



# 2017 RAI User's Manual Provider Updates



*October 1, 2017*

# Coming October 1, 2017

Version 1.15.1 of the Minimum Data Set (MDS) and its' three new Items go into effect October 1, 2017.

Also effective October 1, 2017 is Version 1.15 of the RAI User's Manual

Centers for Medicare &  
Medicaid Services



**Long-Term Care  
Facility Resident  
Assessment  
Instrument 3.0  
User's Manual**

Version 1.15

October 2017

# 2017 RAI Manual Changes

This presentation is an overview of some, but not all, of the changes to the RAI User's Manual, Version 1.15, effective October 1, 2017.

Providers should review the RAI Manual Change Tables for the details on all of the manual changes effective October 1, 2017.

# Overview of Changes

- Title page updated with required Paperwork Reduction Act language
- Regulatory citations updated throughout to reflect new regulatory numbering
- Coding instructions for the new items effective Oct. 1 2017
- Clarifications to various coding instructions, tips and examples
- Edits to wording, references, links and page numbers



# Chapter 2: Assessments for the RAI

- Definition of a Significant change updated to include the term “Major” before decline or improvement
- Examples of decline and improvement have been revised for clarity and new examples added
- Incorporation of the requirement to review and revise the resident’s care plan after each assessment (except discharge)
- The need to have ongoing discussions with the resident and resident representative throughout the stay, so that changes in the resident’s goals and preferences can be reflected in the comprehensive care plan.
- Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care

# Chapter 3 - 3.3 Coding Conventions

Updated bullet concerning the look-back period exception:

There are several standard conventions to be used when completing the MDS assessment, as follows.

- The standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated.
- **With the exception of certain items (e.g., some items in Sections K and O), the look-back period *does not extend into the preadmission period unless the item instructions state otherwise. In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise.***

# A2400: Medicare Stay

## Updated examples:

3. Mr. R. began receiving services under Medicare Part A on October 15, 2016. Due to complications from his recent surgery, he was unexpectedly discharged to the hospital for emergency surgery on October 20, 2016, but is expected to return within 30 days. Code the following on his OBRA Discharge assessment:

- A0310H = 1

**Rationale:** Mr. R's physical discharge to the hospital was unplanned, yet it is anticipated that he will return to the facility within 30 days. Therefore, only an OBRA Discharge was required. *Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.*

# A2400: Medicare Stay

## Updated examples:

5. Mr. W began receiving services under Medicare Part A on November 15, 2016. His Medicare Part A stay ended on November 25, 2016, and he was unexpectedly discharged to the hospital on November 26, 2016. However, he is expected to return to the facility within 30 days. Code the following on his OBRA Discharge assessment:

- A0310H = 1

**Rationale:** Mr. W's Medicare stay ended the day before discharge and he is expected to return to the facility within 30 days. Because his discharge to the hospital was unplanned, only an OBRA Discharge assessment was required. *Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.*

# Section G: Functional Status

## 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. Start by counting the number of episodes at each ADL Self-Performance Level.

**\* Exceptions to Rule of 3:**

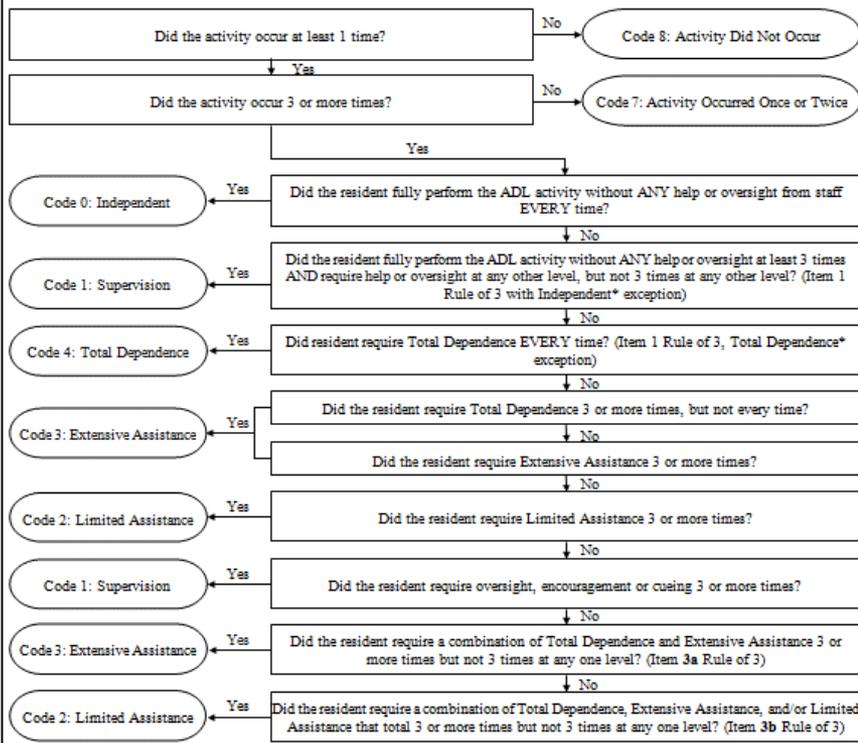
- The Rule of 3 does not apply when coding Independent (0), Total Dependence (4) or Activity Did Not Occur (8), since these levels must be EVERY time the ADL occurred during the look-back period.
- The Rule of 3 does not apply when Activity Occurred Only Once or Twice (7), since the activity did not 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) – if this change makes 3 episodes at Extensive Assistance (3), code as 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**



ADL Self-Performance Algorithm replaced with new Rule of 3 Algorithm

# G0110: Activities of Daily Living (ADL) Assistance

Coding Tips and Special Populations, added the following bullets:

- *Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff, using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer.*
- *Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support.*

# G0110: Activities of Daily Living (ADL) Assistance

Coding Tips and Special Populations, added following bullets:

- *How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting.*
- *When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.*

# G0600C: Wheelchair (manual or electric)

## Coding Instructions, updated bullet:

- **Check G0600C, wheelchair (manual or electric):** if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. *Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.*

# Section GG: Functional Abilities and Goals

## GG0130 Self Care - updated Steps for Assessment:

1. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 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).*

# GG0130: Self-Care

## Steps for Assessment – new step added:

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.*

# GG0130: Self-Care

## Steps for Assessment updated:

- 7. 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 3-day assessment period to obtain the resident's usual performance.*

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips updated

- **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 *three*). 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.*

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips updated

**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.

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips updated

- 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 *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*.

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips added definition of “effort”:

- *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.*

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips updated:

- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, *Code 07* if the resident refused to attempt the activity, *Code 09* if the *resident did not perform this activity prior to the current illness, exacerbation, or injury*, or *Code 88* if the resident was not able to attempt the activity due to medical condition or safety concerns.

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips

Added new bullet:

- *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.*

# GG0130: Self-Care

## Admission or Discharge – Coding Tips updated

- 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 result in a reduction in the annual payment update. 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), or the activity was not attempted due to medical condition or safety concerns (Code 88), use these codes instead of a dash (“-”). ***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 (“-”) for Discharge Goals is provided below under Discharge Goal(s): Coding Tips.***

# GG0130: Self-Care

## Admission or Discharge Performance Coding Tips – new bullets added:

- *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.*
- *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.*

# GG0130A: Eating

## Example #2 updated:

- **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, Eating 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.

# GG0130A: Eating

## Example #3 updated:

- **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, Eating 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.*

# GG0130A: Eating

## Example #8 updated:

- **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, Eating 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.

# GG0130C: Toileting Hygiene

Example #1 updated:

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

# GG0130: Self-Care

## Examples of Probing Conversation with Staff – Eating Example #1 Updated:

- **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.*”

# GG0130: Self-Care

## Discharge Goal(s): Coding Tips - bullets updated:

- 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.

# GG0170: Mobility

## Steps for Assessment – steps updated:

1. Assess the resident's mobility *status* based on direct observation, the resident's self-report, *family reports, and direct care staff reports* documented in the *resident's* medical record during the assessment period. *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 start of most recent Medicare stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).*

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.*

# GG0170: Mobility

## Steps for Assessment – added steps

- 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.*

# GG0170: Mobility

## Steps for Assessment – step updated

*7. 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 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.*

# GG0170: Mobility

## 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* (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 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.*

# GG0170: Mobility

## Admission or Discharge Performance Coding Tips

- **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

## Admission or Discharge Performance Coding Tips

- When reviewing the *medical record*, interviewing staff, and observing the resident, be familiar with the definition of each activity. For example, when assessing Walk 50 feet with 2 turns (item GG0170J), determine the level of assistance required to walk 50 feet while making 2 turns.
- *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.
- *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.*

# GG0170: Mobility

## Admission or Discharge Performance Coding Tips

- *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).***
- *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.*

# GG0170: Mobility

## Admission or Discharge Performance Coding Tips

- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, Code 07 if the resident refused to attempt the activity, Code 09 if the activity is not applicable for the resident *because the resident did not perform this activity prior to the current illness, exacerbation, or injury*, or Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

# GG0170: Mobility

## Admission or Discharge Performance Coding Tips

- *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).*

# GG0170: Mobility

## Admission or Discharge Performance Coding Tips

- 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 result in a reduction in annual payment update. 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), 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.*
- *Completion of the Mobility 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.*

# GG0170B: Sit to lying

## Example #1, updated

- **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. Overall, Mrs. H performs more than half of the effort.
- **Coding:** GG0170B, Sit to lying 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.*

# GG0170B: Sit to lying

## Example #6, updated

- **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:** GG0170B, Sit to lying 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.*

# GG0170E, Chair/bed-to-chair transfer

## Coding tips updated and added:

- 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 the side of the 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 a mechanical lift transfer, then Code 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.*

# GG0170F: Toilet Transfer

## Example #4 updated:

- **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, Toilet transfer 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.

# GG0170H1: Does the resident walk?

Example #1 updated:

- **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.

# GG0170Q1: Does the resident use a wheelchair/scooter?

Example added:

- **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 and coding the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

# GG0170R: Wheel 50 feet with two turns

Example #7 updated:

- **Coding: Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet, then asks the certified nursing assistant to push the wheelchair an additional 40 feet into her room and her bathroom.
- GG0170R, Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.
- **Rationale:** The helper provides more than half the effort *to assist the resident to complete the activity.*

# GG0170S: Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

Example added:

**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, Wheel 150 feet 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.*

# GG0170S: Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

Example added:

**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, Indicate the type of wheelchair/scooter used would be coded 1, Manual.*
- **Rationale:** *Mr. M used a manual wheelchair during the 3-day assessment period*

# GG0170S: Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

Example added:

**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, Wheel 150 feet 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.*

# GG0170S: Wheel 150 feet and GG0170SS3, Indicate the type of wheelchair/scooter used

Example added:

**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, Indicate the type of wheelchair/scooter used would be coded 1, Manual.*
- **Rationale:** *Mr. A is assisted using a manual wheelchair during the 3-day assessment period.*

# GG0170R and GG0170S: Wheelchair items

## Coding tips added:

- *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.*

# GG0170R and GG0170S: Wheelchair items

## Coding tips added:

- *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.*

# GG0170R and GG0170S: Wheelchair items

## Coding tips added:

- *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 stay, even if the resident is anticipated to ambulate during the stay or by discharge.*
  - *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.*

# H0100: Appliances

## Coding Tips and Special Populations, added bullet:

- *Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.*

Removed “sterile” from intermittent catheterization definition. Coding of Item H0100D, Intermittent Catheterization, now includes clean technique intermittent catheterization.

# I2300: Urinary Tract Infection (UTI)

## Coding Tips, updated bullets:

- **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:***
      - *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**
- *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.*

# 12300: Urinary Tract Infection (UTI)

## Coding Tips, updated bullets:

- *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.*

# 12300: Urinary Tract Infection (UTI)

Coding Tips, updated bullets:

– ***Resources for evidence-based UTI criteria:***

- ***Loeb criteria:***

<https://www.researchgate.net/publication/12098745> *Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term-Care Facilities Results of a Consensus Conference*

- ***Surveillance Definitions of Infections in LTC (updated McGeer criteria):***

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/>

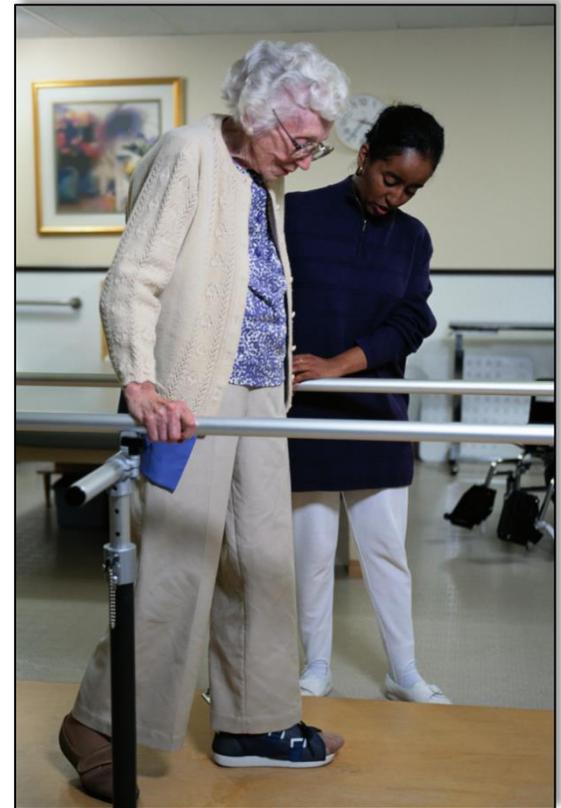
- ***National Healthcare Safety Network (NHSN):***

<https://www.cdc.gov/nhsn/ltc/uti/index.html>

# Section J: Health Conditions

J1700: Fall History on Admission/Entry or Reentry, expanded definition for Fall to include:

*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.*



# Section L: Oral/Dental Status

Lo200: Dental, added definition for edentulous:

*Edentulous - Having no natural permanent teeth in the mouth.  
Complete tooth loss.*

Lo200: Dental, Coding Tips, added bullets:

- *The dental status for a resident who has some, but not all, of his/her natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above.*

# Section L: Oral/Dental Status

## Lo200: Dental, Coding Tips, added bullets:

- *Many residents have dentures or partials that fit well and work properly. However, for individualized care planning purposes, consideration should be taken for these residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication pass, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.*

# Section M: Skin Conditions

Intent, added disclaimer acknowledging existence of varying terms used to describe pressure ulcers:

*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.*

# Section M: Skin Conditions

## M0210: Unhealed Pressure Ulcer(s)

### Coding Tips, updated:

- 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.*

## M0300C: Stage 3 Pressure Ulcers

*Examples #1 and #3 updated*

# Section M: Skin Conditions

M1040D: Open Lesion Other than Ulcers, Rashes, Cuts,  
Changed e.g. from cancer lesions to *bullous pemphigoid*

Coding Tips, added bullet:

- *Do **not** code pressure ulcers, venous or arterial ulcers, diabetic foot ulcers or skin tears here. These conditions are coded in other items on the MDS.*

# Section M: Skin conditions

Mo800: Worsening in Pressure ulcer Status ...

Coding Tips, updated:

- 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.

# Section N: Medications

Clarified the intent of Section N and coding instructions for N0300, by deleting “(subcutaneous, intramuscular or intradermal)” after “any type of injection.”

*The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.*

*Count the number of days that the resident received any type of injection while a resident of the nursing home.*

*Record the number of days that any type of injection was received in Item N0300.*

# Section N: Medications

## No410H: Opioid, new item:

N0410. Medications Received	
Indicate the number of <b>DAYS</b> the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days	
Enter Days <input type="text"/>	<b>A. Antipsychotic</b>
Enter Days <input type="text"/>	<b>B. Antianxiety</b>
Enter Days <input type="text"/>	<b>C. Antidepressant</b>
Enter Days <input type="text"/>	<b>D. Hypnotic</b>
Enter Days <input type="text"/>	<b>E. Anticoagulant</b> (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days <input type="text"/>	<b>F. Antibiotic</b>
Enter Days <input type="text"/>	<b>G. Diuretic</b>
Enter Days <input type="text"/>	<b>H. Opioid</b>

# N0410H: Opioid

## Added Coding Instructions:

*N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).*

## Coding Tips and Special Populations, added bullet:

*Opioid medications can be an effective intervention in a resident's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.*

# Section N: Medications

## Coding Tips and Special Populations, added bullets:

- *Medications that have more than one therapeutic category and/or pharmacological classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.*
- *In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's **website**.*

# N0410: Medications Received

## Coding Tips and Special Populations, added bullets

- *Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant.*
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., **melatonin**, chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is taking.

# N0450 Antipsychotic Medication Review

## No450: Antipsychotic Medication Review, new item:

N0450. Antipsychotic Medication Review																					
Enter Code <input type="checkbox"/>	<b>A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?</b> 0. <b>No</b> - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs 1. <b>Yes</b> - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted? 2. <b>Yes</b> - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted? 3. <b>Yes</b> - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?																				
Enter Code <input type="checkbox"/>	<b>B. Has a gradual dose reduction (GDR) been attempted?</b> 0. <b>No</b> → Skip to N0450D, Physician documented GDR as clinically contraindicated 1. <b>Yes</b> → Continue to N0450C, Date of last attempted GDR																				
	<b>C. Date of last attempted GDR:</b> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td>-</td><td><input type="text"/></td><td><input type="text"/></td><td>-</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td></td><td colspan="2">Day</td><td></td><td colspan="4">Year</td></tr></table>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month			Day			Year			
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Month			Day			Year															
Enter Code <input type="checkbox"/>	<b>D. Physician documented GDR as clinically contraindicated</b> 0. <b>No</b> - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs 1. <b>Yes</b> - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated																				
	<b>E. Date physician documented GDR as clinically contraindicated:</b> <table><tr><td><input type="text"/></td><td><input type="text"/></td><td>-</td><td><input type="text"/></td><td><input type="text"/></td><td>-</td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td colspan="2">Month</td><td></td><td colspan="2">Day</td><td></td><td colspan="4">Year</td></tr></table>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Month			Day			Year			
<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>												
Month			Day			Year															

# N0450 Antipsychotic Medication Review: 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.

# N0450 Antipsychotic Medication Review: 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 (GDR) 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.

# N0450 Antipsychotic Medication Review: Coding Instructions for N0450A

- **Code 0, no:** if antipsychotics were not received: Skip to O0100, Special Treatments, Procedures, and Programs.
- **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: Coding Instructions for N0450B

- **Code 0, no:** if a GDR has not been attempted. Skip to No450D, Physician documented GDR as clinically contraindicated.
- **Code 1, yes:** if a GDR has been attempted. Continue to No450C, Date of last attempted GDR.



# N0450 Antipsychotic Medication Review: Coding Instructions for N0450C–E

## Coding Instructions for No450C

- Enter the date of the last attempted Gradual Dose Reduction (GDR).

## Coding Instructions for No450D

- **Code 0, no:** if a GDR has not been documented by a physician as clinically contraindicated. Skip to O0100, Special Treatments, Procedures, and Programs.
- **Code 1, yes:** if a GDR has been documented by a physician as clinically contraindicated. Continue to No450E, Date physician documented GDR as clinically contraindicated.

## Coding Instructions or No450E

- Enter date the physician documented GDR attempts as clinically contraindicated.

# N0450 Antipsychotic Medication Review: Coding Tips and Special Populations

- Any medication that has a pharmacological classification or therapeutic category as an antipsychotic medication must be recorded in this section, regardless of why the medication is being used.
- In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.
- Do not include Gradual Dose Reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission 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.

# N0450 Antipsychotic Medication Review: Coding Tips and Special Populations (cont.)

- Within the first year in which a resident is admitted on a psychotropic medication or after the facility has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated.
- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section.

# N0450 Antipsychotic Medication Review: Coding Tips and Special Populations (cont.)

- In cases where 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 No450C, Date of last attempted GDR.
- If multiple dose reductions have been attempted since admission/entry or reentry or the prior OBRA assessment, record the date of the most recent reduction attempt in No450C, Date of last attempted GDR.
- Federal requirements regarding GDRs are found at 42 CFR §483.45(d) Unnecessary drugs and 483.5(e) Psychotropic drugs.

# O0300B: Pneumococcal Vaccination

## Coding Instructions, added bullets:

- *“Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.*
- *If a resident has received one pneumococcal vaccination 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.*

# 00400: Therapies, Minutes of Therapy

## Added bullet:

- *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.*

# Appendix A: Respiratory Therapy

Updated Respiratory Therapy definition, removing “heated” from heated nebulizer and deleting “aerosol treatments”:

*Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.*

# Section O: Special Treatments, Procedures, and Programs

Oo600: Physician Examinations and Oo700: Physician Orders, added statement to beginning of these sections:

*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.*

Oo600 and Oo700, Coding Instructions, added bullet:

- *If the State does not require the completion of this item, use the standard “no information” code (a dash, “-”).*

# O0700: Physician Orders

## Steps for Assessment

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 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.

# P0200 Alarms

## P0200: Alarms, new item:

P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
<b>Coding:</b> 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Bed alarm
	<input type="checkbox"/> B. Chair alarm
	<input type="checkbox"/> C. Floor mat alarm
	<input type="checkbox"/> D. Motion sensor alarm
	<input type="checkbox"/> E. Wander/elopement alarm
	<input type="checkbox"/> F. Other alarm

# P0200 Alarms: Item Rationale— Health-related Quality of Life

- An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected.
- Examples may include:
  - Bed, chair, and floor sensor pads
  - Cords that clip to the resident's clothing
  - Motion sensors
  - Door alarms
  - Elopement/wandering devices

# P0200 Alarms: Steps for Assessment

1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the nursing staff to determine the resident's cognitive and physical status/ limitations.
3. Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?

# P0200 Alarms: Coding Instructions

- Identify all alarms that were used at any time (day or night) during the 7-day look-back period. After determining whether or not an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:
  - **Code 0, not used:** if the device was not used during the 7-day look-back period.
  - **Code 1, used less than daily:** if the device was used less than daily.
  - **Code 2, used daily:** if the device was used on a daily basis during the look-back period.

# P0200 Alarms: Coding Tips

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.
- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.

# P0200 Alarms: Coding Tips (cont.)

- **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in this section.
- Do not code a universal building exit alarm applied to alert staff when *anyone*, including staff members or visitors, exit the door.

# Section Q: Participation in Assessment and Goal Setting

Language has been updated throughout the section to add emphasis on:

- The resident's civil rights
- Resident's right to request and receive information on community based services, regardless of facility staff's opinion
- A request to learn about home and community based services is not a request for discharge, it is a request for information
- Family support is not always necessary for a discharge to take place
- Importance of knowing your State's policies for contacting and making referrals to the Local Contact Agency

# Chapter 4: Care Area Assessment Process and Care Planning

Updates throughout the chapter aligned with person-centered care planning requirements

- Such as incorporating the resident's goals, preferences and strengths, as well as individualized interventions into the resident's care plan.
- The requirement to review and revise the resident's care plan after each assessment (except Discharge assessments) based on changing goals, preferences and needs of the resident and in response to current interventions.
- The need to have ongoing discussions with the resident and resident representative throughout the resident's stay, so that changes in the resident's preferences and goals can be reflected in the comprehensive care plan.

# RAI Manual Change Tables

Please remember this is an overview of some, but not all, of the changes to the RAI User's Manual, Version 1.15, effective October 1, 2017.

Providers should review the RAI Manual Change Tables for the details on all of the manual changes effective October 1, 2017.

# Questions?

## Contact your State RAI Coordinator

Your State RAI Coordinator is available to assist you with MDS Questions.

Appendix B of the RAI User's Manual instructs providers, consultants and industry associations to contact their State RAI Coordinator with MDS related questions.

Appendix B is updated monthly and is located on the CMS MDS 3.0 RAI Manual webpage at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html>