. It can bright pink and shiny, over areas with dry, rough, or inflamed skin.
2. **Granulation tissue** - pink or red tissue with thin, moist, granular appearance.
3. **Tough, yellow, or white tissue** that adheres to the ulcer bed in strips or thick layers, or is macerated.
4. **Neurotic tissue (fissure)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.
5. **None of the Above**

**M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission Entry or Reentry**

Complete only if A0310 E0 = 0

<table>
<thead>
<tr>
<th>Level Number</th>
<th>Level Name</th>
<th>Enter Number</th>
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<tbody>
<tr>
<td>A. Stage 2</td>
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<td>B. Stage 3</td>
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<td>C. Stage 4</td>
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**M0700–M0800 image deleted.**

**M0960: Healed Pressure Ulcers**

Complete only if A0310 E0 = 0

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?</th>
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<tbody>
<tr>
<td>0</td>
<td>Yes → Continue to M01060. Number of Vascular and Arterial Ulcers</td>
</tr>
<tr>
<td>0</td>
<td>No → Go to M09700–M0800. Tissue Type of Any Pressure Ulcer</td>
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</table>

**M1030: Number of Vascular and Arterial Ulcers**

Enter the total number of venous and arterial ulcers present

**M1640: Other Ulcers, Wounds and Skin Problems**

Check all that apply

- A. Infection of the foot (e.g., cellulitis, purulent drainages)
- B. Diabetic foot ulcer(s)
- C. Other open lesion(s) on the foot
- D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- E. Surgical wound(s)
- F. Burns (second or third degree)
- G. Skin tear(s)
- H. Moisture Associated Skin Damage (MASS) (i.e., incontinence, IMS, perspiration, drainage)
- None of the Above
- Z. None of the above were present

**M1200: Skin and Ulcer Treatments**

Check all that apply

- A. Pressure reducing device for chair
- B. Pressure reducing device for bed
- C. Turning/repositioning program
- D. Nutrition or hydration intervention to manage skin problems
- E. Pressure ulcer care
- F. Surgical wound care
- G. Application of nonsurgical dressings (with or without topical medications other than to feet)
- H. Applications of ointments/medications other than to feet
- I. Application of dressings to feet (with or without topical medications)
- Z. None of the above were provided
Updated graphic

3 N0450A N-12 **Code 0, no:** if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E to O0100, Special Treatments, Procedures, and Programs.

3 N0450D N-14 **Code 0, no:** if a GDR has not been documented by a physician as clinically contraindicated. Skip N0450E Date physician documented GDR as clinically contraindicated to O0100, Special Treatments, Procedures, and Programs.

Page length changed due to revised content.


**N2001: Drug Regimen Review**

**Intent:** The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident’s admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident’s stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.

N2001: Drug Regimen Review - Complete only if A03108 = 0

1. Yes - Issues found during review
2. No - No issues found during review
3. NA - Resident is not taking any medications
Item Rationale

Health-related Quality of Life

- Potential and actual resident medication adverse consequences and errors are prevalent in health care settings and often occur during transitions in care.
- Adverse consequences related to medications may result in serious harm or death, emergency department visits, and rehospitalizations and affect the resident’s health, safety, and quality of life.
- Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident’s admission (start of SNF PPS stay) and throughout the resident’s stay (through Part A PPS discharge).

Planning for Care

- Drug regimen review is an important component of the overall management and monitoring of a resident’s medication regimen.
- Prevention and timely identification of potential and actual medication-related adverse consequences reduces the resident’s risk for harm and improves quality of life.
- Educate staff in proper medication administration techniques and adverse effects of medications, as well as to be observant for these adverse effects.

DEFINITIONS

DRUG REGIMEN REVIEW
A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.

The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.
• Implement a system to ensure that each resident’s medication usage is evaluated upon admission and on an ongoing basis and that risks and problems are identified and acted upon.

**Steps for Assessment**

Complete if A0310B = 01.

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.

Medical record sources include medical records received from facilities where the resident received health care, the resident’s most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident’s family/significant other) may supplement and/or clarify the information gleaned from the resident’s medical records.

3. Clinically significant medication issues may include, but are not limited to:
   - Medication prescribed despite documented medication allergy or prior adverse reaction.
   - Excessive or inadequate dose.
   - Adverse reactions to medication.
   - Ineffective drug therapy.
   - Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
   - Duplicate therapy (for example, generic-name and brand-name equivalent drugs are coprescribed).
   - Wrong resident, drug, dose, route, and time errors.
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**DEFINITIONS**

**POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE**

A clinically significant medication issue is a potential or actual issue that, in the clinician’s professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.

“Clinically significant” means effects, results, or consequences that materially affect or are likely to affect an individual’s mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.
**Coding Instructions**

**Code 0, No:** if no clinically significant medication issues were identified during the drug regimen review.

**Code 1, Yes:** if one or more clinically significant medication issues were identified during the drug regimen review.

**Code 9, NA:** if the resident was not taking any medications at the time of the drug regimen review.

**Coding Tips**

- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

- The drug regimen review includes all medications, prescribed and over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

**Examples**

1. The admitting nurse reviewed and compared the acute care hospital discharge medication orders and the physician’s admission medication orders for Ms. D. The nurse interviewed Ms. D, who confirmed the medications she was taking for her current medical conditions. The nurse found no discrepancies between the acute care hospital discharge medications and the admitting physician’s medication orders. After the nurse contacted the pharmacy to request the medication, the pharmacist reviewed and confirmed the medication orders as appropriate for Ms. D. As a result of this collected and communicated information, the nurse determined that there were no potential or actual clinically significant medication issues.

   **Coding:** N2001 would be coded **0, No**—No issues found during review.

   **Rationale:** The admitting nurse reviewed and compared Ms. D’s discharge medication records from the acute care hospital with the physician’s admission medication orders, collaborated with the pharmacist, and interviewed the resident. The nurse determined there were no potential or actual clinically significant medication issues.

2. Mr. H was admitted to the nursing facility after undergoing cardiac surgery for mitral valve replacement. The acute care hospital discharge information indicated that Mr. H had a
mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of Mr. H’s discharge records from the hospital with the physician’s admission medication orders and admission note, the nurse noted that the admitting physician had ordered Mr. H’s anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0, however, the physician’s admission note indicated that the desired therapeutic INR parameters for Mr. H was 2.5–3.5. The nurse questioned the INR level listed on the admitting physician’s order, based on the therapeutic parameters of 2.5–3.5 documented in the physician’s admission note, which prompted the nurse to call the physician immediately to address the issue.

Coding: N2001 would be coded 1, Yes—Issues found during review.

Rationale: The admitting nurse reviewed and compared Mr. H’s discharge health care records from the acute care hospital with the nursing facility physician’s admission medication orders and admission note. The nurse identified a discrepancy between the physician’s documented therapeutic INR level (2.5–3.5) for Mr. H in the admission note and the physician’s order to hold anticoagulation medication for an INR level of 1.0. The nurse considered this discrepancy to be a potential clinically significant medication issue that could lead to potential clotting issues for Mr. H.

N2003: Medication Follow-up

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<th>Item Rationale</th>
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<td>DEFINITION</td>
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<tr>
<td>MEDICATION FOLLOW-UP</td>
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<td>The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions</td>
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Coding Instructions

**Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions in response to each identified potential or actual clinically significant medication issue by midnight of the next calendar day.

**Code 1, Yes:** if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.

Coding Tips

- If the physician prescribes/recommends an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes**, should still be entered, if by midnight of the next calendar day the facility has taken the appropriate steps to comply with the prescribed/recommended action.
  - Example of a physician-recommended action that would take longer than midnight of the next calendar day to complete:
    - The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of by midnight of the next calendar day:
    - A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/recommended action is completed on or before 11:59 PM on 9/13/2017.

**DEFINITION**

**CONTACT WITH PHYSICIAN**

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, and a response from the physician to convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident’s status.
A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

**Examples**

1. Mr. P was admitted to the nursing facility with active diagnoses of pneumonia and atrial fibrillation. The acute care facility medication record indicated that Mr. P was on a seven-day course of antibiotics and had three remaining days of this treatment plan. The nurse reviewing the discharge records from the acute care facility and the nursing facility admission medication orders noted that Mr. P had an order for an anticoagulant medication that required INR monitoring, as well as the antibiotic. On the date of admission, the nurse contacted the physician responsible for Mr. P and communicated a concern about a potential increase in Mr. P’s INR with this combination of medications that could place him at greater risk for bleeding. The physician provided orders for laboratory testing so that Mr. P’s INR levels would be monitored over the next three days, starting that day. However, the nurse did not request the first INR laboratory test until after midnight of the next calendar day.

   **Coding:** N2003 would be coded 0, No.

   **Rationale:** A potential clinically significant medication issue was identified during the drug regimen review; the staff did contact the physician before midnight of the next calendar day, but did not complete, to the extent possible, the physician-prescribed actions related to the INR laboratory test until after midnight of the next calendar day.

2. Ms. S was admitted to the facility from an acute care hospital. During the admitting nurse’s review of Ms. S’s hospital discharge records, it was noted that Ms. S had been prescribed metformin. However, laboratory tests at admission indicated that Ms. S had a serum creatinine of 2.4, consistent with renal insufficiency. The admitting nurse contacted the physician to ask whether this medication would be contraindicated with Ms. S’s current serum creatinine level. Three hours after Ms. S’s admission to the facility, the physician provided orders to discontinue the metformin and start Ms. S on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour.

   **Coding:** N2003 would be coded 1, Yes.
**Rationale:** A potential clinically significant medication issue was identified during the drug regimen review; the physician communication occurred, and the nurse completed the physician-prescribed actions, by midnight of the next calendar day.

### N2005: Medication Intervention

#### Item Rationale

**Health-related Quality of Life**
- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.
- Potential or actual clinically significant medication issues can occur throughout the resident’s stay.

#### Planning for Care
- Every time a potential or actual clinically significant medication issue is identified throughout the resident’s stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

#### Steps for Assessment
The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

1. Review the resident’s medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident’s stay:

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<tbody>
<tr>
<td>3</td>
<td>N2005</td>
<td>N-21–N-23</td>
<td><strong>Rationale:</strong> A potential clinically significant medication issue was identified during the drug regimen review; the physician communication occurred, and the nurse completed the physician-prescribed actions, by midnight of the next calendar day.</td>
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<td><strong>N2005: Medication Intervention</strong></td>
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<td><strong>Item Rationale</strong></td>
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<td><strong>Health-related Quality of Life</strong></td>
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<td>- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.</td>
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<td>- Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.</td>
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<td>- Potential or actual clinically significant medication issues can occur throughout the resident’s stay.</td>
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<td><strong>Planning for Care</strong></td>
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<td>- Every time a potential or actual clinically significant medication issue is identified throughout the resident’s stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.</td>
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<td><strong>Steps for Assessment</strong></td>
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<td>The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).</td>
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<td>1. Review the resident’s medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident’s stay:</td>
</tr>
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</table>
Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND

All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

Medical record sources include medical records received from facilities where the resident received health care, the resident’s most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident’s family/significant other) may supplement and/or clarify the information gleaned from the resident’s medical records.

**Coding Instructions**

- **Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).

- **Code 1, Yes:** if the facility contacted the physician and completed prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).

- **Code 9, NA:** if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident’s stay or the resident was not taking any medications at admission or at any time throughout the stay.

**Coding Tips**

- If the physician prescribes an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes**, should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.

  - Example of a physician-recommended action that would take longer than midnight of the next calendar day to complete:
- The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.
  - Examples of **by midnight of the next calendar day**:
    - A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.

• A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

**Examples**

1. At the end of the resident’s Part A PPS stay, the discharging nurse reviewed Ms. T’s medical records, from the time of admission (start of SNF PPS stay) through her entire Part A PPS stay (Part A PPS discharge) and noted that a clinically significant medication issue was documented during the admission assessment. Ms. T’s medical records indicated that a nurse had attempted to contact the assigned physician several times about the clinically significant medication issue. After midnight of the second calendar day, the physician communicated to the nurse, via telephone, orders for changes to Ms. T’s medications to address the clinically significant medication issue. The nurse implemented the physician’s orders. Upon further review of Ms. T’s medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T’s stay.

**Coding:** N2005 would be coded **0, No**—the facility did not contact the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since the resident’s admission (start of SNF PPS stay).

**Rationale:** Coding of this item includes all potential or actual clinically significant medication issues identified at any time during the resident’s stay. When reviewing Ms. T’s medical record at discharge, the nurse found that a clinically significant medication issue was identified...
2. At discharge, the nurse completing a review of Ms. K’s medical records found that two clinically significant medication issues had been identified during the resident’s stay. During the admission drug regimen review, the admitting nurse had identified a clinically significant medication issue, contacted the physician, and implemented new orders provided by the physician on the same day. Another potentially significant medication issue was identified on day 12 of Ms. K’s stay; the nurse communicated with the physician and carried out the orders within one hour of identifying the potential issue. Both medication issues identified during Ms. K’s stay were communicated to the physician and resolved by midnight of the next calendar day after identification. There were no other clinically significant medication issues identified during Ms. K’s stay.

**Coding:** N2005 would be coded as 1, **Yes**—all potential or actual clinically significant medication issues identified at any time during the resident’s stay (admission through discharge) were communicated to the physician and prescribed/recommended actions were completed by midnight of the next calendar day after each issue was identified.

**Rationale:** While a medication error was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. During Ms. K’s stay, an additional clinically significant medication issue was identified; it too was resolved by midnight of the following day. Each time a clinically significant medication issue was identified (at admission and during the stay), it was communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day after identification.
### Track Changes

**from Chapter 3 Section O v1.15**  
to Chapter 3 Section O v1.16

<table>
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<tbody>
<tr>
<td>3</td>
<td>O0100</td>
<td>O-1</td>
<td>Page length changed due to revised content on O-2–O-13.</td>
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<tr>
<td>3</td>
<td>O0100–O0700</td>
<td>O-2–O-45</td>
<td>Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. The drugs Medicated here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do <strong>not</strong> code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should <strong>not</strong> be coded in this item, as they are <strong>not considered</strong> chemotherapy for the purpose of coding the MDS. IVs, IV medication, and blood transfusions administered during chemotherapy are <strong>not</strong> recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O01001 (Transfusions). <strong>Example:</strong> Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.</td>
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<td>O0100</td>
<td>O-3–O-4</td>
<td>• <strong>O0100F, Invasive Mechanical Ventilator (Ventilator or respirator)</strong>&lt;br&gt;Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensures adequate ventilation in the resident who is, or who may become (such as during weaning attempts), unable to support his or her own respiration in this item. During invasive mechanical ventilation the resident’s breathing is controlled by the ventilator. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a or tracheostomy. A resident who has been is being weaned off of a respirator or ventilator in the last 14 days, or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP. Example: Mrs. J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day, because of an irreversible neurological injury and inability to breathe on her own. O0100F should be checked, as Mrs. J is using an invasive mechanical ventilator because she is unable to initiate spontaneous breathing on her own and the ventilator is controlling her breathing.</td>
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<td>• <strong>O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)</strong>&lt;br&gt;Code any type of Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP) respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device. Example: Mr. M has sleep apnea and requires a CPAP device to be worn when sleeping. The staff set up the water receptacle and humidifier element of the machine. Mr. M puts on the CPAP mask and starts the machine prior to falling asleep. O0100G should be checked, as Mr. M is able to breathe on his own and wears the CPAP mask when he is sleeping to manage his sleep apnea.</td>
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<td>3</td>
<td>O0250</td>
<td>O-9</td>
<td>• <strong>Code 3, Not eligible—medical contraindication:</strong> if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination. Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination.</td>
</tr>
</tbody>
</table>
| 3       | O0300   | O-11–O-12 | **Item Rationale**  
**Health-related Quality of Life**  
• Pneumococcal disease accounts for more deaths than any other vaccine-preventable bacterial disease.  
• Case fatality rates for pneumococcal bacteremia are approximately 20%; however, they can be as high as 60% in the elderly (CDC, 2009).  
• Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.  
• Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case fatality rates.  
• Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.  
**Planning for Care**  
• Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.  
• Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive |
pneumococcal disease or its complications, i.e., those 65 years of age and older or with certain medical conditions, should receive pneumococcal vaccination.

- Conditions that increase the risk of invasive pneumococcal disease include: decreased immune function; damaged or no spleen; sickle cell and other hemoglobinopathies; cerebrospinal fluid (CSF) leak; cochlear implants; and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking. Other risk factors include smoking and cerebrospinal fluid (CSF) leak (CDC, 2009).

- Determining the rate of pneumococcal vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23) national goal of 90% immunization among nursing home residents.

### Steps for Assessment

1. Determine whether or not the resident should receive the vaccine.

   - All adults 65 years of age or older should receive the pneumococcal vaccine. However, certain persons should be vaccinated before the age of 65, including, but not limited to, the following:

     - Immunocompromised persons 2 years of age and older who are at increased risk of pneumococcal disease should be vaccinated. This group includes those with the risk factors listed under Planning for Care, as well as Hodgkin’s disease, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, cochlear implant, or those who have had organ transplants and are on immunosuppressive protocols. Those on chemotherapy who are immunosuppressed, or those taking high-dose corticosteroids (14 days or longer) should also be vaccinated.

     - Individuals 2 years of age or older with asymptomatic or symptomatic HIV should be vaccinated.
Individuals living in environments or social settings (e.g., nursing homes and other long-term care facilities) with an identified increased risk of invasive pneumococcal disease or its complications should be considered for vaccination populations.

If vaccination status is unknown or the resident/family is uncertain whether or not the vaccine was received, the resident should be vaccinated.

Pneumococcal vaccine is given once in a lifetime, with certain exceptions. Revaccination is recommended for the following:

- Individuals 2 years of age or older who are at highest risk for serious pneumococcal infection and for those who are likely to have a rapid decline in pneumococcal antibody levels. Those at highest risk include individuals with asplenia (functional or anatomic), sickle cell disease, HIV infections or AIDS, cancer, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression (e.g., organ or bone marrow transplant, medication regimens that lower immunity (such as chemotherapy or long-term steroids).

- Persons 65 years or older should be administered a second dose of pneumococcal vaccine if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.

If the resident has had a severe allergic reaction to vaccine components or following a prior dose of the vaccine, they should not be vaccinated.

If the resident has a moderate to severe acute illness, he or she should not be vaccinated until his or her condition improves. However, someone with a minor illness (e.g., a cold) should be vaccinated since minor illnesses are not a contraindication to receiving the vaccine.
Review the resident’s medical record and interview resident or responsible party/legal guardian and/or primary care physician to determine pneumococcal vaccination status, using the following steps:

1. Review the resident’s medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.

2. Ask the resident if he or she received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.

3. If the resident is unable to answer, ask the same question of the responsible party/legal guardian and/or primary care
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<td>physician. If vaccination status is still unknown, proceed to the next step.</td>
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<td>4.</td>
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<td>If pneumococcal vaccination status cannot be determined, administer the recommended appropriate vaccine(s) to the resident, according to the standards of clinical practice.</td>
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<td>• If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.</td>
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<td></td>
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<td></td>
<td>• If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.</td>
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<td>• If the resident has a minor illness (e.g., a cold), check with the resident’s physician before administering the vaccine.</td>
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**Coding Tips**

- The CDC has evaluated inactivated influenza vaccine co-administration with the pneumococcal vaccine systematically among adults. It is safe to give these two vaccinations simultaneously. If the influenza vaccine and pneumococcal vaccine will be given to the resident at the same time, they should be administered at different sites (CDC, 2009). If the resident has had both upper extremities amputated or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.
- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at [https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf](https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf).
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at

- [https://www.cdc.gov/vaccines/schedules/hcp/index.html](https://www.cdc.gov/vaccines/schedules/hcp/index.html)
- [http://www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
Track Changes
from Chapter 3 Section O v1.15
to Chapter 3 Section O v1.16

- https://www.cdc.gov/pneumococcal/vaccination.html

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, and it has been less than one year since the resident received the vaccination, he/she is not yet eligible for the second pneumococcal vaccination; therefore, O0300A is coded 1, yes, indicating the resident’s pneumococcal vaccination is up to date.

Examples

1. Mr. L., who is 72 years old, received the PCV13 pneumococcal vaccine at his physician’s office last year. He had previously been vaccinated with PPSV23 at age 66.
   
   **Coding:** O0300A would be **coded 1, yes**; skip to O0400, Therapies.
   
   **Rationale:** Mr. L., who is over 65 years old, has received the recommended PCV13 and PPSV23 vaccines and received the pneumococcal vaccine in his physician’s office last year at age 71.

2. Mrs. B, who is 95 years old, has never received a pneumococcal vaccine. Her physician has an order stating that she is NOT to be immunized.
   
   **Coding:** O0300A would be **coded 0, no**; and O0300B would be **coded 1, not eligible**.
   
   **Rationale:** Mrs. B. has never received the pneumococcal vaccine; therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.

3. Mrs. A. received the pneumococcal vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 and is being admitted to the nursing home for rehabilitation. Her covering physician offered the pneumococcal vaccine to her during his last visit in the nursing home, which she accepted. The facility administered the pneumococcal vaccine to Mrs. A.
   
   **Coding:** O0300A would be **coded 1, yes**; skip to O0400, Therapies.
   
   **Rationale:** Mrs. A. received the pneumococcal vaccine
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<td>prior to the age of 65. Guidelines suggest that she should be revaccinated since she is over the age of 65 and 5 years have passed since her original vaccination. Mrs. A received the pneumococcal vaccine in the facility.</td>
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<td>3.</td>
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<td>Mrs. A, who has congestive heart failure, received PPSV23 vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 years old and was admitted to the nursing home one week ago for rehabilitation. She was offered and given PCV13 on admission.</td>
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<td>Coding:</td>
<td>O0300A would be coded 1, yes; skip to O0400, Therapies.</td>
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<tr>
<td>Rationale:</td>
<td>Mrs. A. received PPSV23 before age 65 years because she has a chronic heart disease and received PCV13 at the facility because she is age 65 years or older. She should receive another dose of PPSV23 at least 1 year after PCV13 and 5 years after the last PPSV23 dose (i.e., Mrs. A. should receive 1 dose of PPSV23 at age 79 years, but is currently up to date because she must wait at least 1 year since she received PCV13).</td>
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<td>4.</td>
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<td>Mr. T., who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 64 years old and is being admitted to the nursing home for chemotherapy and respite care. He has not been offered any additional pneumococcal vaccines.</td>
</tr>
<tr>
<td>Coding:</td>
<td>O0300A would be coded 0, no; and O0300B would be coded 3, Not offered.</td>
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<tr>
<td>Rationale:</td>
<td>Mr. T. received 1 dose of PPSV23 vaccine prior to 65 years of age because he is a smoker. Because Mr. T. is now immunocompromised, he should receive PCV13 for this indication. He will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after his last dose of PPSV23 (i.e., Mr. T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).</td>
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<tr>
<td>Coding:</td>
<td>O0300A would be coded 1, yes; skip to O0400, Therapies.</td>
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</table>
| Rationale: | Mr. T. received his first dose of pneumococcal vaccine prior to the age of 65 due to his residing in congregate care at the age of 62. Even though Mr. T. is now immunocompromised, less than 5 years have
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<td>lapsed since he originally received the vaccine. He would be considered up to date with his vaccination.</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-7</td>
<td>• Opioids (N0410H narcotic pain drug)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-8</td>
<td>• Sleep disturbances (for example, up and awake at night/asleep during the day) (D02400C, D0500C)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-11</td>
<td>• Mood State (D03400, D06000) CAA triggered. Analysis of Findings indicates possible impact on cognition – important to consider when drawing conclusions about cognitive loss</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-15</td>
<td>• Opioids (N0410H) Narcotics</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-17</td>
<td>• Opioids (N0410H) Narcotic analgesics (medication administration record)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-17</td>
<td>• Parkinson’s medications (medication administration record)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-17</td>
<td>• Gentamycin (N0410F) (medication administration record)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-17</td>
<td>• Tobramycin (N0410F) (medication administration record)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-17</td>
<td>• Aspirin (medication administration record)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-22</td>
<td>• Opioids (N0410H)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-22</td>
<td>• Complications of immobility, such as — Pressure ulcers ulcer/injury (M0210)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-26</td>
<td>• Anticholinergics – can lead to overflow incontinence — Parkinson’s medications (except Sinemet and Deprenyl) — Disopyramide — Antispasmodics — Antihistamines — Antipsychotics (N0410A) — Antidepressants (N0410C) — Opioids (N0410H) Narcotics</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-34</td>
<td>• Opioids (N0410H) Narcotics</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Resident is immediate threat to self – IMMEDIATE INTERVENTION REQUIRED (D0200I.1=1, D0500I.1=1, E0500A=1, E1000A=1)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) (E0200A=1, 2, or 3)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Verbal behaviors directed toward others (e.g., threatening, screaming at, or cursing at others) (E0200B=1, 2, or 3)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Other behavior symptoms not directed toward others (e.g., hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds) (E0200C=1, 2, or 3)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Behavior significantly interferes with the resident’s care (E0500B=1)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Behavior significantly interferes with the resident’s participation in activities or social interaction (E0500C=1)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Behavior significantly intrudes on the privacy or activity of others (E0600B=1, E1000B=1)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Behavior significantly disrupts care or living environment (E0600C=1)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36</td>
<td>• Resident rejects care that is necessary to achieve his or her goals for health and well-being (E0800=1, 2, or 3)</td>
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<tr>
<td>Ap. C</td>
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<td>C-36</td>
<td>• Resident’s behavior status, care rejection, or wandering has worsened since last assessment (E1100=2)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-36–C-86</td>
<td>Page length changed due to revised content on C-36.</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-39</td>
<td>• Alarm Use (P0200)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-39</td>
<td>• Need for repositioning (M1200C)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-44</td>
<td>• Indicators of psychosis (E0100A–E0100B,C)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>Medications (from medication record)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>• Cardiovascular medications (from medication administration record)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>• Diuretics (N0410G) (from medication administration record)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>• Opioids (N0410H) Narcotic anaglesics (from medication administration record)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>• Neuroleptics (from medication administration record)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-47</td>
<td>• Other medications that cause lethargy or confusion (from medication administration record)</td>
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<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-54</td>
<td>• Recent surgical procedure (I8000, M1200F, M1200F)</td>
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<td>Ap. C</td>
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<td>C-56</td>
<td>• Unable to swallow or to eat food and unlikely to eat within a few days due to</td>
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<td>— Physical problems in chewing or swallowing (for example, stroke or Parkinson’s disease) (L0200F, K0100D)</td>
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<td>— Mental problems (I5700 – I6100) (for example, Alzheimer’s (I4200), Other Dementia (I4800), depression (I5800))</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-60</td>
<td>• Malnutrition (I5600)</td>
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<td>Ap. C</td>
<td>—</td>
<td>C-63</td>
<td>• Medications (from MDS and medication administration record)</td>
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<td>— Antipsychotics (N0410A)</td>
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<td>— Antidepressants (N0410C)</td>
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<td>— Antianxiety agents (N0410B)</td>
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<td>— Sedatives/hypnotics (N0410D)</td>
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<td>— Diuretics (N0410G)</td>
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<td>— Antihypertensives</td>
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<td>— Antiparkinsons medications</td>
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<td>— Opioids (N0410H) Narcotics</td>
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<td>— Anticonvulsants</td>
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<td>— Antihistamines</td>
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<td>— Antiemetics</td>
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<td>16. Pressure Ulcer/Injury(s)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-66</td>
<td>Review of Indicators of Pressure Ulcer/Injury(s)</td>
</tr>
<tr>
<td>Ap. C</td>
<td>—</td>
<td>C-66</td>
<td>• Existing pressure ulcer/Injury(s) (M0210)</td>
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| Ap. C   | —       | C-66 | • Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin (M0640)  
— Note if eschar or slough is present (M0300F, M0770-4)  
— Assess for signs of infection, such as the presence of a foul odor, increasing pain, surrounding skin is reddened (erythema) or warm, or there is a presence of purulent drainage  
— Note whether granulation tissue (required for healing) is present and the wound is healing as expected (M0700-2) |
| Ap. C   | —       | C-66 | • If the ulcer/injury does not show signs of healing despite treatment, consider complicating factors  
— Elevated bacterial level in the absence of clinical infection  
— Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed  
— Underlying osteomyelitis (bone infection) |
| Ap. C   | —       | C-67 | • Poor nutrition (I5600) (see Nutrition CAA) |
| Ap. C   | —       | C-67 | Medications that increase risk for pressure ulcer/injury development |
| Ap. C   | —       | C-67 | • Opioids (N0410H)  
Narcotics |
| Ap. C   | —       | C-67 | Diagnoses and conditions that present complications or increase risk for pressure ulcer/injury |
| Ap. C   | —       | C-67 | Terminal illness (J1400, O0100K) |
| Ap. C   | —       | C-68 | Diagnoses and conditions that present complications or increase risk for pressure ulcer/injury (continued) |
| Ap. C   | —       | C-68 | • Pain (J0300, J0800) |
| Ap. C   | —       | C-68 | • Dehydration (J15500C, J8000) |
| Ap. C   | —       | C-68 | • History of healed pressure ulcer(s)/injury (M0900) |
| Ap. C   | —       | C-70 | • Antipsychotic (N0410A, N0450A) |
| Ap. C   | —       | C-70 | • Excessive duration and/or without gradual dose reductions (N0450B, N0450C) |
| Ap. C   | —       | C-73 | • Decline in behavior (E1100) |
| Ap. C   | —       | C-75 | • Pressure ulcer/injury (M0210) or pressure ulcer/injury care (M1200E) |
| Ap. C   | —       | C-75 | • Alarm use (P0200) |
| Ap. C   | —       | C-79 | • Skin/Wound  
— Pressure ulcer/injury (section M) |
<p>| Ap. C   | —       | C-79 | • Terminal condition (J1400) |
| Ap. C   | —       | C-83 | 5. Look at the previous care plans of this individual to identify their previous responses and the issues or barriers they expressed. Consider the individual’s overall goals of care and discharge planning from previous items responses (Q0300 and Q0400A,B). Has the individual indicated that his or her goal is for end-of-life-care (palliative or hospice care)? Or does the individual expect to return home after rehabilitation in your facility? (Q0300, Q0400) |</p>
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