Centers for Medicare & Medicaid Services

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

Version 1.15

October 2017

Centers for Medicare & Medicaid Services'
Long-Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual
October 2017
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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:

Item Set	Estimated response time
NP	51 minutes
NOD	39 minutes
NO/SO	26.52 minutes
NSD	34.17 minutes
NS/SS	14.03 minutes

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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(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483.35(e) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments, Procedures and Programs	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

1.8 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.70(i) and 483.75(i)(4), release of information from the resident's clinical record is permissible only when required by:

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

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. Information regarding The Privacy Act can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-16 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Contractual Agreements

Providers who are part of a multi-facility corporation may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in 42 CFR at 483.10(h)(3)(i)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities;

CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Medicare assessments in nursing homes and the mandated Medicare assessments in non-critical access hospitals with a swing bed agreement.

2.1 Introduction to the Requirements for the RAI

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919 (f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.

The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.

MDS assessments are also required for Medicare payment (Prospective Payment System [PPS]) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF QRP required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

It is important to note that when the OBRA and Medicare PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. (Refer to Sections 2.11 and 2.12 for combining OBRA and Medicare assessments).

2.2 CMS Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items.

- CMS' specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.
- CMS' specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
- All comprehensive RAIs specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the RAI specified by CMS).

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM). For more information about your State's assessment requirements, contact your State RAI coordinator (see Appendix B).

2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice Residents:** When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved

record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
  - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The15-month requirement for maintenance of the RAI data must be adhered to.
  - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
  - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.

- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident.
- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a handwritten **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion date for all assessments and correction requests. This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility Tracking records and MDS Correction Requests (including signed attestation).
- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR
- when the resident has been in this facility previously and was discharged return not anticipated; OR
- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

Assessment Combination refers to the use of one assessment to satisfy both OBRA and Medicare PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the

requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. Sections 2.11 and 2.12 provide more detailed information on combining Medicare and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and OBRA Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.

Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59PM should be included for MDS 3.0 coding.

Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

Assessment Submission refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

Assessment Timing refers to when and how often assessments must be conducted, based upon the resident's length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the Medicare-required PPS assessment timing schedule is provided in Section 2.8.

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.
- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have a SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.
- Early Medicare-required assessments completed with an ARD prior to the beginning of the prescribed ARD window will have a payment penalty applied (see Section 2.13).

Assessment Transmission refers to the electronic transmission of submission files to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

Comprehensive MDS assessments include both the completion of the MDS as well as completion of the Care Area Assessment (CAA) process and care planning. Comprehensive MDSs include Admission, Annual, Significant Change in Status Assessment (SCSA), and Significant Correction to Prior Comprehensive Assessment (SCPA).

Death In Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required.

Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Section 2.6 provides detailed instructions regarding return anticipated and return not anticipated types, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.
- Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed.
- Resident's Medicare Part A stay ends, but the resident remains in the facility.

Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. This assessment includes clinical items for quality monitoring as well as discharge tracking information.

Entry is a term used for both an admission and a reentry, and requires completion of an Entry tracking record.

Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.

Interdisciplinary Team (IDT[1]) is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident.

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1 42 CFR 483.21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).

Item Set refers to the MDS items that are active on a particular assessment type or tracking form. There are 11 different item subsets for nursing homes and 8 for swing bed providers as follows:

- Nursing Home
  - **Comprehensive (NC[2]) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction of Prior Comprehensive Assessments). This item set is used whether the OBRA Comprehensive assessment is stand-alone or combined with any other assessment (PPS assessment and/or Discharge assessment).
  - **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly Assessment). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.
  - **PPS (NP) Item Set.** This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day). This item set is used for a standalone scheduled PPS assessment or a scheduled PPS assessment combined with a PPS OMRA assessment and/or a Discharge assessment.
  - **OMRA - Start of Therapy (NS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
  - **OMRA - Start of Therapy and Discharge (NSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **OMRA (NO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and a change of therapy OMRA assessment. The code used is "NO" since this was the only type of OMRA when the code was initially assigned.
  - **OMRA - Discharge (NOD) Item Subset.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
  - **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
  - **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

[2] The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

- **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a scheduled PPS assessment (5-day, 14-day, 30-day, 60-day, or 90-day) or a Swing Bed Clinical Change assessment. This item set is used for a scheduled PPS assessment that is standalone or in any combination with other swing bed assessments (Swing Bed Clinical Change assessment, OMRA assessment, and/or Discharge assessment). This item set is also used for a Swing Bed Clinical Change assessment that is standalone or in any combination with other swing bed assessments (scheduled PPS assessment, OMRA assessment, and/or Discharge assessment).
  - **OMRA – Start of Therapy (SS) Item Set.** This is the set of items active on a standalone start of therapy OMRA assessment.
  - **OMRA – Start of Therapy and Discharge Assessment (SSD) Item Set.** This is the set of items active on a PPS start of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **OMRA (SO) Item Set.** This is the set of items active on a standalone end of therapy OMRA and change of therapy OMRA assessment.
  - **OMRA - Discharge Assessment (SOD) Item Set.** This is the set of items active on a PPS end of therapy OMRA assessment combined with a Discharge assessment (either return anticipated or not anticipated).
  - **Discharge (SD) Item Set.** This is the set of items active on a standalone swing bed Discharge assessment (either return anticipated or not anticipated).
  - **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the Type of Provider, Item A0200 (indicating nursing home or swing bed), and the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2.15 of this chapter provides manual lookup tables for determining the item set when automated software is unavailable.

Item Set Codes are those values that correspond to the OBRA-required and Medicare-required PPS assessments represented in Items A0310A, A0310B, A0310C, A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the patient.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.

Medicare-Required PPS Assessments provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. Medicare-required PPS MDSs can be scheduled or unscheduled. These assessments are coded on the MDS 3.0 in Items A0310B (PPS Assessment), A0310C (PPS Other Medicare Required Assessment – OMRA), and A0310H (Is this a Part A PPS Discharge Assessment?). They include:

- 5-day
- 14-day
- 30-day
- 60-day
- 90-day
- SCSA
- SCPA
- Swing Bed Clinical Change (CCA)
- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA
- Change of Therapy (COT) OMRA
- Part A PPS Discharge Assessment

Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.

Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation

period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS.

OBRA-Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

Tracking records

- Entry
- Death in facility

Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and an OBRA Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in Items A0310A and A0310F (Discharge Assessment). Medicare reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

Assessment Management Requirements and Tips for Annual Assessments:

- The ARD (Item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or Significant Correction to Prior Quarterly assessment (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (CAA(s) completion date + 7 calendar days).

03. Significant Change In Status Assessment (SCSA) (A0310A=04)

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

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

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

A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.
A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

Assessment Management Requirements and Tips for Significant Change in Status Assessments:

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

SCSA. This timeframe may vary depending on clinical judgment and resident needs. For example, a 5% weight loss for a resident with the flu would not normally meet the requirements for a SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

- A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require a SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, a SCSA may be warranted.
- **If there is only one change**, staff may still decide that the resident would benefit from a SCSA. It is important to remember that each resident's situation is unique and the IDT must make the decision as to whether or not the resident will benefit from a SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.
- A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- A SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.
- **Decline in two or more of the following:**
  - Resident's decision-making ability has changed;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
  - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;
  - Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
  - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.

- **Improvement in two or more of the following:**
  - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - Resident's decision making improves;
  - Resident's incontinence pattern improves.

Examples (SCSA):

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

2. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.

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

Guidelines for When a Change in Resident Status Is Not Significant: Note: this is not an exhaustive list

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

04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A=05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- A SCPA is appropriate when:
  - the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (Item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (Item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (Item V0200B2) (CAA(s) completion date + 7 calendar days).

change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[6] In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[6] When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and a SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into the MDS system and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing a SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan.
- The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

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

2.7 The Care Area Assessment (CAA) Process and Care Plan Completion

Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.

CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (Item V0200B2) must be either later than or the same date as the MDS completion date (Item Z0500B). In no event can either date be later than the established timeframes as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. 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 (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

Care Plan Completion

- Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (Item V0200C2) must be either later than or the same date as the CAA completion date (Item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (Item Z0500B) must be earlier than or the same date as the care plan completion date. In no event can either date be later than the established timeframes as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

Skilled nursing facilities (SNFs) must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF PPS. In addition to the Medicare-required assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the Medicare-required assessments, such as completion and submission time frames.

Assessment Window

Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The facility is required to set the ARD on the

MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 8. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS Assessments chart below for the allowed ARDs for each of the Medicare-required assessments and other assessment information.

When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may do so no more than two days after the window has passed.

The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes. In most cases, the first day of Medicare Part A coverage is the date of admission or reentry. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date. See Chapter 6, Section 6.7, for more detailed information.

Grace Days

There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. For example, the Medicare-required 5-Day ARD can be extended 1 to 3 grace days (i.e., days 6 to 8). The use of grace days allows clinical flexibility in setting ARDs. See chart below for the allowed grace days for each of the scheduled Medicare-required assessments. Grace days are not applied to unscheduled Medicare PPS Assessments.

Scheduled Medicare PPS Assessments

The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments, each with a predetermined time period for setting the ARD for that assessment.

The SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Applicable Standard Medicare Payment Days^
5-day	01	Days 1-5	6-8	1 through 14
14-day	02	Days 13-14	15-18	15 through 30
30-day	03	Days 27-29	30-33	31 through 60
60-day	04	Days 57-59	60-63	61 through 90
90-day	05	Days 87-89	90-93	91 through 100

+Grace Days: a specific number of days that can be added to the ARD window without penalty.

^Applicable Standard Medicare Payment Days may vary when assessment types are combined. For example, when a provider combines an unscheduled assessment, such as a Significant Change in Status Assessment (SCSA), with a scheduled assessment, such as a 30-day Medicare-required assessment, the new resource utilization group (RUG) would take effect on the ARD of the assessment. If the ARD of this assessment was day 28, the new RUG would take effect on day 28 of the stay. The exception would be if the ARD fell within the grace days. In that case, the new RUG would be effective on the first day of the regular payment period. For example, if the ARD of an unscheduled assessment combined with the 60-day assessment, was day 62, the new RUG would take effect on day 61.

Unscheduled Medicare PPS Assessments

There are situations when a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments. These assessments are known as unscheduled assessments. When indicated, a provider must complete the following unscheduled assessments:

1. Significant Change in Status Assessment (for swing bed providers this unscheduled assessment is called the Swing Bed Clinical Change Assessment) (see Section 2.6).
2. Significant Correction to Prior Comprehensive Assessment (see Section 2.6).
3. Start of Therapy Other Medicare Required Assessment (SOT-OMRA) (see Section 2.9).
4. End of Therapy Other Medicare Required Assessment (EOT- OMRA) (see Section 2.9).
5. Change of Therapy Other Medicare Required Assessment (COT-OMRA) (see Section 2.9).

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window—the two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has been completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. See Chapter 6 (Section 6.4) and Section 2.10 below for complete details.

Tracking Records and Discharge Assessments Reporting

Tracking records and discharge assessments reporting are required on **all** residents in the SNF and swing bed facilities. Tracking records and standalone Discharge assessments do not impact payment.

Part A PPS Discharge Assessment (A0310H)

The Part A PPS Discharge assessment contains data elements used to calculate current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which post-acute care (PAC) providers (which includes SNFs) are required to submit standardized patient assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that patient assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting.

- Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment can also be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required.

Part A PPS Discharge Assessment (A0310H = 1):

- Must be completed when the resident's Medicare Part A stay ends, but the resident remains in the facility (i.e., is not physically discharged from the facility).
- For the Part A PPS Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.
- If the End Date of the Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000). The Part A PPS Discharge assessment may be combined with most PPS and OBRA-required assessments when requirements for all assessments are met (please see Section 2.11 Combining Medicare Assessments and OBRA Assessments).

- Must be completed (Item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day PPS assessment.

The following chart summarizes the Medicare-required scheduled and unscheduled assessments, tracking records, and discharge assessments:

Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
5-day A0310B = 01	Days 1-5	6-8	Days 1-8	Sets payment rate for days 1-14	• See Section 2.13 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA.
14-day A0310B = 02	Days 13-14	15-18	Days 13-18	Sets payment rate for days 15-30	• CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. • Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.
30-day A0310B = 03	Days 27-29	30-33	Days 27-33	Sets payment rate for days 31-60	
60-day A0310B = 04	Days 57-59	60-63	Days 57-63	Sets payment rate for days 61-90	
90-day A0310B = 05	Days 87-89	90-93	Days 87-93	Sets payment rate for days 91-100	• If combined with the OBRA Quarterly assessment the completion date requirements for the OBRA Quarterly assessment must also be met.

(continued)

Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities (cont.)

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Start of Therapy Other Medicare-required Assessment (OMRA) A0310C = 1	• 5–7 days after the start of therapy • The day of the first therapy evaluation counts as day 1	N/A	N/A	Modifies payment rate starting on the date of the first therapy evaluation	• Voluntary assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG.
End of Therapy OMRA A0310C = 2	• 1–3 days after all therapy (Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP)) services are discontinued. • The first non-therapy day counts as day 1.	N/A	N/A	Modifies payment rate starting on the day after the latest therapy end date	• Not required if the resident has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG Classification. • Only required for patients who are classified into Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment. • For circumstances when an End of Therapy with Resumption option would be used, See Section 2.9.
Change of Therapy OMRA A0310C = 4	• Day 7 of the COT observation period	N/A	N/A	Modifies payment rate starting on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other scheduled or unscheduled PPS assessment	• Required only if the intensity of therapy during the 7-day look back period would change the RUG category classification of the most recent PPS Assessment • Establishes a new RUG classification

(continued)

Medicare Scheduled and Unscheduled MDS Assessments, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities (cont.)

Assessment Type/Item Set Required for Medicare	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Grace Days ARD Can Also be Set on These Days	Allowed ARD Window	Billing Cycle Used by the Business Office	Special Comment
Significant Change in Status Assessment (SCSA) A0310A = 04	Completed by the end of the 14th calendar day after determination that a significant change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Swing Bed Clinical Change Assessment (CCA) A0310D = 1	Completed by the end of the 14th calendar day after determination that a clinical change has occurred.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Significant Correction to Prior Comprehensive Assessment (SCPA) A0310A = 05	Completed by the end of the 14th calendar day after identification of a significant, uncorrected error in prior comprehensive assessment.	N/A	N/A	Modifies payment rate effective with the ARD when not combined with another assessment*	• May establish a new RUG Classification.
Entry tracking record A0310F = 01	N/A	N/A	N/A	N/A	• May not be combined with another assessment
OBRA Discharge Assessment A0310F = 10 or 11	Must be set for the day of discharge	N/A	N/A	N/A	• May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment and the resident is physically discharged from the facility.
Part A PPS Discharge Assessment A0310H = 1	Must be set for the last day of the Medicare Part A Stay (A2400C)	N/A	N/A	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).
Death in facility tracking record A0310F = 12	N/A	N/A	N/A	N/A	May not be combined with another assessment.

*NOTE: When SCSA, SCPA, and CCA are combined with another assessment, payment rate may not be effective on the ARD. For example, a provider combines the 30-day Medicare-required assessment with a Significant Change in Status assessment with an ARD of day 33, a grace day, payment rate would become effective on day 31, not day 33. See Chapter 6, Section 6.4.

2.9 MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in Items A0310A and A0310B respectively. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item A0310B. The OBRA Reason for Assessment is described earlier in this section while the Medicare PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and Medicare requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Sections 2.11 and 2.12.

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (ASAP) system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).
- Is the first Medicare-required assessment to be completed when the resident is first admitted for SNF Part A stay.
- Is the first Medicare-required assessment to be completed when the Part A resident is re-admitted to the facility following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5-day PPS assessment as the resident is now beginning a Medicare Part A stay.

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 13 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 18 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 27 through 29 of the Part A SNF covered stay.
- ARD may be extended up to day 33 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 31 through 60 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

04. Medicare-required 60-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 57 through 59 of the Part A SNF covered stay.
- ARD may be extended up to day 63 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 61 through 90 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

05. Medicare-required 90-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 87 through 89 of the Part A SNF covered stay.
- ARD may be extended up to day 93 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 91 through 100 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

PPS Unscheduled Assessments for a Medicare Part A Stay

07. Unscheduled Assessments Used for PPS

There are several unscheduled assessment types that may be required to be completed during a resident's Part A SNF covered stay.

Start of Therapy (SOT) OMRA

- **Optional.**

- Completed **only** to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Completed **only** if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group.
- ARD (Item A2300) must be set on days 5–7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) with the exception of the Short Stay Assessment (see Chapter 6, Section 6.4). The date of the earliest therapy evaluation is counted as day 1 when determining the ARD for the Start of Therapy OMRA, regardless if treatment is provided or not on that day.
- May be combined with scheduled PPS assessments.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example if the 5-day assessment is performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued for any reason (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided whether therapy was scheduled or not scheduled for that day. For example:
  - If the resident was discharged from all therapy services on Tuesday, day 1 is Wednesday.
  - If the resident was discharged from all therapy services on Friday, Day 1 would be Saturday.
  - If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday.

- For purposes of determining when an EOT OMRA must be completed, a treatment day is defined exactly the same way as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.
- May be combined with any scheduled PPS assessment. In such cases, the item set for the scheduled assessment should be used.
- The ARD for the End of Therapy OMRA may not precede the ARD of the first scheduled PPS assessment of the Medicare stay (5-day assessment).
  - For example: if the 5-day assessment is completed on day 8 and an EOT is completed in that window, the ARD for the EOT should be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment regardless of day selected for ARD.
- Must be submitted electronically to the QIES ASAP system and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- In cases where a resident is discharged from the SNF ***on or prior to*** the third consecutive day of missed therapy services, then no EOT is required. More precisely, in cases where the date coded for Item A2000 is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If a SNF chooses to complete the EOT OMRA in this situation, they may combine the EOT OMRA with the discharge assessment.
- In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.
- In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.
- If the EOT OMRA is performed because three or more consecutive days of therapy were missed, and it is determined that therapy will resume, there are three options for completion:
  1. Complete only the EOT OMRA and keep the resident in a non-Rehabilitation RUG category until the next scheduled PPS assessment is completed. For example:
     - Mr. K. was discharged from all therapy services on Day 22 of his SNF stay. The EOT OMRA was performed on Day 24 of his SNF stay and classified into HD1. Payment continued at HD1 until the 30- day assessment was completed. At that point, therapy resumed (with a new therapy evaluation) and the resident was classified into RVB.
  2. In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or

therapy services will not resume at the same RUG-IV therapy classification level that had been in effect prior to the EOT OMRA, an SOT OMRA is required to classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well. For example: Mr. G. who had been classified into RVX did not receive therapy on Saturday and Sunday. He also missed therapy on Monday because his family came to visit, on Tuesday he missed therapy due to a doctor's appointment and refused therapy on Wednesday. An EOT OMRA was performed on Monday classifying him into the ES2 non-therapy RUG. He missed 5 consecutive calendar days of therapy. A new therapy evaluation was completed and he resumed therapy services on Thursday. An SOT OMRA was then completed and Mr. G. was placed back into the RVX therapy RUG category.

- Mrs. B., who had been classified into RHC did not receive therapy on Monday, Tuesday, and Wednesday because of an infection, and it was determined that she would be able to start therapy again on Thursday. An EOT OMRA was completed to pay for the three days she did not have therapy with a non-therapy RUG classification of HC2. It was determined that Mrs. B. would not be able to resume therapy at the same RUG-IV therapy classification, and an SOT OMRA was completed to place her into the RMB RUG-IV therapy category. A new therapy evaluation was required.

3. 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, and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. For Example:

   - 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, but resumed therapy Tuesday. 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. An EOT-R was completed and Mrs. A was placed into ES3 for the three days she did not receive therapy. On Tuesday, Mrs. A. was placed back into RVL, which was the same therapy RUG group she was in prior to the discontinuation of therapy. A new therapy evaluation was not required.

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 has 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 EOT-R items and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

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 filled out with dashes.

In cases when the therapy end date is in one payment period and the resumption date is in the next payment period, the facility should bill the non-therapy RUG given on the EOT OMRA beginning the day after the last day of therapy treatment and begin billing the therapy RUG that was in effect prior to the EOT OMRA beginning on the day that therapy resumed (O0450B). If the resumption of therapy occurs after the next billing period has started, then this therapy RUG should be used until modified by a future scheduled or unscheduled assessment.

- For example, a resident misses therapy on Days 11, 12, and 13 and resumes therapy on Day 15. In this case the facility should bill the non-therapy RUG for Days 11, 12, 13, and 14 and on Day 15 the facility should bill the RUG that was in effect prior to the EOT.

Change of Therapy (COT) OMRA

- Required when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.
- ARD is set for Day 7 of a COT observation period. The COT observation periods are successive 7-day windows with the first observation period beginning on the day following the ARD set for the most recent scheduled or unscheduled PPS assessment, except for an EOT-R assessment (see below). For example:
  - If the ARD for a patient's 30-day assessment is set for day 30, and there are no intervening assessments, then the COT observation period ends on Day 37.
  - If the ARD for the patient's most recent COT (whether the COT was completed or not) was Day 37, the next COT observation period would end on Day 44.
- In cases where the last PPS Assessment was an EOT-R, the end of the first COT observation period is Day 7 after the Resumption of Therapy date (O0450B) on the EOT-R, rather than the ARD. The resumption of therapy date is counted as day 1 when determining Day 7 of the COT observation period. For example:
  - If the ARD for an EOT-R is set for day 35 and the resumption date is the equivalent of day 37, then the COT observation period ends on day 43.
- An evaluation of the necessity for a COT OMRA (that is, an evaluation of the therapy intensity, as described above) must be completed after the COT observation period is over.
- The COT would be completed if the patient's therapy intensity, as described above, has changed to classify the resident into a higher or lower RUG category. For example:

  If a facility sets the ARD for its 14-day assessment to day 14, Day 1 for purposes of the COT period would be Day 15 of the SNF stay, and the facility would be required to review the therapy services provided to the patient for the week consisting of Day

15 through 21. The ARD for the COT OMRA would then be set for Day 21, if the facility were to determine that, for example, the total RTM has changed such that the resident's RUG classification would change from that found on the 14-day assessment (assuming no intervening assessments). If the total RTM would not result in a RUG classification change, and all other therapy category qualifiers have remained consistent with the patient's current RUG classification, then the COT OMRA would not be completed.

- If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS assessment, the SNF may choose to complete the scheduled PPS assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is ***on or prior to*** Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS assessment ARD. Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.
- In cases where a resident is discharged from the SNF ***on or prior to*** Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the OBRA Discharge assessment.

  In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met. If the date listed in A2400C is on Day 7 of the COT observation period, then the SNF must complete both the COT OMRA and the Part A PPS Discharge Assessment. These assessments must be completed separately.

  Finally, in cases where the date used to code A2400C is equal to the date used to code A2000—that is, cases where the discharge from Medicare Part A is the same day as the discharge from the facility—and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the OBRA Discharge assessment under the rules outlined for such combination in this chapter.
- The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's initial RUG-IV therapy classification in a Medicare Part A SNF stay.
- Except as described below, a COT OMRA may only be completed when a resident is currently classified into a RUG-IV therapy group (regardless of whether or not the resident is classified into this group for payment), based on the resident's most recent assessment used for payment.
- The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions are met*:
  1. Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, and

2. No discontinuation of therapy services (planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group.

Under these circumstances, completing the COT OMRA to reclassify the resident into a therapy group may be considered optional. Additionally, the COT OMRA which classifies a resident into a non-therapy group or the COT OMRA which reclassifies the resident into a therapy group may be combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual.

— Example 1: Mr. T classified into the RUG group RUA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount of therapy provided to Mr. T. and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to the lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. T. did not qualify for a therapy RUG group. The facility completes a COT OMRA for Mr. T, with an ARD set for Day 37, on which he qualifies for LB1. Mr. T's rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 44, the facility checks the amount of therapy provided to Mr. T during the previous 7 days and finds that Mr. T again qualifies for the RUG-IV therapy group RUA.

In example 1 above, because Mr. T had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment) and no discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group (Day 31, in this scenario) and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (Day 44, in this scenario), the facility may complete a COT OMRA with an ARD of Day 44 to reclassify Mr. T. back into the RUG-IV therapy group RUA.

— Example 2: Mr. A classified into the RUG group RVA on his 30-day assessment with an ARD set for Day 30 of his stay. On Day 37, the facility checked the amount of therapy provided to Mr. A during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for a Very-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. A did not qualify for any RUG-IV therapy group. The facility completes a COT OMRA for Mr. A, with an ARD set for Day 37, on which he qualifies for LB1. Mr. A's rehabilitation regimen is intended to continue from that point, but Mr. A does not receive therapy on Days 36, 37 and 38. On Day 44, the facility checks the amount of therapy provided to Mr. A during the

previous 7 days and finds that Mr. A again qualifies for the RUG-IV therapy group RVA.

In example 2 above, while Mr. A had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (i.e., the 30-day assessment), a discontinuation of therapy services occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group (i.e., the discontinuation due to Mr. A missing therapy on Days 36-38). Therefore, the facility may not complete a COT OMRA with an ARD of Day 44 to reclassify Mr. A back into the RUG-IV therapy group RVA.

- A COT OMRA may be used to reclassify a resident into a RUG-IV therapy group only when the resident was classified into a RUG-IV non-therapy by a previous COT OMRA (which may have been combined with another assessment, per the rules for combining assessments discussed in Sections 2.10 through 2.12 of this manual).

  — For example: Mr. E classified into the RUG group RUA on his 14-day assessment with an ARD set for Day 15 of his stay. No unscheduled assessments were required or completed between Mr. E's 14-day assessment and his 30-day assessment. On Day 29, the facility checked the amount of therapy provided to Mr. E during the previous 7 days and found that while he did receive the requisite number of therapy minutes to qualify for this RUG category, he only received therapy on 4 distinct calendar days, which would make it impossible for him to qualify for an Ultra-High Rehabilitation RUG group. Moreover, due to lack of 5 distinct calendar days of therapy and a lack of restorative nursing services, Mr. E did not qualify for any RUG-IV therapy group. The facility completes a 30-day assessment for Mr. E, with an ARD set for Day 29, on which he qualifies for LB1, but opts not to combine this 30-day assessment with a COT OMRA (as permitted under the COT rules outlined in Section 2.9 of the MDS 3.0 manual). Mr. E.'s rehabilitation regimen continues from that point, without any discontinuation of therapy or three consecutive days of missed therapy. On Day 36, the facility checks the amount of therapy provided to Mr. E during the previous 7 days and finds that Mr. E again qualifies for the RUG-IV therapy group RUA.

  In the scenario above, although Mr. E had qualified into a RUG-IV therapy group on a prior assessment during his current Medicare Part A stay (e.g., the 14-day assessment), the assessment which classified Mr. E into a RUG-IV non-therapy group was not a COT OMRA. Therefore, the facility may not complete a COT OMRA with an ARD of Day 36 to reclassify Mr. E back into the RUG-IV therapy group RUA.

  If a resident is classified into a non-therapy RUG on a COT OMRA and the facility subsequently decides to discontinue therapy services for that resident, an EOT OMRA is not required for this resident.

- When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.

- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a new RUG-IV category. Payment begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other PPS assessment.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Significant Change in Status Assessment (SCSA)

- Is an OBRA-required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification.
- When a SCSA for a SNF PPS resident is not combined with a PPS assessment (A0310A = 04 and A0310B = 99), the RUG-IV classification and associated payment rate begin on the ARD. For example, a SCSA is completed with an ARD of day 20 then the RUG-IV classification begins on day 20.
- When the SCSA is completed with a scheduled Medicare-required assessment and grace days are not used when setting the ARD, the RUG-IV classification begins on the ARD. For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.
- When the SCSA is completed with a scheduled Medicare-required assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. For example, the SCSA is combined with the Medicare-required 30-day scheduled assessment, which pays for days 31 to 60, and the ARD is set at day 33, the RUG-IV classification begins day 31.

Swing Bed Clinical Change Assessment

- Is a required assessment for swing bed providers. Staff is responsible for determining whether a change (either an improvement or decline) in a patient's condition constitutes a "clinical change" in the patient's status.
- Is similar to the OBRA Significant Change in Status Assessment with the exceptions of the CAA process and the timing related to the OBRA Admission assessment. See Section 2.6 of this chapter.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Significant Correction to Prior Comprehensive Assessment

- Is an OBRA-required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Coding Tips and Special Populations

- When coding a standalone 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.
- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. For example, if Day 7 of the COT observation period is May 23rd and the COT is required, then the ARD for this COT must be set for May 23rd and this must be done by May 25th. Facilities may still exercise the use of this flexibility period in cases where the resident discharges from the facility during that period.
- Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, J) on or prior to the ARD for a standalone unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).

2.10 Combining Medicare Scheduled and Unscheduled Assessments

There may be instances when more than one Medicare-required assessment is due in the same time period. To reduce provider burden, CMS allows the combining of assessments. Two Medicare-required Scheduled Assessments may **never** be combined since these assessments have specific ARD windows that do not occur at the same time. However, it is possible that a Medicare-required Scheduled Assessment and a Medicare Unscheduled Assessment may be combined or that two Medicare Unscheduled assessments may be combined.

When combining assessments, the more stringent requirements must be met. For example, when a Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the PPS item set must be used. The PPS item set contains all the required items for the 14-Day Medicare-required assessment, whereas the Start of Therapy OMRA item set consists of fewer items, thus the provider would need to complete the PPS item set. The ARD window (including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.

> **DEFINITION**
>
> **USED FOR PAYMENT**
> An assessment is considered to be "used for payment" in that it either controls the payment for a given period or, with scheduled assessments, may set the basis for payment for a given period.

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in this chapter and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software the coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15).

In cases when a facility fails to combine a scheduled and unscheduled PPS assessment as required by the combined assessment policy, the payment is controlled by the unscheduled assessment. For example: if the ARD of an EOT OMRA is set for Day 14 and the ARD of a 14-day assessment is set for Day 15, this would violate the combined assessment policy. Consequently, the EOT OMRA would control the payment. The EOT would begin payment on Day 12, and continue paying into the 14-day payment window until the next scheduled or unscheduled assessment used for payment.

PPS Scheduled Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within the ARD window for the Medicare-required scheduled assessment **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

A0310A = 99
A0310B = 01, 02, 03, 04, or 05 as appropriate
A0310C = 1
A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare scheduled assessment **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). If both ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 2
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 3
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Change of Therapy OMRA

- The ARD must be set within the window for the scheduled assessment and on day 7 of the COT observation period. If both ARD requirements are not met, the assessments may not be combined.
- Must complete the scheduled PPS assessment item set.

- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current standard payment period and the next payment period appropriate to the given scheduled assessment, assuming no intervening assessments. For example:
  - Based on her 14-day assessment, Mrs. T is currently classified into group RVB. Based on the ARD set for the 14-day assessment, a change of therapy evaluation for Mrs. T is necessary on Day 28. The change of therapy evaluation reveals that the therapy services Mrs. T received during that COT observation period were only sufficient to qualify Mrs. T for RHB. Therefore, a COT OMRA is required. Since the facility has not yet completed a 30-day assessment for Mrs. T, the facility must combine the 30-day assessment with the required COT OMRA. The combined assessment confirms Mrs. T's appropriate classification into RHB. The payment for the revised RUG classification will begin on Day 22 and, assuming no intervening assessments, will continue until Day 60.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 4
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- If the ARD for the Swing Bed Clinical Change Assessment falls within the ARD (including grace days) of a PPS scheduled assessment that has not been completed yet, the assessments MUST be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99 (only value allowed for Swing Beds)
  A0310B = 01, 02, 03, 04, or 05 as appropriate
  A0310C = 0
  A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination

that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.

- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 07
  A0310C = 1
  A0310D = 1

Swing Bed Clinical Change Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 07
  A0310C = 2
  A0310D = 1

Swing Bed Clinical Change Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 07
  A0310C = 3
  A0310D = 1

2.11 Combining Medicare Assessments and OBRA Assessments[7]

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

- The OBRA standards are designated by the reason selected in Item A0310A, **Federal OBRA Reason for Assessment**, and Item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, Item A0310C, **PPS Other Medicare Required Assessment - OMRA**, and Item A0310H, **Is this a SNF Part A PPS Discharge Assessment**?, and are required for residents whose stay is covered by Medicare Part A.
- When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA Admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

Some states require providers to complete additional state-specific items (Section S) for selected assessments. States may also add comprehensive items to the Quarterly and/or PPS item sets. Providers must ensure that they follow their state requirements in addition to any OBRA and/or Medicare requirements.

7 OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.

The following tables provide the item set for each type of assessment or tracking record. When two or more assessments are combined then the appropriate item set contains all items that would be necessary if each of the combined assessments were being completed individually.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly and PPS* Item Sets	Other Required Assessments and Tracking Records/Item Sets
Stand-alone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day)	• Entry Tracking Record • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Start of Therapy OMRA • Change of Therapy OMRA • End of Therapy OMRA
Combined Assessment Types	• OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required PPS • Annual and any OMRA • SCSA and any Medicare-required • SCSA and any OMRA • SCPA and any Medicare-required • SCPA and any OMRA • Any OBRA comprehensive and any Discharge	• Quarterly and any Medicare-scheduled • Quarterly and any OMRA • Medicare required and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Medicare required and any Discharge • Quarterly and OMRA Discharge • Significant Correction to Prior Quarterly and any Discharge	• Start of Therapy OMRA and End of Therapy OMRA • Start of Therapy OMRA and OBRA Discharge • End of Therapy OMRA and OBRA Discharge • Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge • Change of Therapy OMRA and OBRA Discharge

*Provider must check with State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS/Item Set	Other Required Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	• PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • Swing Bed Clinical Change Assessment	• Entry Record • OBRA Discharge assessment • Death in Facility record • Start of Therapy OMRA • Change of Therapy OMRA • End of Therapy OMRA
Assessment Type Combinations*	• Any Medicare required and any OMRA • Any Medicare required and any Discharge • Swing Bed Clinical Change and any Medicare required • Swing Bed Clinical Change and any Discharge	• Start of Therapy OMRA and End of Therapy OMRA • Start of Therapy OMRA and OBRA Discharge • End of Therapy OMRA and OBRA Discharge • Start of Therapy OMRA and End of Therapy OMRA and OBRA Discharge • Change of Therapy OMRA and OBRA Discharge

Tracking records (Entry and Death in Facility) are never combined with other assessments.

The OMRA item sets are all unique item sets and are never completed when combining with other assessments, which require completion of additional items. For example, a **Start of Therapy OMRA** item set is completed only when an assessment is conducted to capture the start of therapy **and** assign a RUG-IV therapy group. In addition, a **Start of Therapy OMRA and OBRA Discharge** item set is only completed when the facility staff choose to complete an assessment to reflect both the start of therapy and discharge from facility. If assessments are completed in combination with another assessment type, an item set that contains all items required for both assessments must be selected.

2.12 Medicare and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. A provider may choose to combine more than two assessment types when all requirements are met. The coding of Item A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in Item A0310 (see Section 2.15).

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).

- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required 14-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 13 or 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 18 (i.e., grace days may not be used).
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Quarterly assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Quarterly ARD is met.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Medicare-required Scheduled Assessment and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Annual assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Annual ARD is met.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- Must be completed (Item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.

- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- Must be completed (Item Z0500B) within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Quarterly Assessment

- See Medicare-required Scheduled Assessment and OBRA Quarterly Assessment.

Medicare-required Scheduled Assessment and OBRA Discharge Assessment

- PPS item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Medicare-required Scheduled Assessment and Part A PPS Discharge Assessment

- PPS item set.
- ARD (Item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.

- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) and meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that criteria are met for a Significant Change in Status assessment **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after determination that an uncorrected significant error in a comprehensive assessment has occurred **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in a comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment.

Start of Therapy OMRA and OBRA Discharge Assessment

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) within 14 days after the ARD.

End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1–3 days after the last day therapy was furnished (difference is 3 or less for Item A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.

- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 1–3 days after the end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.

- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 1–3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and OBRA Discharge Assessment

- OMRA and OBRA Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start and End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (Item A2300) must be 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start and End of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** meet the requirements for OBRA Annual assessment requirements as described in Section 2.6.

- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the end of therapy (O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Z0500B) within 14 days after the ARD and within 14 days after the determination that criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1–3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.

- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Start and End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See Start and End of Therapy OMRA and OBRA Quarterly Assessment.

Start and End of Therapy OMRA and OBRA Discharge Assessment

- OMRA-Start of Therapy and OBRA Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must fall within 5–7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1–3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Change of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier after admission **and** be on the last day of a COT 7-day observation period. Must be completed (Item Z0500B) by day 14 after admission (admission date plus 13 calendar days).
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.

- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must meet the requirements for an OBRA Quarterly assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period. Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Change of Therapy OMRA and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must meet the requirements for an OBRA Annual assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that the criteria are met for a Significant Change in Status assessment **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected error in the prior comprehensive assessment has occurred **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Correction assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and OBRA Discharge Assessment

- COT OMRA and OBRA Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** be on the last day of a COT 7-day observation period. The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

2.13 Factors Impacting the SNF Medicare Assessment Schedule[8]

Resident Expires Before or On the Eighth Day of SNF Stay

If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail). The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (e.g., transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required. If there is not a PPS MDS in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The Medicare Short Stay Policy may apply (see Chapter 6, Section 6.4 for greater detail).

[8] These requirements/policies also apply to swing bed providers.

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required.

When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments may be combined. (See Sections 2.11 and 2.12 for details on combining a Medicare-required assessment with a Discharge assessment.)

Short Stay

If the beneficiary dies, is discharged from the SNF, or discharged from Part A level of care on or before the eighth day of covered SNF stay, the resident may be a candidate for the short stay policy. The short stay policy allows the assignment into a Rehabilitation Plus Extensive Services or Rehabilitation category when a resident received rehabilitation therapy and was not able to have received 5 days of therapy due to discharge from Medicare Part A. See Chapter 6, Section 6.4 for greater detail.

Resident Is Admitted to an Acute Care Facility and Returns

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted.

For all providers, including Swing bed providers, the first required Medicare assessment is always the Medicare-required 5-Day assessment (Item A0310B = 01) as long as the resident is eligible for Medicare Part A services, requires and receives skilled services and has days remaining in the benefit period.

Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, the Medicare assessment schedule is not restarted. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the "midnight rule." The Medicare assessment schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment clock is adjusted by skipping that day in calculating when the next Medicare assessment is due. For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes day 22 of his Part A stay.

Resident Takes a Leave of Absence from the SNF

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-13 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments. For **scheduled PPS assessments**, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves

a SNF at 6:00pm on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00am, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay. Therefore, a facility that would choose Day 27 for the ARD of their 30-day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day.

In the case of **unscheduled PPS assessments**, the ARD of the relevant assessment is not affected by the LOA because the ARDs for unscheduled assessments are not tied directly to the Medicare assessment calendar or to a particular day of the resident's stay. For instance, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. For example, if the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 9, returning on November 10, Day 7 of the COT observation period would remain November 14.

Moreover, a SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

There may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days.

If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3).

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation when a beneficiary's Medicare Part A stay ends but he/she remains in the facility in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission and must also complete a Part A PPS Discharge assessment. There is no reason to change the OBRA schedule

when Part A benefits resume. If the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

The original date of entry (Item A1600) is retained. The beneficiary should be assessed to determine if there was a significant change in status. A SCSA could be completed with either the Medicare-required 5-day or 14-day assessment or separately.

Resident Discharged from Part A Skilled Services and Is Not Physically Discharged from the Skilled Nursing Facility

In the situation when a resident's Medicare Part A stay ends but the resident is not physically discharged from the facility, the Part A PPS Discharge assessment is required. If the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

Delay in Requiring and Receiving Skilled Services

There are instances when the beneficiary does not require SNF level of care services when initially admitted to the SNF. See Chapter 6, Section 6.7.

Non-Compliance with the PPS Assessment Schedule

According to Part 42 Code of Federal Regulation (CFR) Section 413.343, an assessment that does not have its ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent early or late assessment scheduling practices may result in a review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. On November 8, which is Day 7 of the COT observation period, it is determined that a COT is required. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be

paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

If the ARD on the late assessment is set for **prior to the end of the period during which the late assessment would have controlled the payment,** had the ARD been set timely, and/or **no intervening assessments have occurred, the SNF will bill the default rate for the number of days that the assessment is out of compliance.** This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.** For example, a Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for 8 days and therefore would be paid at the default rate for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. In this example, if there are no other assessments until the 60-day assessment, the remaining 22 days are billed according to the HIPPS code on the late assessment.

A second example, involving a late unscheduled assessment would be if a COT OMRA was completed with an ARD of Day 39, while Day 7 of the COT observation period was Day 37. In this case, the COT OMRA would be considered 2 days late and the facility would bill the default rate for 2 days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment, in this case, for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar.

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment,** had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment.** For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8).

A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the

resident's last day of therapy was Day 39. Upon further review of the resident's record on Day 52, the facility determines that a COT should have been completed with an ARD of Day 37 but was not. The ARD for the COT OMRA is set for day 52. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. Because there was an intervening assessment (in this case the EOT OMRA) prior to the ARD of the late COT OMRA, the facility would bill the default rate for 9 days (the period during which the COT OMRA would have controlled payment). The facility would bill the RUG from the EOT OMRA as per normal beginning the first non-therapy day, in this case Day 40, until the next scheduled or unscheduled assessment used for payment.

Missed PPS Assessment

If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system may be used to bill for some Part A days when specific circumstances are met. See Chapter 6, Section 6.8 for greater detail.

In the case of an unscheduled PPS assessment, if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with the late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

Errors on a PPS Assessment

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

*These requirements/policies also apply to swing bed providers.

2.14 Expected Order of MDS Records

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (Item A1700) indicating admission, and the next record is expected to be an admission assessment, a 5-day PPS assessment, a discharge, or death in facility. The QIES ASAP system will issue a warning when an unexpected record is submitted. Examples include, an assessment record after a discharge (an entry is expected) or any record after a death in facility record.

The target date, rather than the submission date, is used to determine the order of records. The target date is the assessment reference date (Item A2300) for assessment records, the entry date (Item A1600) for entry records, and the discharge date (Item A2000) for discharge or death in facility records. In the following table, the prior record is represented in the columns and the next (subsequent) record is represented in the rows. A "no" has been placed in a cell when the next record is not expected to follow the prior record; the QIES ASAP system will issue a record order warning for record combinations that contain a "no." A blank cell indicates that the next

record is expected to follow the prior record; a record order warning will ***not*** be issued for these combinations.

For the first MDS 3.0 record with event date on or after October 1, 2010, the last MDS 2.0 record (if available) should be used to determine if the record order is expected. The QIES ASAP system will find the last MDS 2.0 record and issue a warning if the order of these two records is unexpected.

Note that there are not any QIES ASAP record order warnings produced for Swing Bed MDS records.

Expected Order of MDS Records

	Prior Record													
Next Record	**Entry**	**OBRA Admission**	**OBRA Annual**	**OBRA Quarterly**	**PPS 5-day**	**PPS 14-day**	**PPS 30-day**	**PPS 60-day**	**PPS 90-day**	**PPS OMRA/ Clinical Change**	**OBRA Discharge**	**Part A PPS Discharge**	**Death in facility**	**No prior record**
Entry	no	no	no	no	no	no	no	no	no	no		no	no	
OBRA Admission		no	no	no			no	no	no		no		no	no
OBRA Annual		no	no								no		no	no
OBRA Quarterly, sign. change, sign correction											no		no	no
PPS 5-day					no	no	no	no	no		no		no	no
PPS 14-day	no					no	no	no	no		no		no	no
PPS 30-day	no				no		no	no	no		no		no	no
PPS 60-day	no	no			no	no		no	no		no		no	no
PPS 90-day	no	no			no	no	no		no		no		no	no
PPS Unscheduled											no	no	no	no
OBRA Discharge											no		no	no
Part A PPS Discharge											no		no	no
Death in facility											no		no	no

Note: “no” indicates that the record sequence is not expected; record order warnings will be issued for these combinations. Blank cells indicate expected record sequences; no record order warning will be issued for these combinations.

2.15 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, A0310 F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310F, and A0310H. Item A0310D (swing bed clinical change assessment) has been omitted because it will always be skipped on a nursing home record. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of Items A0310A, A0310B, A0310C, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01	01,02,99	0	10,11,99	0,1	NC	Comprehensive
01	01,02,07	1,2,3	10,11,99	0,1	NC	Comprehensive
01	02,07	4	10,11,99	0,1	NC	Comprehensive
03	01 thru 05,99	0	10,11,99	0,1	NC	Comprehensive
03,04,05	01 thru 07	1,2,3	10,11,99	0,1	NC	Comprehensive
03,04,05	02 thru 05,07	4	10,11,99	0,1	NC	Comprehensive
04,05	01 thru 07,99	0	10,11,99	0,1	NC	Comprehensive
02,06	01 thru 05,99	0	10,11,99	0,1	NQ	Quarterly
02,06	01 thru 07	1,2,3	10,11,99	0,1	NQ	Quarterly
02,06	02 thru 05,07	4	10,11,99	0,1	NQ	Quarterly
99	01 thru 05	0,1,2,3	10,11,99	0,1	NP	PPS
99	02 thru 05	4	10,11,99	0,1	NP	PPS
99	07	1	99	0	NS	SOT OMRA
99	07	1	10,11	0,1	NSD	SOT OMRA and Discharge
99	07	2,3,4	99	0	NO	EOT, EOT-R or COT OMRA
99	07	2,3,4	10,11	0,1	NOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	10,11	0,1	ND	OBRA Discharge
99	99	0	01,12	0	NT	Tracking
99	99	0	99	1	NPE	Part A PPS Discharge

Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C = 0, Item A0310F = 99, and A0310H = 0 (a standalone OBRA Admission assessment), then these

values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C = 0, Item A0310F = 12, and A0310H = 0 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C = 0, A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.

There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. An inactivation request is indicated by A0050 = 3. The item set for this type of record is "Inactivation" with an ISC code of XX.

The next lookup table is for swing bed records. The first 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310C, A0310D, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	Part A Discharge (A0310H)	ISC	Description
99	01 thru 05	0,1,2,3	0	10,11,99	0,1	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	0,1	SP	PPS
99	02 thru 05	4	0	10,11,99	0,1	SP	PPS
99	02 thru 05,07	4	1	10,11,99	0,1	SP	PPS
99	07	1	0	99	0	SS	SOT OMRA
99	07	1	0	10,11	0,1	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	0	SO	EOT, EOT-R or COT OMRA
99	07	2,3,4	0	10,11	0,1	SOD	EOT, EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	0,1	SD	Discharge
99	99	0	0	01,12	0	ST	Tracking

The "Inactivation" (XX) item set is also used for swing beds when Item A0050 = 3.

- Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.
- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.
- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete your initial case differently?
- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

4. **Use of information in this chapter:**
   - Keep this chapter with you during the assessment process.
   - Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

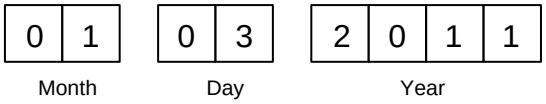
3.3 Coding Conventions

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.
- When determining the response to items that have a look-back period to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to the QIES ASAP system. PPS assessments that are completed for private insurance and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore should not be considered when determining the "prior assessment."
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as

directed (e.g., item B0100, **Comatose**, directs the assessor to skip to item G0110, **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes.** The intervening items from B0200-F0800 would not be coded (i.e. left blank). If B0100 was recorded as **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200).

- Use a check mark for boxes where the instructions state to "check all that apply," if specified condition is met; otherwise these boxes remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., D0350, **Safety Notification**).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2011 is recorded as:



- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system.
  - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
  - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
  - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
  - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.
- When the term "physician" is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.
- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident's family, significant other, and guardian or legally authorized representative should be consulted.
- Several times throughout the manual the word "significant" is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0 , the term "significant" when discussing clinical, medical, or laboratory findings

refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term "significant" is used in discussing relationships between people, as in "significant other," it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.

- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g., for item K0200B, if the weight was 1010 lbs, you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
GG	Functional Abilities and Goals	Assess the need for assistance with self-care and mobility activities.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Diagnoses	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments, Procedures, and Programs	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.

Section	Title	Intent
P	Restraints and Alarms	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

A0600: Social Security and Medicare Numbers (cont.)

Coding Instructions

- Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no social security number is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank.
- Enter Medicare number in A0600B exactly as it appears on the resident's documents.
- If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the leftmost space followed by one letter/digit per space. If no Medicare number or RRB number is known or available, the item may be left blank.
- For PPS assessments (A0310B = 01, 02, 03, 04, 05, and 07), either the Medicare or Railroad Retirement Board (RRB) number (A0600B) must be present (i.e., may not be left blank). Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.
- A0600B can only be a Medicare number or a Railroad Retirement Board number.

DEFINITIONS

SOCIAL SECURITY NUMBER
A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER (OR COMPARABLE RAILROAD INSURANCE NUMBER)
An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier may be different from the resident's social security number (SSN), and may contain both letters and numbers. For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.

A0700: Medicaid Number

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient	

Item Rationale

- Assists in correct resident identification.

A1300: Optional Resident Items (cont.)

Coding Instructions for A1300D, Lifetime Occupation(s)

- Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the nursing home. When two occupations are identified, place a slash (/) between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker." For a resident who is a child or an intellectually disabled/developmentally disabled adult resident who has never had an occupation, record as "none."

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR) Complete only if A0310A = 01, 03, 04, or 05	
Enter Code ☐	**Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation)/developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when a Significant Change in Status Assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.[1]

[1] The statute may also be referenced as 42 USC 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html for CMS information on PASRR.

Planning for Care

- The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.
- The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to Resident Review upon change in condition.

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

- Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:
  - PASRR Level I screening did not result in a referral for Level II screening, or
  - Level II screening determined that the resident does not have a serious mental illness and/or intellectual/developmental disability or related condition, or
  - PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

A2400: Medicare Stay (cont.)

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:

   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 10-20-2016
   - A2100 = 03
   - A2300 = 10-20-2016
   - A2400A = 1
   - A2400B = 10-15-2016
   - A2400C = 10-20-2016

   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.

4. Mrs. K began receiving services under Medicare Part A on October 4, 2016. She was discharged from Medicare Part A services on December 17, 2016. She and her family had already decided that Mrs. K would remain in the facility for long-term care services, and she was moved into a private room (which was dually certified) on December 18, 2016. Code the following on her Part A PPS Discharge assessment:

   - A0310F = 99
   - A0310G = ^
   - A0310H = 1
   - A2000 = ^
   - A2100 = ^
   - A2300 = 12-17-2016
   - A2400A = 1
   - A2400B = 10-04-2016
   - A2400C = 12-17-2016

   Rationale: Because Mrs. K's Medicare Part A stay ended, and she remained in the facility for long-term care services, a **standalone** Part A PPS Discharge was required.

A2400: Medicare Stay (cont.)

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:

   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 11-26-2016
   - A2100 = 03
   - A2300 = 11-26-2016
   - A2400A = 1
   - A2400B = 11-15-2016
   - A2400C = 11-25-2016

   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.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- For the purposes of completing Section G, "facility staff" pertains to 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. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.
- The ADL Self-Performance coding level definitions are intended to reflect real world situations where slight variations in level of ADL self-performance are common.
- To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-8.
- This section involves a two-part ADL evaluation: Self-Performance, which measures how much of the ADL activity the resident can do for himself or herself, and Support Provided, which measures how much facility staff support is needed for the resident to complete the ADL. Each of these sections uses its own scale; therefore, it is recommended that the ADL Self-Performance evaluation (Column 1) be completed for all ADL activities before beginning the ADL Support evaluation (Column 2).

Coding Instructions for G0110, Column 1, ADL Self-Performance

- Code 0, independent: if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- Code 1, supervision: if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.
- Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
  - Weight-bearing support provided **three or more times, OR**
  - Full staff performance of activity **three or more times** during part but not all of the last 7 days.

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.**

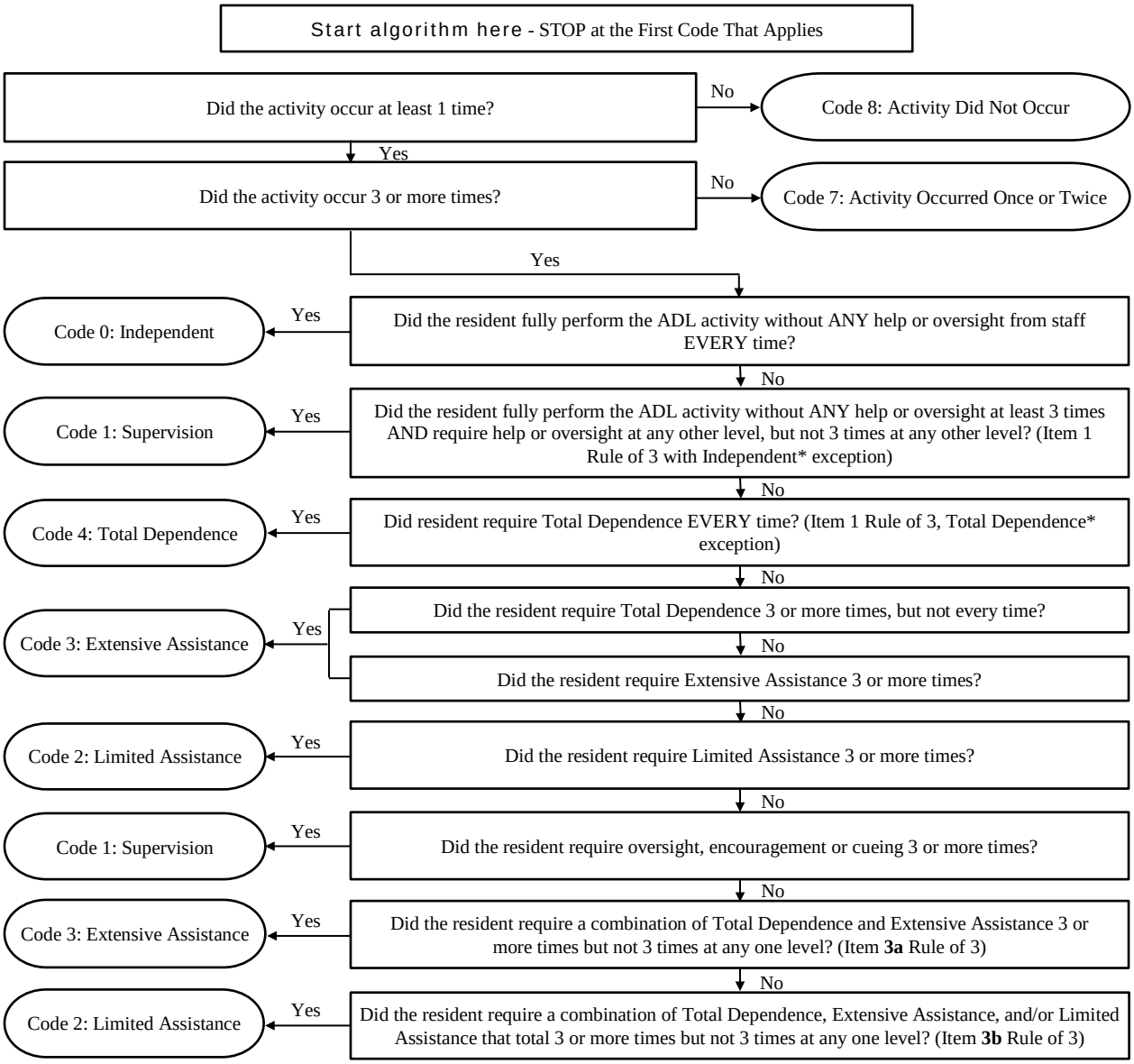
*** Exceptions to Rule of 3:**

- 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).



G0110: Activities of Daily Living (ADL) Assistance (cont.)

Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.*

- Code 0, no setup or physical help from staff: if resident completed activity with no help or oversight.
- Code 1, setup help only: if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- Code 2, one person physical assist: if the resident was assisted by one staff person.
- Code 3, two+ person physical assist: if the resident was assisted by two or more staff persons.
- Code 8, ADL activity itself did not occur during the entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Tips and Special Populations

- Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.
- Do **NOT** record the staff's assessment of the resident's potential capability to perform the ADL activity. The assessment of potential capability is covered in **ADL Functional Rehabilitation Potential** Item (G0900).
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- 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.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- 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.
- 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.
- Do **NOT** include assistance provided by family or other visitors.
- **Some examples for coding for ADL Support Setup Help when the activity involves the following:**
  - Bed Mobility—handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and then provides no further help.
  - Transfer—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
  - Locomotion
    - Walking—handing the resident a walker or cane.
    - Wheeling—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
  - Dressing—retrieving clothes from the closet and laying out on the resident's bed; handing the resident a shirt.
  - Eating—cutting meat and opening containers at meals; giving one food item at a time.
  - Toilet Use—handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
  - Personal Hygiene—providing a washbasin and grooming articles.
- **Supervision**
  - **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
  - General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Coding activity did not occur, 8:**
  - **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
  - **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

- **Coding activity occurred only once or twice, 7:**
  - Walk in corridor would be **coded 7, activity occurred only once or twice**: if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the 7-day look-back period.
  - Locomotion off unit would be **coded 7, activity occurred only once or twice**: if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building.
- **Residents with tube feeding, TPN, or IV fluids**
  - **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
  - **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

   RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"
   NA: "She can lay down and sit up by herself, but I help her turn on her side."
   RN: "She lays down and sits up without any verbal instructions or physical help?"
   NA: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."
   RN: "How do you help her turn side to side?"
   NA: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."
   RN: "Do you lift her by yourself or does someone help you?"
   NA: "I do it by myself."
   RN: "How many times during the last 7 days did you give this type of help?"
   NA: "Every day, probably 3 times each day."

G0110: Activities of Daily Living (ADL) Assistance (cont.)

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, so be sure to consider each activity definition fully. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of the actual assistance Mrs. L. received. This information is important to know and document because accurate coding and supportive documentation provides the basis for reporting on the type and amount of care provided.

Coding: Bed Mobility ADL assistance would be coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.

Examples for G0110A, Bed Mobility

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. She requires use of a single side rail that staff place in the up position when she is in bed.

   Coding: G0110A1 would be coded 0, independent.
   G0110A2 would be coded 1, setup help only.

   Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must verbally remind her to reposition off her right side daily during the 7-day look-back period.

   Coding: G0110A1 would be coded 1, supervision.
   G0110A2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place her hands on the side rail and encourage her to change her position when in bed daily over the 7-day look-back period.

   Coding: G0110A1 would be coded 2, limited assistance.
   G0110A2 would be coded 2, one person physical assist.

   Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

4. Mr. Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition him toward the head of the bed. Mr. Q. was able to assist by bending his knees and pushing with legs when reminded by staff.

   Coding: G0110A1 would be coded 3, extensive assistance.
   G0110A2 would be coded 3, two+ persons physical assist.

   Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She must be physically assisted to a seated position in bed when reading.

   Coding: G0110A1 would be coded 4, total dependence.
   G0110A2 would be coded 3, two+ persons physical assist.

   Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position her in bed.

Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

   Coding: G0110B1 would be coded 0, independent.
   G0110B2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident is independent each and every time she transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as she transfers from her bed to wheelchair daily. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

   Coding: G0110B1 would be coded 1, supervision.
   G0110B2 would be coded 1, setup help only.

   Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then assist the resident with guided maneuvering as she transfers. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

   Coding: G0110B1 would be coded 2, limited assistance.
   G0110B2 would be coded 2, one person physical assist.

   Rationale: Resident requires staff to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

4. Mrs. B. requires weight-bearing assistance of one staff member to partially lift and support her when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

   Coding: G0110B1 would be coded 3, extensive assistance.
   G0110B2 would be coded 2, one person physical assist.

   Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

5. Mr. T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. T. is unable to assist or participate in any way.

   Coding: G0110B1 would be coded 4, total dependence.
   G0110B2 would be coded 3, two+ persons physical assist.

   Rationale: Resident did not participate and required two staff to transfer him out of his bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

6. Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

   Coding: G0110B1 would be coded 8, activity did not occur.
   G0110B2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: Activity did not occur.

7. Mr. M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

   Coding: G0110B1 would be coded 7, activity occurred only once or twice.
   G0110B2 would be coded 3, two+ persons physical assist.

   Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110C, Walk in Room

1. Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff at all during the entire 7-day look-back period.

   Coding: G0110C1 would be coded 0, independent.
   G0110C2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident is independent.

2. Mr. B. was able to walk in his room daily, but a staff member needed to cue and stand by during ambulation because the resident has had a history of an unsteady gait.

   Coding: G0110C1 would be coded 1, supervision.
   G0110C2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident requires staff supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from staff.

3. Mr. K. is able to walk in his room, and, with hand-held assist from one staff member, the resident was noted to ambulate daily during the 7-day look-back period.

   Coding: G0110C1 would be coded 2, limited assistance.
   G0110C2 would be coded 2, one person physical assist.
   Rationale: Resident requires hand-held (non-weight-bearing) assistance of one staff member daily for ambulation in his room.

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to help support him when he selects clothing from his closet. During the 7-day look-back period the resident was able to ambulate with weight-bearing assistance from one staff member in his room four times.

   Coding: G0110C1 would be coded 3, extensive assistance.
   G0110C2 would be coded 2, one person physical assist.
   Rationale: The resident was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one staff member.

5. Mr. J. is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance to stand pivot to a commode next to his bed.

   Coding: G0110C1 would be coded 8, activity did not occur.
   G0110C2 would be coded 8, ADL activity itself did not occur during entire period.
   Rationale: Activity did not occur.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110D, Walk in Corridor

1. Mr. X. ambulated daily up and down the hallway on his unit with a cane and did not require any setup or physical help from staff at any time during the 7-day look-back period.

   Coding: G0110D1 would be coded 0, independent.
   G0110D2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident requires no setup or help from the staff at any time during the entire 7-day look-back period.

2. Staff members provided verbal cueing while resident was walking in the hallway every day during the 7-day look-back period to ensure that the resident walked slowly and safely.

   Coding: G0110D1 would be coded 1, supervision.
   G0110D2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident requires staff supervision, cueing, and reminders daily while ambulating in the hallway during the 7-day look-back period.

3. A resident had back surgery 2 months ago. Two staff members must physically support the resident as he is walking down the hallway because of his unsteady gait and balance problem. During the 7-day look-back period the resident was ambulated in the hallway three times with physical assist of two staff members.

   Coding: G0110D1 would be coded 3, extensive assistance.
   G0110D2 would be coded 3, two+ persons physical assist.
   Rationale: The resident was ambulated three times during the 7-day look-back period, with the resident partially participating in the task. Two staff members were required to physically support the resident so he could ambulate.

4. Mrs. J. ambulated in the corridor once with supervision and once with non-weight-bearing assistance of one staff member during the 7-day look-back period.

   Coding: G0110D1 would be coded 7, activity occurred only once or twice.
   G0110D2 would be coded 2, one person physical assist.
   Rationale: The activity occurred only twice during the look-back period. It does not matter that the level of assistance provided by staff was at different levels. During ambulation, the most support provided was physical help by one staff member.

Example for G0110E, Locomotion on Unit

1. Mrs. L. is on complete bed rest. During the 7-day look-back period she did not get out of bed or leave the room.

   Coding: G0110E1 would be coded 8, activity did not occur.
   G0110E2 would be coded 8, ADL activity itself did not occur during entire period.
   Rationale: The resident was on bed rest during the look-back period and never left her room.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110F, Locomotion off Unit

1. Mr. R. does not like to go off his nursing unit. He prefers to stay in his room or the day room on his unit. He has visitors on a regular basis, and they visit with him in the day room on the unit. During the 7-day look-back period the resident did not leave the unit for any reason.

   Coding: G0110F1 would be coded 8, activity did not occur.
   G0110F2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: Activity did not occur at all.

2. Mr. Q. is a wheelchair-bound and is able to self-propel on the unit. On two occasions during the 7-day look-back period, he self-propelled off the unit into the courtyard.

   Coding: G0110F1 would be coded 7, activity occurred only once or twice.
   G0110F2 would be coded 0, no setup or physical help from staff.

   Rationale: The activity of going off the unit happened only twice during the look-back period with no help or oversight from staff.

3. Mr. H. enjoyed walking in the nursing home garden when weather permitted. Due to inclement weather during the assessment period, he required multiple levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.

   Coding: G0110F1 would be coded 1, supervision.
   G0110F2 would be coded 2, one person physical assist.

   Rationale: Activity did not occur at any one level for three times and he did not require physical assistance for at least three times. The most support provided by staff was one person assist.

Example for G0110G, Dressing

1. Mrs. C. did not feel well and chose to stay in her room. She requested to stay in night clothes and rest in bed for the entire 7-day look-back period. Each day, after washing up, Mrs. C. changed night clothes with staff assistance to guide her arms and assist in guiding her nightgown over her head and buttoning the front.

   Coding: G0110G1 would be coded 2, limited assistance.
   G0110G2 would be coded 2, one person physical assist.

   Rationale: Resident was highly involved in the activity and changed clothing daily with non-weight-bearing assistance from one staff member during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110H, Eating

1. After staff deliver Mr. K.'s meal tray, he consumes all food and fluids without any cueing or physical help during the entire 7-day look-back period.

   Coding: G0110H1 would be coded 0, independent.
   G0110H2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

2. One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.

   Coding: G0110H1 would be coded 1, supervision.
   G0110H2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.

3. Mr. V. is able to eat by himself. Staff must set up the tray, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the resident to eat and handing him his utensils and cups, staff must also guide the resident's hand so he will get the utensil to his mouth.

   Coding: G0110H1 would be coded 2, limited assistance.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident is unable to complete the evening meal without staff providing him non-weight-bearing assistance daily.

4. Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

   Coding: G0110H1 would be coded 3, extensive assistance.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident partially participated in the task daily at each meal, but one staff member provided weight-bearing assistance with some portion of each meal.

5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. She relied on one staff member for all nourishment during the 7-day look-back period.

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: Resident did not participate and required one staff person to feed her all of her meals during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

6. Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she did not participate in the gastrostomy nourishment process.

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.

   Rationale: During the 7-day look-back period, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full staff performance of these functions.

Examples for G0110I, Toilet Use

1. Mrs. L. transferred herself to the toilet, adjusted her clothing, and performed the necessary personal hygiene after using the toilet without any staff assistance daily during the entire 7-day look-back period.

   Coding: G0110I1 would be coded 0, independent.
   G0110I2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident was independent in all her toileting tasks.

2. Staff member must remind resident to toilet frequently during the day and to unzip and zip pants and to wash his hands after using the toilet. This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be coded 1, supervision.
   G0110I2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident required staff supervision, cueing and reminders daily.

3. Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.

   Coding: G0110I1 would be coded 2, limited assistance.
   G0110I2 would be coded 2, one person physical assist.

   Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Mrs. M. has had recent bouts of vertigo. During the 7-day look-back period, the resident required one staff member to assist and provide weight-bearing support to her as she transferred to the bedside commode four times.

   Coding: G0110I1 would be coded 3, extensive assistance.
   G0110I2 would be coded 2, one person physical assist.

   Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

5. Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and hygiene needs several times each day.

   Coding: G0110I1 would be coded 4, total dependence.
   G0110I2 would be coded 2, one person physical assist.

   Rationale: Resident did not participate and required one staff person to provide total care for toileting and hygiene each time during the entire 7-day look-back period.

Examples for G0110J, Personal Hygiene

1. The nurse assistant takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

   Coding: G0110J1 would be coded 1, supervision.
   G0110J2 would be coded 1, setup help only.

   Rationale: Staff placed grooming devices at sink for his use, and during the 7-day look-back period staff provided cueing three times.

2. Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.

   Coding: G0110J1 would be coded 3, extensive assistance.
   G0110J2 would be coded 2, one person physical assist.

   Rationale: A staff member had to complete part of the activity of personal hygiene for the resident 3 out of 7 days during the look-back period. The assistance, although non-weight-bearing, is considered full staff performance of the personal hygiene sub-task of brushing and styling her hair. Because this ADL sub-task was completed for the resident 3 times, but not every time during the last 7 days, it qualifies under the second criterion of the extensive assistance definition.

Scenario Examples

1. Scenario: The following dressing assistance was provided to Mr. X during the look-back period: Two times, he required guided maneuvering of his arms to don his shirt; this assistance was non-weight-bearing assistance. Four times, he required the staff to assist him to put his shirt on due to pain in his shoulders. During these four times that the staff had to assist Mr. X to put his shirt on, the staff had to physically assist him by lifting each of his arms. This component of the dressing activity occurred six times in the 7-day look-back period. There were two times where Mr. X required non-weight-bearing assistance and four times where he required weight-bearing assistance, therefore the appropriate code to enter on the MDS is Extensive assistance (3).

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Rationale: This ADL activity component occurred six times in the 7-day look-back period. Mr. X required limited assistance two times and weight-bearing (extensive) assistance four times. Lifting the resident's arms is considered weight-bearing assistance. The ADL activity component occurred three or more times at one level, extensive - thus, this weight-bearing assistance is the highest level of dependence identified that occurred three or more times. The scenario is consistent with the ADL Self-Performance coding level definition of Extensive assistance and meets the first Rule of 3. The assessor uses the steps in the Rule of 3 in sequence and stops once one has been identified as applying to the scenario. Therefore the final code that should be entered in Column 1, ADL Self-Performance, G0110G – Dressing is Extensive assistance (3).

2. Scenario: The following assistance was provided to Mrs. C over the last seven days: Four times, she required verbal cueing for hand placement during stand-pivot transfers to her wheelchair and three times she required weight-bearing assistance to help her rise from the wheelchair, steady her and help her turn with her back to the edge of the bed. Once she was at the edge of the bed and put her hand on her transfer bar, she was able to sit. She completed the activity without assistance the 14 remaining instances during the 7-day look-back period. The four times that she required verbal cueing from the staff for hand placement are considered supervision. The three times that the staff had to physically support Mrs. C during a portion of the transfer are considered weight-bearing assistance. This ADL occurred 21 times over the 7-day look-back period. There were three or more times where supervision was required, and three times where weight-bearing assistance was required; therefore, the appropriate code to enter on the MDS is Extensive assistance (3).

   Rationale: The ADL activity occurred 21 times over the 7-day look-back period. Mrs. C required supervision four times and weight-bearing assistance was provided three times during the 7-day look-back period. The ADL activity also occurred three or more times at multiple levels (four times with supervision, three times with weight-bearing assistance, and 14 times without assistance). Weight-bearing assistance is also the highest level of dependence identified that occurred three or more times. The first Rule of 3 does not apply because the ADL activity occurred three or more times at multiple levels, not three or more times at any one level. Because the ADL activity occurred three or more times at multiple levels, the scenario meets the second Rule of 3 and the assessor will apply the most dependent level that occurred three or more times. Note that this scenario does meet the definition of Extensive assistance as well, since the activity occurred at least three times and there was weight-bearing support provided three times. The final code that should be entered in Column 1, ADL Self-Performance, G0110B – Transfer is Extensive assistance (3).

G0110: Activities of Daily Living (ADL) Assistance (cont.)

3. Scenario: Mrs. F. was in the nursing home for only one day prior to transferring to another facility. While there, she was unable to complete a component of the eating ADL activity without assistance three times. The following assistance was provided: Twice she required weight-bearing assistance to help lift her fork to her mouth. One time in the evening, the staff fed Mrs. F. because she could not scoop the food on her plate with the fork, nor could she lift the fork to her mouth. The three times that Mrs. F. could not complete the activity, the staff had to physically assist her by either holding her hand as she brought the fork to her mouth, or by actually feeding her. There were two times where the staff provided weight-bearing assistance and one time where they provided full staff performance. This component of the ADL eating activity where assistance was required, occurred three times in the look-back period, but not three times at any one level. Based on the third Rule of 3, the final code determination is Extensive assistance (3).

   Rationale: Eating occurred three times in the look-back period during the day that Mrs. F was in the nursing home. Mrs. F performed part of the activity by scooping the food and holding her fork two times, but staff had to assist by lifting her arm to her mouth resulting in two episodes of weight-bearing assistance. The other time, the staff had to feed Mrs. F. The first Rule of 3 does not apply because even though the ADL assistance occurred three or more times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three or more times it did not occur three or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred three times at multiple levels but not three times at any one level. Sub-item "a" under the third Rule of 3 states to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. Therefore, the one episode of full staff performance is considered weight-bearing assistance and can be added to the other two episodes of weight-bearing assistance. This now totals three episodes of weight-bearing assistance. Therefore, according to the application of the third Rule of 3 and the first two sub-items, "a" and "b," the correct code to enter in Column 1, ADL Self-Performance, G0110H, Eating is Extensive assistance (3). Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3 and the first two sub-items that the facility is able to code this item as extensive assistance.

4. Scenario: Mr. N was admitted to the facility, but was sent to the hospital on the 2nd day he was there. The following assistance was provided to Mr. N over the look-back period: Weight-bearing assistance one time to lift Mr. N's right arm into his shirt sleeves when dressing in the morning on day one, non-weight-bearing assistance one time to button his shirt in the morning on day two, and full staff performance one time on day two to put on his pants on after resting in bed in the afternoon. Mr. N was independent in the evening on day one when undressing and getting his bed clothes on. Based on the application of the third Rule of 3s sub-items, the final code determination is Limited assistance (2).

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Rationale: There was one episode where Mr. N required full staff performance to put his pants on, one episode of weight-bearing assistance to put his right arm into his shirt sleeve, and one episode of non-weight-bearing assistance to button his shirt. The first Rule of 3 does not apply because even though the ADL assistance occurred three times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three times it did not occur three times at multiple levels. The third Rule of 3 applies because the activity occurred three times, and at multiple levels but not three times at any one level. The third Rule of 3, sub-item "a," instructs providers to convert episodes of full staff performance to weight-bearing assistance. Therefore, there are now two weight-bearing episodes and one non-weight-bearing episode. The third Rule of 3, sub-item "b," does not apply because even though there are two episodes of weight-bearing assistance, there are not enough weight-bearing episodes to consider it Extensive assistance. There is one episode of non-weight-bearing assistance that can be accounted for. The third sub-item, "c," under the third Rule of 3 applies because there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that together total three times (two episodes of weight-bearing assistance and one episode of non-weight-bearing assistance). Therefore, the appropriate code is Limited assistance (2) which is the correct code to enter in Column 1, ADL Self-Performance, G0110G, Dressing. Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3, working through all of the sub-items, that the facility is able to code this item as Limited assistance.

5. Scenario: During the look-back period, Mr. S was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision.

   Rationale: Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, she determined that Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Mr. S did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either. The assessor continued to apply the coding instructions, looking at the Rule of 3. The first Rule of 3 does not apply because even though the ADL activity occurred three or more

G0110: Activities of Daily Living (ADL) Assistance (cont.)

times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels, and the third Rule of 3 does not apply because the ADL occurred three or more times, at the independent level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, the final instruction to the provider is that when neither the Rule of 3 nor the ADL Self-Performance coding level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use, the code Supervision (1) was entered.

G0120: Bathing

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support.	
Enter Code ☐	**A. Self-performance** 0. **Independent** - no help provided 1. **Supervision** - oversight help only 2. **Physical help limited to transfer only** 3. **Physical help in part of bathing activity** 4. **Total dependence** 8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code ☐	**B. Support provided** (Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

Item Rationale

Health-related Quality of Life

- The resident's choices regarding his or her bathing schedule should be accommodated when possible so that facility routine does not conflict with resident's desired routine.

Planning for Care

- The care plan should include interventions to address the resident's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

DEFINITION

BATHING
How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.

Coding Instructions for G0120A, Self-Performance

Code for the maximum amount of assistance the resident received during the bathing episodes.

- Code 0, independent: if the resident required no help from staff.
- Code 1, supervision: if the resident required oversight help only.
- Code 2, physical help limited to transfer only: if the resident is able to perform the bathing activity, but required help with the transfer only.

G0120: Bathing (cont.)

- Code 3, physical help in part of bathing activity: if the resident required assistance with some aspect of bathing.
- Code 4, total dependence: if the resident is unable to participate in any of the bathing activity.
- Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance),** do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADLs in the 7-day look-back period.
- If a nursing home has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the resident self-performance as supervision, even if the supervision is precautionary because the resident is still being individually supervised. Support for bathing in this instance would be coded according to whether or not the staff had to actually assist the resident during the bathing activity.

Examples

1. Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

   Coding: G0120A would be coded 1, supervision.
   G0120B would be coded 0, no setup or physical help from staff.

   Rationale: Resident needed only supervision to perform the bathing activity with no setup or physical help from staff.

2. For one bath, the resident received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one staff member.

   Coding: G0120A would be coded 4, total dependence.
   G0120B would be coded 2, one person physical assist.

   Rationale: Coding directions for bathing state, "code for most dependent in self-performance and support." Resident's most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.

G0120: Bathing (cont.)

3. On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, the resident had physical help of one person to get into tub but washed himself completely.

Coding: G0120A would be coded 3, physical help in part of bathing activity.

G0120B would be coded 2, one person physical assist.

Rationale: Resident's most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one staff person.

G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking		
After observing the resident, **code the following walking and transition items for most dependent**		
	↓ Enter Codes in Boxes	
Coding: 0. **Steady at all times** 1. **Not steady, but able to stabilize without staff assistance** 2. **Not steady, only able to stabilize with staff assistance** 8. **Activity did not occur**	☐	**A. Moving from seated to standing position**
	☐	**B. Walking** (with assistive device if used)
	☐	**C. Turning around** and facing the opposite direction while walking
	☐	**D. Moving on and off toilet**
	☐	**E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

Item Rationale

Health-related Quality of Life

- Individuals with impaired balance and unsteadiness during transitions and walking
  - — are at increased risk for falls;
  - — often are afraid of falling;
  - — may limit their physical and social activity, becoming socially isolated and despondent about limitations; and
  - — can become increasingly immobile.

DEFINITION

INTERDISCIPLINARY TEAM
Refers to a team that includes staff from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.

Planning for Care

- Individuals with impaired balance and unsteadiness should be evaluated for the need for
  - — rehabilitation or assistive devices;
  - — supervision or physical assistance for safety; and/or
  - — environmental modification.
- Care planning should focus on preventing further decline of function, and/or on return of function, depending on resident-specific goals.

G0300: Balance During Transitions and Walking (cont.)

- Assessment should identify all related risk factors in order to develop effective care plans to maintain current abilities, slow decline, and/or promote improvement in the resident's functional ability.

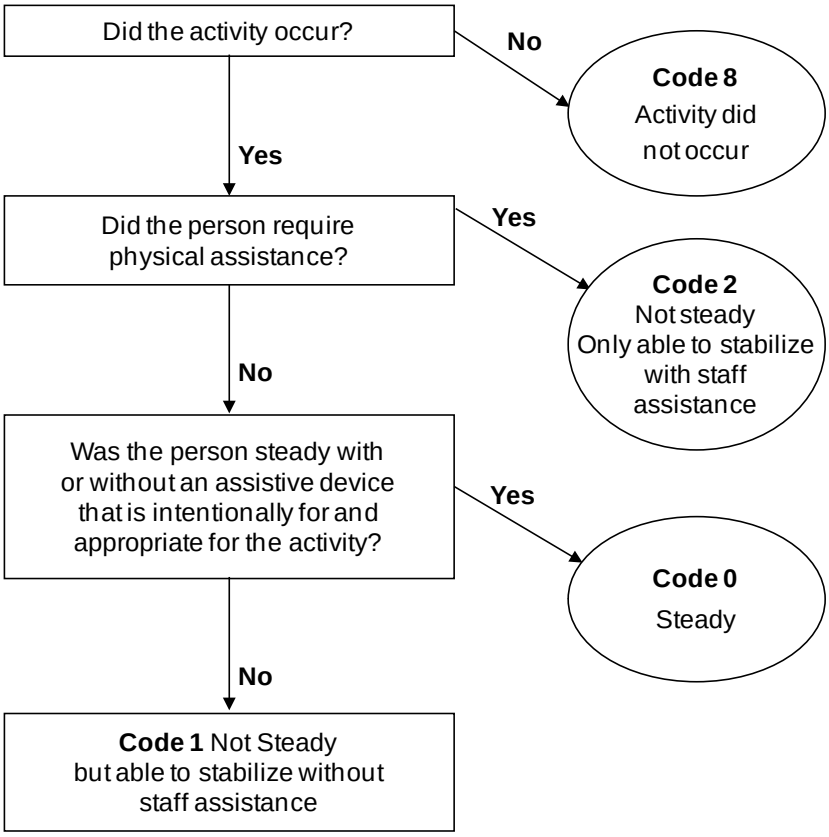
Steps for Assessment

1. Complete this assessment for all residents.
2. Throughout the 7-day look-back period, interdisciplinary team members should carefully observe and document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair (for residents who use a wheelchair).
3. If staff have not systematically documented the resident's stability in these activities at least once during the 7-day look-back period, use the following process to code these items:

    a. Before beginning the activity, explain what the task is and what you are observing for.
    b. Have assistive devices the resident normally uses available.
    c. Start with the resident sitting up on the edge of his or her bed, in a chair or in a wheelchair (if he or she generally uses one).
    d. Ask the resident to stand up and stay still for 3-5 seconds. **Moving from seated to standing position (G0300A) should be rated at this time.**
    e. Ask the resident to walk approximately 15 feet using his or her usual **assistive device**. **Walking (G0300B) should be rated at this time.**
    f. Ask the resident to turn around. **Turning around (G0300C) should be rated at this time.**
    g. Ask the **resident to walk or wheel** from a starting point in his or her room into the bathroom, **prepare for toileting** as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. **Moving on and off toilet (G0300D) should be rated at this time.**
    h. Ask residents who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. **Surface-to-surface transfer should be rated at this time (G0300E).**

G0300: Balance During Transitions and Walking (cont.)

Balance During Transitions and Walking Algorithm



Coding Instructions G0300A, Moving from Seated to Standing Position

Code for the least steady episode, using assistive device if applicable.

- Code 0, steady at all times:
  - If all of the transitions from seated to standing position and from standing to seated position observed during the 7-day look-back period are steady.
  - If resident is stable when standing up using the arms of a chair or an assistive device identified for this purpose (such as a walker, locked wheelchair, or grab bar).
  - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - If resident appears steady and not at risk of a fall when standing up.

G0300: Balance During Transitions and Walking (cont.)

- Code 1, not steady, but able to stabilize without staff assistance:
  - If any of transitions from seated to standing position or from standing to seated position during the 7-day look-back period are not steady, but the resident is able to stabilize without assistance from staff or object (e.g., a chair or table).
  - If the resident is unsteady using an assistive device but does not require staff assistance to stabilize.
  - If the resident attempts to stand, sits back down, then is able to stand up and stabilize without assistance from staff or object.
  - Residents coded in this category appear at increased risk for falling when standing up.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any of transitions from seated to standing or from standing to sitting are not steady, and the resident cannot stabilize without assistance from staff.
  - If the resident cannot stand but can transfer unassisted without staff assistance.
  - If the resident returned back to a seated position or was unable to move from a seated to standing or from standing to sitting position during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If a lift device (a mechanical device operated by another person) is used because the resident requires staff assistance to stabilize, code as 2.
- Code 8, activity did not occur: if the resident did not move from seated to standing position during the 7-day look-back period.

DEFINITION

UNSTEADY
Residents may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

Examples for G0300A, Moving from Seated to Standing Position

1. A resident sits up in bed, stands, and begins to sway, but steadies herself and sits down smoothly into her wheelchair.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.
   Rationale: Resident was unsteady, but she was able to stabilize herself without assistance from staff.

2. A resident requires the use of a gait belt and physical assistance in order to stand.

   Coding: G0300A would be coded 2, not steady, only able to stabilize with staff assistance.
   Rationale: Resident required staff assistance to stand during the observation period.

G0300: Balance During Transitions and Walking (cont.)

3. A resident stands steadily by pushing himself up using the arms of a chair.

   Coding: G0300A would be coded 0, steady at all times.

   Rationale: Even though the resident used the arms of the chair to push himself up, he was steady at all times during the activity.

4. A resident locks his wheelchair and uses the arms of his wheelchair to attempt to stand. On the first attempt, he rises about halfway to a standing position then sits back down. On the second attempt, he is able to stand steadily.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Even though the second attempt at standing was steady, the first attempt suggests he is unsteady and at risk for falling during this transition.

Coding Instructions G0300B, Walking (with Assistive Device if Used)

Code for the least steady episode, using assistive device if applicable.

- Code 0, steady at all times:
  - If during the 7-day look-back period the resident's walking (with assistive devices if used) is steady at all times.
  - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device and is steady while walking with it.
  - Residents in this category do not appear at risk for falls.
  - Residents who walk with an abnormal gait and/or with an assistive device can be steady, and if they are they should be coded in this category.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If during the 7-day look-back period the resident appears unsteady while walking (with assistive devices if used) but does not require staff assistance to stabilize.
  - Residents coded in this category appear at risk for falling while walking.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If during the-7-day look-back period the resident at any time appeared unsteady and required staff assistance to be stable and safe while walking.
  - If the resident fell when walking during the look-back period.
  - Residents coded in this category appear at high risk for falling while walking.
- Code 8, activity did not occur:
  - If the resident did not walk during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300B, Walking (with Assistive Device if Used)

1. A resident with a recent stroke walks using a hemi-walker in her right hand because of left-sided weakness. Her gait is slow and short-stepped and slightly unsteady as she walks, she leans to the left and drags her left foot along the ground on most steps. She has not had to steady herself using any furniture or grab bars.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident's gait is unsteady with or without an assistive device but does not require staff assistance.

2. A resident with Parkinson's disease ambulates with a walker. His posture is stooped, and he walks slowly with a short-stepped shuffling gait. On some occasions, his gait speeds up, and it appears he has difficulty slowing down. On multiple occasions during the 7-day observation period he has to steady himself using a handrail or a piece of furniture in addition to his walker.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident has an unsteady gait but can stabilize himself using an object such as a handrail or piece of furniture.

3. A resident who had a recent total hip replacement ambulates with a walker. Although she is able to bear weight on her affected side, she is unable to advance her walker safely without staff assistance.

   Coding: G0300B would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: Resident requires staff assistance to walk steadily and safely at any time during the observation period.

4. A resident with multi-infarct dementia walks with a short-stepped, shuffling-type gait. Despite the gait abnormality, she is steady.

   Coding: G0300B would be coded 0, steady at all times.

   Rationale: Resident walks steadily (with or without a normal gait and/or the use of an assistive device) at all times during the observation period.

G0300: Balance During Transitions and Walking (cont.)

Coding Instructions G0300C, Turning Around and Facing the Opposite Direction while Walking

Code for the least steady episode, using an assistive device if applicable.

- Code 0, steady at all times:
  - If all observed turns to face the opposite direction are steady without assistance of a staff during the 7-day look-back period.
  - If the resident is stable making these turns when using an assistive device.
  - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transition that involves turning around to face the opposite direction is not steady, but the resident stabilizes without assistance from a staff.
  - If the resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transition that involves turning around to face the opposite direction is not steady, and the resident cannot stabilize without assistance from a staff.
  - If the resident fell when turning around to face the opposite direction during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
- Code 8, activity did not occur:
  - If the resident did not turn around to face the opposite direction while walking during the 7-day look-back period.

Examples for G0300C, Turning Around and Facing the Opposite Direction while Walking

1. A resident with Alzheimer's disease frequently wanders on the hallway. On one occasion, a nursing assistant noted that he was about to fall when turning around. However, by the time she got to him, he had steadied himself on the handrail.

   Coding: G0300C would be coded 1, Not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when turning but able to steady himself on an object, in this instance, a handrail.

G0300: Balance During Transitions and Walking (cont.)

2. A resident with severe arthritis in her knee ambulates with a single-point cane. A nursing assistant observes her lose her balance while turning around to sit in a chair. The nursing assistant is able to get to her before she falls and lowers her gently into the chair.

   Coding: G0300C would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: The resident was unsteady when turning around and would have fallen without staff assistance.

Coding for G0300D, Moving on and off Toilet

Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable. Include stability while manipulating clothing to allow toileting to occur in this rating.

- Code 0, steady at all times:
  - If all of the observed transitions on and off the toilet during the 7-day look-back period are steady without assistance of a staff.
  - If the resident is stable when transferring using an assistive device or object identified for this purpose.
  - If an assistive device is used (e.g., grab bar), the resident appropriately plans and integrates the use of the device into the transition activity.
  - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transitions on or off the toilet during the7-day look-back period are not steady, **but** the resident stabilizes **without** assistance from a staff.
  - If resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transitions on or off the toilet during the 7-day look-back period are not steady, and the resident cannot stabilize without assistance from a staff.
  - If the resident fell when moving on or off the toilet during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If lift device is used.
- Code 8, activity did not occur:
  - If the resident did not transition on and off the toilet during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300D, Moving on and off Toilet

1. A resident sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

   Coding: G0300D would be coded 0, steady at all times.

   Rationale: This resident's use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The resident was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. A resident wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. A resident wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, and then is able to steady himself with the grab bar.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

Code for the least steady episode.

- Code 0, steady at all times:
  - If all of the observed transfers during the 7-day look-back period are steady without assistance of a staff.
  - If the resident is stable when transferring using an assistive device identified for this purpose.
  - If an assistive device or equipment is used, the resident uses it independently and appropriately plans and integrates the use of the device into the transition activity.
  - Residents **coded 0** should not appear to be at risk of a fall during a transition.

G0300: Balance During Transitions and Walking (cont.)

- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transfers during the look-back period are not steady, but the resident stabilizes without assistance from a staff.
  - If the resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transfers during the 7-day look-back period are not steady, and the resident can only stabilize with assistance from a staff.
  - If the resident fell during a surface-to-surface transfer during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the resident requires staff assistance to stabilize, **code 2**.
- Code 8, activity did not occur:
  - If the resident did not transfer between bed and chair or wheelchair during the 7-day look-back period.

Examples for G0300E, Surface-to-Surface Transfer (Transfer Between Bed and Chair or Wheelchair)

1. A resident who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.

   Coding: G0300E would be coded 0, steady at all times.
   Rationale: The resident was steady when transferring from bed to wheelchair.

2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.

   Coding: G0300E would be coded 2, not steady, only able to stabilize with staff assistance.
   Rationale: The resident was unsteady when transferring from bed to chair and required staff assistance to make a steady transfer.

3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

   Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

G0300: Balance During Transitions and Walking (cont.)

Rationale: The resident was unsteady when transferring from bed to wheelchair but did not require staff assistance to complete the activity.

4. A resident who uses her wheelchair for mobility stands up from the edge of her bed, sways to the right, but then is quickly able to pivot and sits in her locked wheelchair in a steady fashion.

   Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when transferring from bed to wheelchair but was able to steady herself without staff assistance or an object.

Additional Example for G0300A-E, Balance during Transitions and Walking

1. A resident sits up in bed, stands up, pivots and sits in her locked wheelchair. She then wheels her chair to the bathroom where she stands, pivots, lifts gown and smoothly sits on the commode.

   Coding: G0300A, G0300D, G0300E would be coded 0, steady at all times.

   Rationale: The resident was steady during each activity.

G0400: Functional Limitation in Range of Motion

G0400. Functional Limitation in Range of Motion		
Code for limitation that interfered with daily functions or placed resident at risk of injury		
Coding: 0. **No impairment** 1. **Impairment on one side** 2. **Impairment on both sides**	↓ **Enter Codes in Boxes**	
	☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
	☐	**B. Lower extremity** (hip, knee, ankle, foot)

Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform.

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION

Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

Item Rationale

Health-related Quality of Life

- Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living.

Planning for Care

- Individualized care plans should address possible reversible causes such as de-conditioning and adverse side effects of medications or other treatments.

G0400: Functional Limitation in Range of Motion (cont.)

Steps for Assessment

1. Review the medical record for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a 3 step process:
   - Test the resident's upper and lower extremity ROM (See #6 below for examples).
   - If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
   - Code G0400 A/B as appropriate based on the above assessment.
4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
5. Staff observations of various activities, including ADLs, may be used to determine if any ROM limitations impact the resident's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM; thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
   - Ask the resident to follow your verbal instructions for each movement.
   - Demonstrate each movement (e.g., ask the resident to do what you are doing).
   - Actively assist the resident with the movements by supporting his or her extremity and guiding it through the joint ROM.

   Lower Extremity – includes hip, knee, ankle, and foot

   While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot. Then ask the resident to lift his or her leg one at a time, bending it at the knee to a right angle (90 degrees) Then ask the resident to slowly lower his or her leg and extend it flat on the mattress. If assessing lower extremity ROM by observing the resident, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower body clothing.

   Upper Extremity – includes shoulder, elbow, wrist, and fingers

   For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct him or her to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

G0400: Functional Limitation in Range of Motion (cont.)

Coding Tips

- Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury. For example, if the resident has an amputation it does not automatically mean that they are limited in function. He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that the resident with an amputation has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If the resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

- Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities.
- Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.
- Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.

Examples for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is able to perform grooming activities (e.g. brush teeth, comb her hair) with her right upper extremity, and is also able to pivot to her wheelchair with the assist of one person. She is, however, unable to voluntarily move her left side (limited arm, hand and leg motion) as she has a flaccid left hemiparesis from a prior stroke.

   Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 1, lower extremity impairment on one side.

   Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows for the resident to be as independent as possible.

G0400: Functional Limitation in Range of Motion (cont.)

2. The resident had shoulder surgery and can't brush her hair or raise her right arm above her head. The resident has no impairment on the lower extremities.

   Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 0, no impairment.

   Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities.

3. The resident has a diagnosis of Parkinson's and ambulates with a shuffling gate. The resident has had 3 falls in the past quarter and often forgets his walker which he needs to ambulate. He has tremors of both upper extremities that make it very difficult to feed himself, brush his teeth or write.

   Coding: G0400A would be coded 2, upper extremity impairment on both sides. G0400B would be coded 2, lower extremity impairment on both sides.

   Rationale: Impairment due to Parkinson's disease affects the resident at the upper and lower extremities on both sides.

G0600: Mobility Devices

G0600. Mobility Devices	
↓ Check all that were normally used	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

Item Rationale

Health-related Quality of Life

- Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.

Planning for Care

- Resident ability to move about his or her room, unit or nursing home may be directly related to the use of devices. It is critical that nursing home staff assure that the resident's independence is optimized by making available mobility devices on a daily basis, if needed.

G0600: Mobility Devices (cont.)

Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the look-back period.
3. Observe the resident during locomotion.

Coding Instructions

Record the type(s) of mobility devices the resident normally uses for locomotion (in room and in facility). Check all that apply:

- Check G0600A, cane/crutch: if the resident used a cane or crutch, including single prong, tripod, quad cane, etc.
- Check G0600B, walker: if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with/without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.
- 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.
- Check G0600D, limb prosthesis: if the resident used an artificial limb to replace a missing extremity.
- Check G0600Z, none of the above: if the resident used none of the mobility devices listed in G0600 or locomotion did not occur during the look-back period.

Examples

1. The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that she self-propels when leaving the unit due to her issues with endurance.

   Coding: G0600A, use of cane/crutch, and G0600C, wheelchair, would be checked.
   Rationale: The resident uses a quad cane in her room and on the unit and a wheelchair off the unit.

2. The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied the resident is able to ambulate independently.

   Coding: G0600D, limb prosthesis, would be checked.
   Rationale: The resident uses a leg prosthesis for ambulating.

G0900: Functional Rehabilitation Potential

Complete only on OBRA Admission Assessment (A0310A = 1)

G0900. Functional Rehabilitation Potential Complete only if A0310A = 01	
Enter Code ☐	**A. Resident believes he or she is capable of increased independence** in at least some ADLs 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**B. Direct care staff believe resident is capable of increased independence** in at least some ADLs 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Attaining and maintaining independence is important to an individual's feelings of autonomy and self-worth.
- Independence is also important to health status, as decline in function can trigger all of the complications of immobility, depression, and social isolation.

Planning for Care

- Beliefs held by the resident and staff that the resident has the capacity for greater independence and involvement in self-care in at least some ADL areas may be important clues to assist in setting goals.
- Even if highly independent in an activity, the resident or staff may believe the resident can gain more independence (e.g., walk longer distances, shower independently).
- Disagreement between staff beliefs and resident beliefs should be explored by the interdisciplinary team.

Steps for Assessment: Interview Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the resident thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the resident believes, even if it appears unrealistic.
   - It is sometimes helpful to have a conversation with the resident that helps him/her break down this question. For example, you might ask the resident what types of things staff assist him with and how much of those activities the staff do for the resident. Then ask the resident, "Do you think that you could get to a point where you do more or all of the activity yourself?"

Coding Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if the resident indicates that he or she believes he or she will probably stay the same and continue with his or her current needs for assistance.

G0900: Functional Rehabilitation Potential (cont.)

- Code 1, yes: if the resident indicates that he or she thinks he or she can improve. Code even if the resident's expectation appears unrealistic.
- Code 9, unable to determine: if the resident cannot indicate any beliefs about his or her functional rehabilitation potential.

Example for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Mr. N. is cognitively impaired and receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff are not looking.

   Coding: G0900A would be coded 1, yes.
   Rationale: The resident believes he is capable of increased independence.

Steps for Assessment for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. Discuss in interdisciplinary team meeting.
2. Ask staff who routinely care for or work with the resident if they think he or she is capable of greater independence in at least some ADLs.

Coding Instructions for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if staff believe the resident probably will stay the same and continue with current needs for assistance. Also **code 0** if staff believe the resident is likely to experience a decrease in his or her capacity for ADL care performance.
- Code 1, yes: if staff believe the resident can gain greater independence in ADLs or if staff indicate they are not sure about the potential for improvement, because that indicates some potential for improvement.

Example for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. The nurse assistant who totally feeds Mrs. W. has noticed in the past week that Mrs. W. has made several attempts to pick up finger foods. She believes Mrs. W. could become more independent in eating if she received close supervision and cueing in a small group for restorative care in eating.

   Coding: G0900B would be coded 1, yes.
   Rationale: Based upon observation of the resident, the nurse assistant believes Mrs. W. is capable of increased independence.

GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)

GG0130. Self-Care (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

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.

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 or TOUCHING/STEADYING 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 applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance	
Enter Code ☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/ tray. Includes modified food consistency.
Enter Code ☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
Enter Code ☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

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.

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

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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. 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 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.
8. 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Admission or Discharge Performance Coding Instructions

- 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 resident did not perform this activity prior to the current illness, exacerbation, or injury.
- 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.)

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 (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.

- **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.
- 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.
- 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- At admission, 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 "activity was not attempted" codes that are used for the admission assessment to identify the resident's usual performance on the Discharge assessment.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- 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.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to 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.
- 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.
- 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 <u>at least one</u> 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.
- 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- 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.
- 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.

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, Eating 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, 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.

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, 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Eating would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

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, Eating 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, Eating 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, Eating 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, 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Eating 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.

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, Eating 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, 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.

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, Oral hygiene 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, Oral hygiene 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, Oral hygiene 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, Oral hygiene 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 tooth brushing and the certified nursing assistant usually completes the activity by performing more than half of this activity.

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

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, 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 (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Toileting hygiene 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, Toileting hygiene 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, Toileting hygiene 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, Toileting hygiene 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Eating would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat his meals.

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, Oral hygiene 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Discharge Goal(s): Coding Tips

- Use the 6-point scale to code the resident's Discharge Goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code Discharge Goal(s). Use a dash (-) to indicate 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. Using the dash in this allowed instance does not affect APU determination.
- Licensed clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. 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 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Example 2: Discharge Goal Code Is the *Same* as 5-Day PPS Assessment Admission Performance Code

The 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 clinician determines that the resident would be able to maintain her admission functional performance level. The 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 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 clinician observes Mrs. E's 5-Day PPS admission performance and discusses her usual performance with 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 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 clinician anticipates Mrs. E's discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the 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 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.

GG0130: Self-Care (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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 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 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 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. Do not use codes 07, 09, or 88 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.
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 or TOUCHING/STEADYING 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 applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**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 safely 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 safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
		☐ **H1. Does the resident walk?** 0. **No**, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter? 1. **No**, and walking goal is clinically indicated → Code the resident's discharge goal(s) for items GG0170J and GG0170K 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	☐☐	**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.
		☐ **Q1. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair/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

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.

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 or TOUCHING/STEADYING 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 applicable.**
88. Not attempted due to **medical condition or safety concerns.**

3. Discharge Performance Enter Codes in Boxes	
☐☐	**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 safely 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 safely come to a standing position from sitting in a chair or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to safely get on and off a toilet or commode.
	☐ **H3. Does the resident walk?** 0. **No** → Skip to GG0170Q3, Does the resident use a wheelchair/scooter? 2. **Yes** → Continue to GG0170J, Walk 50 feet with two turns
☐☐	**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.
	☐ **Q3. Does the resident use a wheelchair/scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair/scooter used.** 1. **Manual** 2. **Motorized**

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

Item Rationale

- Residents in Medicare Part A SNF stays 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 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).
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.

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.

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 (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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.
8. 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.

Admission or Discharge Performance Coding Instructions

- 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 resident did not perform this activity prior to the current illness, exacerbation, or injury.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

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.
- **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.
- 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 (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- 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.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- 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.
- 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.
- 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).
- 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- 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 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.
- 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.
- 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.

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 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. 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.

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, Sit to lying 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Sit to lying 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, Sit to lying 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, Sit to lying 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: 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Sit to lying 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.

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

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Lying to sitting on side of bed 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.

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, Lying to sitting on side of bed 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 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.
- 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.
- Back support refers to an object or person providing support of the resident's back.

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, Sit to stand would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides touching assistance only.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Sit to stand 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, Sit to stand 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 to a standing position and must also provide assistance to steady Ms. Z's balance to complete the activity.

   Coding: GG0170D, Sit to stand 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, Sit to stand 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Chair/bed-to-chair transfer 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.

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, Chair/bed-to-chair transfer 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, Chair/bed-to-chair transfer 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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 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, Chair/bed-to-chair transfer 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. 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.

   Coding: GG0170E, Chair/bed-to-chair transfer 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.

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 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.

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, Toilet transfer 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, Toilet transfer 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, Toilet transfer 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, 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt as Mrs. M pivots and lowers herself onto the toilet. The therapist provides less than half the effort during the toilet transfer.

   Coding: GG0170F, Toilet transfer 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.

6. **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 slowly lowers Ms. W onto the bedside commode. Ms. W contributes less than half of the effort to transfer onto the toilet.

   Coding: GG0170F, Toilet transfer 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.

7. **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, Toilet transfer would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

8. **Toilet transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

   Coding: GG0170F, Toilet transfer 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 GG0170H1, Does the resident walk?

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.

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, Walk 50 feet with two turns 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, Walk 50 feet with two turns 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 and provides less than half the effort.

   Coding: GG0170J, Walk 50 feet with two turns 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, Walk 50 feet with two turns 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 more than half of the effort.

   Coding: GG0170J, Walk 50 feet with two turns 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, Walk 150 feet 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, Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.
   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, Walk 150 feet 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. The therapist provides more than half the effort for the activity.

   Coding: GG0170K, Walk 150 feet 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 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: GG0170QI, 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Wheel 50 feet with two turns 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, Indicate the type of wheelchair/scooter used 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. Overall, Mr. R provides more than half of the effort.

   Coding: GG0170R, Wheel 50 feet with two turns 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, Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. R used a motorized wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Wheel 50 feet with two turns 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, Indicate the type of wheelchair/scooter used 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, then asks the certified nursing assistant to push the wheelchair an additional 40 feet into her room and her bathroom.

   Coding: 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.

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, Indicate the type of wheelchair/scooter used 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 GG0170SS3, 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, Wheel 150 feet would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

2. **Indicate the type of wheelchair/scooter used:** In the example above, Mr. G uses a motorized scooter.

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used 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, Wheel 150 feet 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, Indicate the type of wheelchair/scooter used 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, Wheel 150 feet 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.

6. **Indicate the type of wheelchair/scooter used:** Mr. L used a motorized wheelchair during the 3-day assessment period.

   Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 2, Motorized.
   Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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.

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.

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.

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.

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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

- 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 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.

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, Sit to lying 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Lying to sitting on side of bed 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.

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

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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, Chair/bed-to-chair transfer 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, Toilet transfer 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, Walk 50 feet with two turns 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, Walk 150 feet 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.

GG0170: Mobility (3-day assessment period) Admission/Discharge (Start/End of Medicare Part A Stay) (cont.)

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."

   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, Wheel 50 feet with two turns 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, Wheel 150 feet would be coded 06, Independent.
   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.
2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

Check next to each appliance that was used at any time in the past 7 days. Select ***none of the above*** *if none of the appliances A-D were used in the past 7 days.*

- H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B, external catheter
- H0100C, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D, intermittent catheterization
- H0100Z, none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters (males) and external urinary pouches (females) are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterization for urine specimen during look-back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER
Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

OSTOMY
Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY
A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

ILEOSTOMY
A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

COLOSTOMY
A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

INTERMITTENT CATHETERIZATION
Insertion and removal of a catheter through the urethra for bladder drainage.

H0100: Appliances (cont.)

- 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.

H0200: Urinary Toileting Program

H0200. Urinary Toileting Program	
Enter Code ☐	**A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. **No** → Skip to H0300, Urinary Continence 1. **Yes** → Continue to H0200B, Response 9. **Unable to determine** → Skip to H0200C, Current toileting program or trial
Enter Code ☐	**B. Response** - What was the resident's response to the trial program? 0. **No improvement** 1. **Decreased wetness** 2. **Completely dry** (continent) 9. **Unable to determine** or trial in progress
Enter Code ☐	**C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
  - — determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - — completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
  - — implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.

H0200: Urinary Toileting Program (cont.)

- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence and changing his or her brief if needed and providing good skin care).

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

DEFINITIONS

BLADDER REHABILITATION/ BLADDER RETRAINING
A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

PROMPTED VOIDING
Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet.

HABIT TRAINING/ SCHEDULED VOIDING
A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE
Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- Code 0, no: if for any reason the resident did not undergo a toileting trial. This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial. Skip to **Urinary Continence** item (H0300).
- Code 1, yes: for residents who underwent a trial of an individualized, resident-centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
- Code 9, unable to determine: if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- Code 0, no improvement: if the frequency of resident's urinary incontinence did not decrease during the toileting trial.
- Code 1, decreased wetness: if the resident's urinary incontinence frequency decreased, but the resident remained incontinent. There is no quantitative definition of improvement. However, the improvement should be clinically meaningful—for example, having at least one less incontinent void per day than before the toileting program was implemented.

H0200: Urinary Toileting Program (cont.)

- Code 2, completely dry (continent): if the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial. (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)
- Code 9, unable to determine or trial in progress: if the response to the toileting trial cannot be determined because information cannot be found or because the trial is still in progress.

Coding Instructions H0200C, Current Toileting Program

- Code 0, no: if an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- Code 1, yes: for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
  - simply tracking continence status,
  - changing pads or wet garments, and
  - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
  - H0200A would be coded 1, yes,
  - H0200B would be coded 9, unable to determine or trial in progress, and
  - H0200C would be coded 1, yes.

H0200: Urinary Toileting Program (cont.)

Examples

1. Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment/diary indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb her sleep.

   Coding: H0200A would be coded as 0, no. H0200B and H0200C would be skipped.

   Rationale: Based on this resident's voiding assessment/diary, there was no pattern to her incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no, skip to H0300, Urinary Continence.

2. Mr. M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving his 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

   Coding: H0200A would be coded as 1, yes.

   H0200B would be coded as 9, unable to determine or trial in progress.

   H0200C would be coded as 1, current toileting program or trial.

   Rationale: Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code ☐	**Urinary continence** - Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (less than 7 episodes of incontinence) 2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. **Always incontinent** (no episodes of continent voiding) 9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - — interfere with participation in activities,
  - — be socially embarrassing and lead to increased feelings of dependency,
  - — increase risk of long-term institutionalization,
  - — increase risk of skin rashes and breakdown,
  - — increase risk of repeated urinary tract infections, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

CONTINENCE
Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
  - — bladder retraining, prompted voiding, or scheduled toileting.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the resident if he or she is capable of reliably reporting his or her continence. Speak with family members or significant others if the resident is not able to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

H0300: Urinary Continence (cont.)

Coding Instructions

- Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
- Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.
- Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids.
- Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Examples

1. An 86-year-old female resident has had longstanding stress-type incontinence for many years. When she has an upper respiratory infection and is coughing, she involuntarily loses urine. However, during the current 7-day look-back period, the resident has been free of respiratory symptoms and has not had an episode of incontinence.

   Coding: H0300 would be coded 0, always continent.

   Rationale: Even though the resident has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

2. A resident with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

   Coding: H0300 would be coded as 2, frequently incontinent.

   Rationale: The resident had seven documented episodes of urinary incontinence over the look-back period. The criterion for "frequent" incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

H0300: Urinary Continence (cont.)

3. A resident with Parkinson's disease is severely immobile, and cannot be transferred to a toilet. He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed. He did not have a continent void during the 7-day look-back period.

   Coding: H0300 would be coded as 3, always incontinent.

   Rationale: The resident has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. Incontinence is managed by a check and change in protocol.

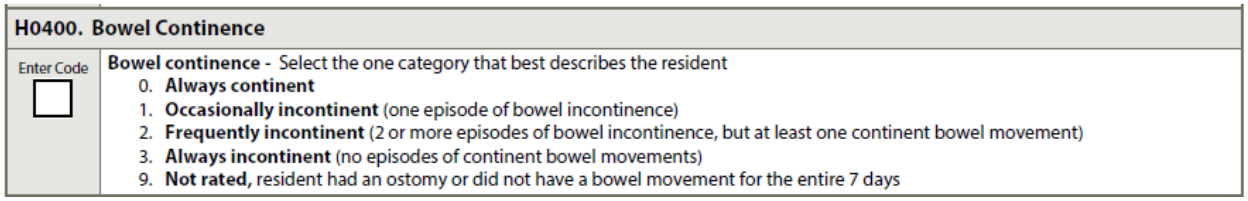
4. A resident had one continent urinary void during the 7-day look-back period, after the nursing assistant assisted him to the toilet and helped with clothing. All other voids were incontinent.

   Coding: H0300 would be coded as 2, frequently incontinent.

   Rationale: The resident had at least one continent void during the look-back period. The reason for the continence does not enter into the coding decision.

H0400: Bowel Continence

Note: There are images imbedded in this manual and if you are using a screen reader to access the content contained in the manual you should refer to the data item set to review the referenced information.



H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
  - — interfere with participation in activities,
  - — be socially embarrassing and lead to increased feelings of dependency,
  - — increase risk of long-term institutionalization,
  - — increase risk of skin rashes and breakdown, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

H0400: Bowel Continence (cont.)

- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if he or she is capable of reliably reporting his or her bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions

- Code 0, always continent: if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- Code 3, always incontinent: if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.
- Code 9, not rated: if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

Coding Tips and Special Populations

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code ☐	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences of incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skin care).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

H0500: Bowel Toileting Program (cont.)

Coding Instructions

- Code 0, no: if the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- Code 1, yes: if the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code ☐	Constipation present? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
  - — dehydration due to a medical condition or inadequate access to and intake of fluid, and
  - — side effects of medications.

DEFINITION

CONSTIPATION
If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period.
2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. Speak with family members or significant others if the resident is unable to report on bowel habits.
3. Ask direct care staff who routinely work with the resident on all shifts about problems with constipation.

DEFINITION

FECAL IMPACTION
A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

H0600: Bowel Patterns (cont.)

Coding Instructions

- Code 0, no: if the resident shows no signs of constipation during the 7-day look-back period.
- Code 1, yes: if the resident shows signs of constipation during the 7-day look-back period.

Coding Tips and Special Populations

- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

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.

Cancer

- I0100, cancer (with or without metastasis)

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.

— **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

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

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/

I: Active Diagnoses in the Last 7 Days (cont.)

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.

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.

I: Active Diagnoses in the Last 7 Days (cont.)

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.

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.

SECTION L: ORAL/DENTAL STATUS

Intent: This item is intended to record any dental **problems** present in the 7-day look-back period.

L0200: Dental

L0200. Dental	
↓ Check all that apply	
☐	**A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
☐	**B. No natural teeth or tooth fragment(s)** (edentulous)
☐	**C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
☐	**D. Obvious or likely cavity or broken natural teeth**
☐	**E. Inflamed or bleeding gums or loose natural teeth**
☐	**F. Mouth or facial pain, discomfort or difficulty with chewing**
☐	**G. Unable to examine**
☐	**Z. None of the above were present**

Item Rationale

Health-related Quality of Life

- Poor oral health has a negative impact on:
  - — quality of life
  - — overall health
  - — nutritional status
- Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Planning for Care

- Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

DEFINITIONS

CAVITY
A tooth with a discolored hole or area of decay that may have debris in it.

BROKEN NATURAL TEETH OR TOOTH FRAGMENT
Very large cavity, tooth broken off or decayed to gum line, or broken teeth (from a fall or trauma).

ORAL LESIONS
A discolored area of tissue (red, white, yellow, or darkened) on the lips, gums, tongue, palate, cheek lining, or throat.

EDENTULOUS
Having no natural permanent teeth in the mouth. Complete tooth loss.

L0200: Dental (cont.)

Steps for Assessment

1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.
5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.

DEFINITIONS

ORAL MASS
A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.

ULCER
Mouth sore, blister or eroded area of tissue on any oral surface.

Coding Instructions

- Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk.
- Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth.
- Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions): select if any ulcer, mass, or oral lesion is noted on any oral surface.
- Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen.
- Check L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing.
- Check L0200G, unable to examine: if the resident's mouth cannot be examined.
- Check L0200Z, none of the above: if none of conditions A through F is present.

L0200: Dental (cont.)

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.
- 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.
- 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: The items in this section document the risk, presence, appearance, and change of pressure ulcers. 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 Risk

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
☐	A. Resident has a stage 1 or greater, 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

Item Rationale

Health-related Quality of Life

- Pressure ulcers 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 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.
- Additional external factors, such as excess moisture, 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 Risk (cont.)

- Throughout this section, terminology referring to "healed" vs. "unhealed" ulcers refers to whether or not the ulcer is "closed" vs. "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 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 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, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer 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, a scar over bony prominence, or a non-removable dressing/device. Review descriptions of pressure ulcer 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.
- 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.

DEFINITIONS

PRESSURE ULCER 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; under nutrition, malnutrition, and hydration deficits; and a healed ulcer.

PRESSURE ULCER RISK TOOLS
Screening tools that are designed to help identify residents who might develop a pressure ulcer. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk©.

M0100: Determination of Pressure Ulcer Risk (cont.)

- Check C if the resident's risk for pressure ulcer 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 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.

M0150: Risk of Pressure Ulcers

M0150. Risk of Pressure Ulcers	
Enter Code ☐	**Is this resident at risk of developing pressure ulcers?** 0. **No** 1. **Yes**

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.
2. If the medical record reveals that the resident currently has a Stage 1 or greater pressure ulcer, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers.
3. Review formal risk assessment tools to determine the resident's "risk score."

M0150: Risk of Pressure Ulcers (cont.)

4. Review the components of the clinical assessment conducted for evidence of pressure ulcer risk.

Coding Instructions

- Code 0, no: if the resident is not at risk for developing pressure ulcers based on a review of information gathered for M0100.
- Code 1, yes: if the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcer(s)

M0210. Unhealed Pressure Ulcer(s)	
Enter Code ☐	**Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → Skip to M0900, Healed Pressure Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

Item Rationale

Health-related Quality of Life

- Pressure ulcers 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.

Planning for Care

- The pressure ulcer definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages.
- An existing pressure ulcer identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI 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.
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.

DEFINITION

PRESSURE ULCER

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

M0210: Unhealed Pressure Ulcer(s) (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 skin ulcers are present.
   - Key areas for pressure ulcer 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.
   - Without a full body skin assessment, a pressure ulcer can be missed.
   - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers.

Coding Instructions

Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days.

- `Code 0, no`: if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Items M0300–M0800.
- `Code 1, yes`: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).

Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- 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 that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer.

M0210: Unhealed Pressure Ulcer(s) (cont.)

- 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 a resident had a pressure ulcer that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment, **code 0**.

M0300: Current Number of Unhealed Pressure Ulcers 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.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

2. 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.
3. 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.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg.
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

Step 3: Determine "Present on Admission"

*For **each** pressure ulcer, determine if the pressure ulcer 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.*

DEFINITION

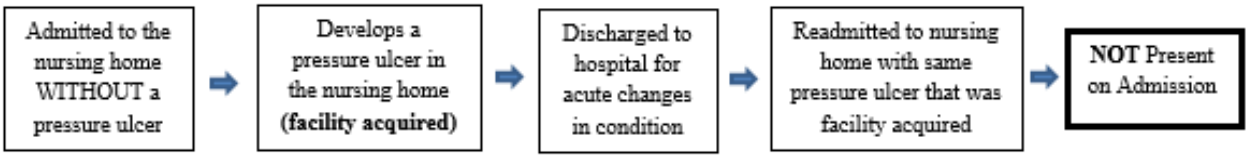
ON ADMISSION
As close to the actual time of admission as possible.

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry.
3. If the pressure ulcer 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 was unstageable on admission/entry or reentry, but 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 "present on admission."**
5. If a resident who has a pressure ulcer that was **originally acquired in the facility** is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as "present on admission**" because it was present and acquired at the facility prior to the hospitalization.
6. If a resident who has a pressure ulcer that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer 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.
7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it **should be coded as "present on admission"** at that higher stage upon reentry.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

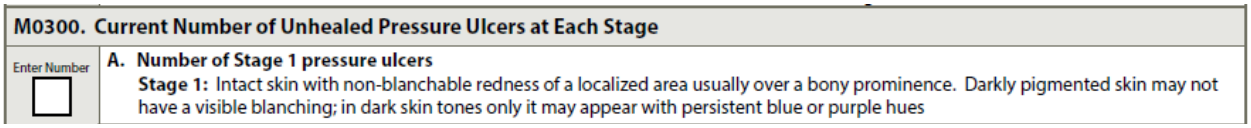
Examples

1. Ms. K is admitted to the facility without a pressure ulcer. 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 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.

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 ulcers (see definition of suspected deep tissue injury on page M-21). The descriptors are similar for these two types of ulcers (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-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.

DEFINITIONS

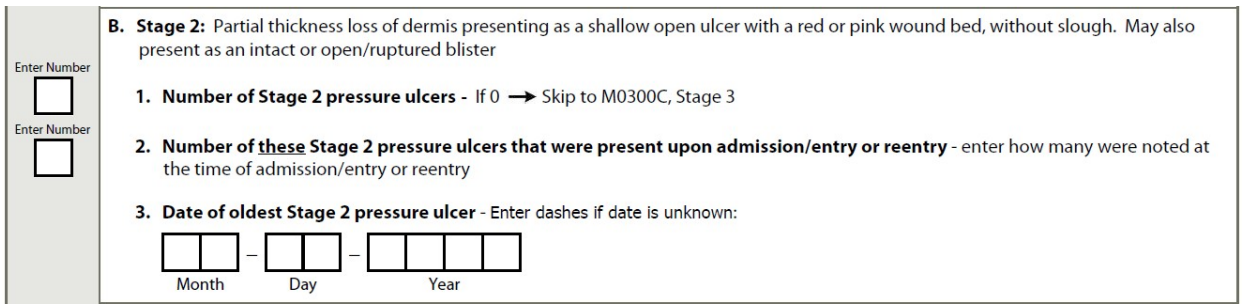
STAGE 1 PRESSURE ULCER
An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the 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.

Coding Instructions for M0300A

- Enter the number of Stage 1 pressure ulcers that are currently present.
- Enter 0 if no Stage 1 pressure ulcers are present.

M0300B: Stage 2 Pressure Ulcers



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.

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, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) 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-6).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

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.

M0300B3

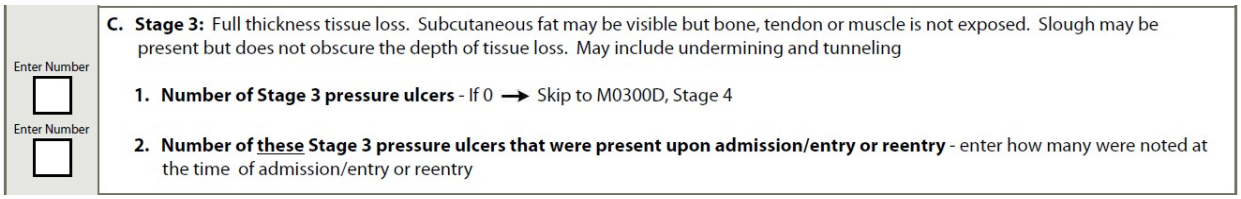
- Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure 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 in with a "0." For example, January 2, 2012, should be entered as 01-02-2012.

M0300B: Stage 2 Pressure Ulcers (cont.)

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- 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.
- 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.

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-16).

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).

M0300C: Stage 3 Pressure Ulcers (cont.)

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.

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 Code 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. This pressure ulcer worsened from a Stage 2 to a 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. 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.

   Coding: The pressure ulcer would be coded at M0300C1 as Code 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 a 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.

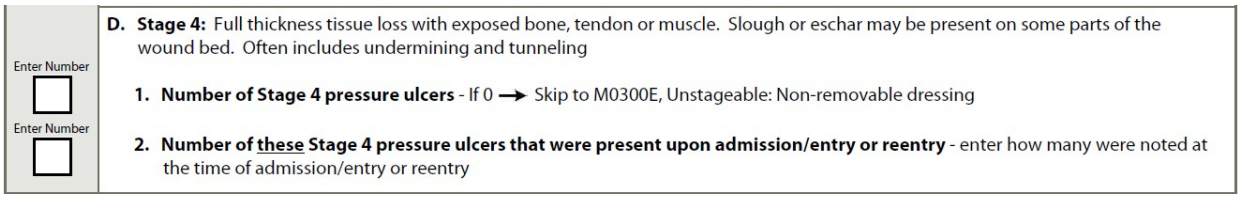
M0300C: Stage 3 Pressure Ulcers (cont.)

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; the Stage 3 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 but in Item M0900, Healed Pressure Ulcers.

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.

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.

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.

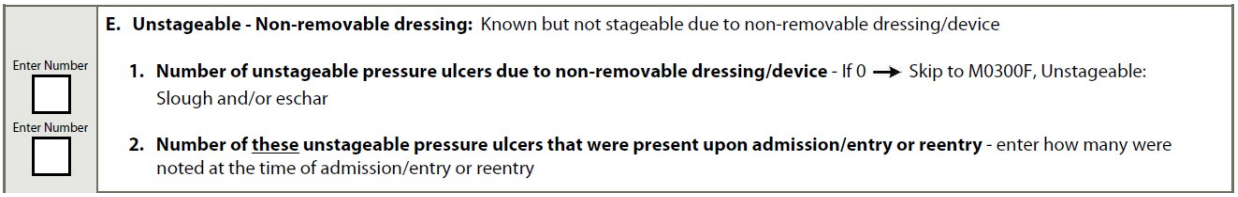
M0300D2

- 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.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device



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 and may be painful.

DEFINITION

NON-REMOVABLE DRESSING/ DEVICE

Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Planning for Care

- Although the pressure ulcer 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 covered by a non-removable dressing.
2. Determine the number of pressure ulcers unstageable related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

Coding Instructions for M0300E

M0300E1

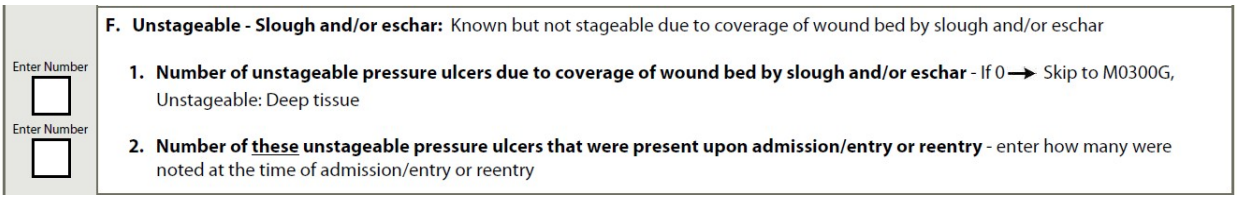
- Enter the number of pressure ulcers that are unstageable related to non-removable dressing/device.
- Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to M0300F, Unstageable – Slough and/or eschar.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

M0300E2

- Enter the number of these unstageable pressure ulcers 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 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 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.

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-6 for assessment process).

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

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

DEFINITION

FLUCTUANCE
Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

- Pressure ulcers that are covered with slough and/or eschar 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.

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.

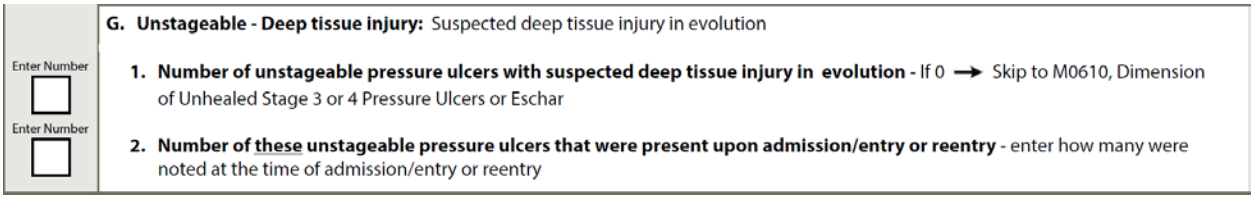
2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. 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. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers 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.

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 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.

M0300G: Unstageable Pressure 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 ulcers that are unstageable related to suspected deep tissue injury.
6. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 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 Ulcers Related to Suspected Deep Tissue Injury (cont.)

Coding Instructions for M0300G

M0300G1

- Enter the number of unstageable pressure 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 ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).

M0300G2

- Enter the number of these unstageable pressure 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 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 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-10).

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
☐☐.☐ cm	**A. Pressure ulcer length:** Longest length from head to toe
☐☐.☐ cm	**B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
☐☐.☐ cm	**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)

Item Rationale

Health-related Quality of Life

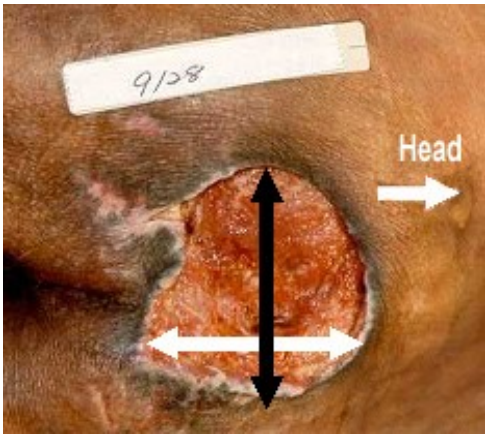
- Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.

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.

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

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 x 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

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code ☐	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 shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 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 9. **None of the Above**

Item Rationale

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.

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.

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.

M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

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

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number ☐	**A. Stage 2**
Enter Number ☐	**B. Stage 3**
Enter Number ☐	**C. Stage 4**

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 ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.

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.

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.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

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.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

— 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.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

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

M0900. Healed Pressure Ulcers Complete only if A0310E = 0	
Enter Code ☐	**A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0900B, Stage 2
	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number ☐	**B. Stage 2**
Enter Number ☐	**C. Stage 3**
Enter Number ☐	**D. Stage 4**

Item Rationale

Health-related Quality of Life

- 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.

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.

M0900: Healed Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.
- **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.
- Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not 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.

M0900: Healed Pressure Ulcers (cont.)

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.

Coding Instructions for M0900B, C, and D

- Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
- Enter 0: if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- 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.

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers	
Enter Number ☐	Enter the total number of venous and arterial ulcers present

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.

M1030: Number of Venous and Arterial Ulcers (cont.)

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.

DEFINITION

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.

Coding Instructions

Check all that apply in the last 7 days.

*Pressure ulcers coded in M0210 through M0900 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.

M1030: Number of Venous and Arterial Ulcers (cont.)

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

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	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)
	None of the Above
☐	**Z. None of the above** were present

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

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.

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 coded in M0200 through M0900 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)

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 OTHER THAN ULCERS, RASHES, CUTS
Most typically skin ulcers 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.)

- 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

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 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 Other than Ulcers, Rashes, Cuts

- Do **not** code rashes 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, 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.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- 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.

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.

M1040H Moisture Associated Skin Damage (MASD)

- 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 incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

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-M0900).**
   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.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

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 Treatments

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

M1200: Skin and Ulcer Treatments (cont.)

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 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.

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.

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.

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 care
- M1200F, Surgical wound care

M1200: Skin and Ulcer Treatments (cont.)

- 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

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. The appropriate reducing (redistribution) 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.

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 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. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, 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 management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

M1200E Pressure Ulcer Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers 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 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 ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer 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).

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 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**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

M1200: Skin and Ulcer 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 (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-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 undernutrition. 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 (redistribution) mattresses.

   Coding: Check items M1200A, M1200B, M1200C, M1200D, and M1200E.

   Rationale: Interventions include pressure reducing (redistribution) pad in 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 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 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).

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 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 M0300, M0610, M0700 and M0800

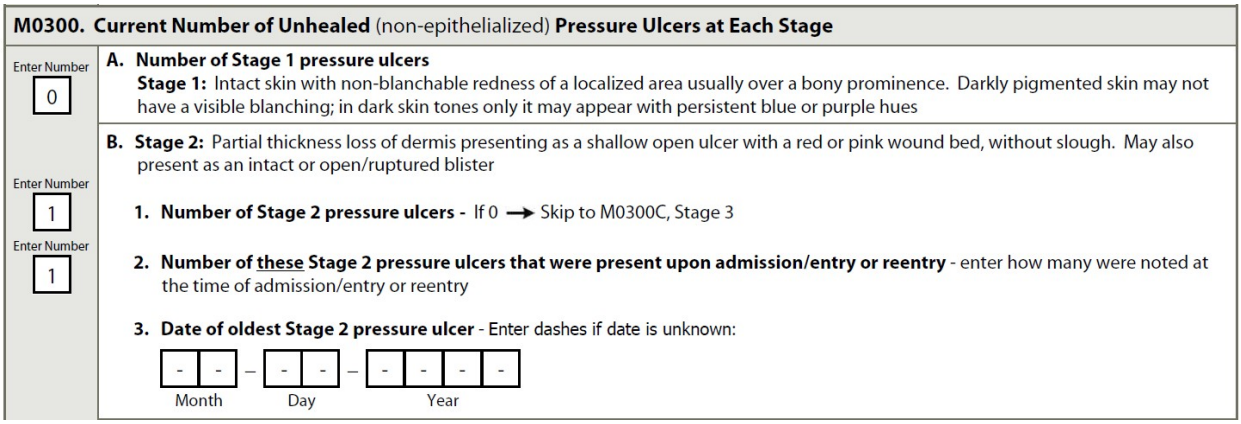
1. Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure 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.
   - M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

   Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.



M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number 0

A. Number of Stage 1 pressure ulcers
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

Enter Number 1

Enter Number 1

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

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

- - – - - – - - - - Month Day Year

Scenarios for Pressure Ulcer Coding (cont.)

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.

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number 0

A. Number of Stage 1 pressure ulcers
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

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

Enter Number 1

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number 1

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

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

[-][-] – [-][-] – [-][-][-][-]
Month Day Year

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.
- M0300D1, M0300E1, M0300F1, and M0300G1 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.
- M0610A (Pressure ulcer length), Code 03.0, M0610B (Pressure ulcer width), Code 02.4, M0610C (Pressure ulcer depth) Code 00.2.
- M0700 (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.
- 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.

Scenarios for Pressure Ulcer Coding (cont.)

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.

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number: 0

A. Number of Stage 1 pressure ulcers
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

Enter Number: 0

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

Enter Number:

2. Number of <u>these</u> 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

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

Month – Day – Year

Enter Number: 1

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

Enter Number: 0

2. Number of <u>these</u> 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

Enter Number: 0

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

Enter Number:

2. Number of <u>these</u> 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.)

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

Enter Number: 0

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number:

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

Enter Number: 0

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

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

Enter Number:

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

Enter Number: 0

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number:

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

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

0 3 . 0 cm	**A. Pressure ulcer length:** Longest length from head to toe
0 2 . 4 cm	**B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
0 0 . 2 cm	**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)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code: 2

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 shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick 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
9. **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 A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number: 0	**A. Stage 2**
Enter Number: 1	**B. Stage 3**
Enter Number: 0	**C. Stage 4**

Scenarios for Pressure Ulcer Coding (cont.)

Example M0100-M1200

1. Mrs. P is 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 break down. 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 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), Code 1.
   - M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 0 and skip to 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, 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. M1040Z was checked since none of these problems were noted. M1200Z was checked because none of these treatments were provided.

Scenarios for Pressure Ulcer Coding (cont.)

M1030. Number of Venous and Arterial Ulcers	
Enter Number [0]	**Enter the total number of venous and arterial ulcers present**
M1040. Other Ulcers, Wounds and Skin Problems	
↓ **Check all that apply**	
	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)** (i.e. incontinence (IAD), 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

Scenarios for Pressure Ulcer Coding (cont.)

14-Day PPS:

Coding:

- M0100A (Resident has a 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), Code 1.
- M0210 (One or more unhealed pressure ulcer(s) 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 M0300D (Stage 4).
- M0300D1 (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable: Non-removable dressing).
- M0300E1 (Unstageable: Non-removable dressing), 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).
- M0300G1 (Unstageable: Deep tissue), Code 0 and skip to 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).

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 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 preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore 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 care).

Scenarios for Pressure Ulcer Coding (cont.)

M0100. Determination of Pressure Ulcer Risk

↓ Check all that apply

[X]	**A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
[X]	**B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
[X]	**C. Clinical assessment**
[ ]	**Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code [1]

Is this resident at risk of developing pressure ulcers?
0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code [1]

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage**

Enter Number [0]

A. Number of Stage 1 pressure ulcers
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

Enter Number [1]

Enter Number [0]

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 <u>these</u> 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

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

Enter Number [0]

Enter Number [ ]

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 <u>these</u> 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

Enter Number [0]

Enter Number [ ]

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

2. **Number of <u>these</u> 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.)

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

Enter Number 0	**E. Unstageable - Non-removable dressing:** Known but not stageable due to non-removable dressing/device **1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
Enter Number	**2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
Enter Number 0	**F. Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **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
Enter Number	**2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry
Enter Number 0	**G. Unstageable - Deep tissue:** Suspected deep tissue injury in evolution **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Enter Number	**2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code 1	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 shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick 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 9. **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 A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.

Enter Number 1	**A. Stage 2**
Enter Number 0	**B. Stage 3**
Enter Number 0	**C. Stage 4**

Scenarios for Pressure Ulcer Coding (cont.)

M0900. Healed Pressure Ulcers Complete only if A0310E = 0	
Enter Code [0]	**A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0900B, Stage 2
	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number [ ]	**B. Stage 2**
Enter Number [ ]	**C. Stage 3**
Enter Number [ ]	**D. Stage 4**
M1030. Number of Venous and Arterial Ulcers	
Enter Number [0]	**Enter the total number of venous and arterial ulcers present**
M1040. Other Ulcers, Wounds and Skin Problems	
↓ **Check all that apply**	
	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)** (i.e. incontinence (IAD), perspiration, drainage)
	None of the Above
[X]	**Z. None of the above** were present
M1200. Skin and Ulcer Treatments	
↓ **Check all that apply**	
[X]	**A. Pressure reducing device for chair**
[X]	**B. Pressure reducing device for bed**
[X]	**C. Turning/repositioning program**
[ ]	**D. Nutrition or hydration intervention** to manage skin problems
[X]	**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

SECTION N: MEDICATIONS

Intent: 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.

In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications.

N0300: Injections

N0300. Injections	
Enter Days ☐	**Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received

Item Rationale

Health-related Quality of Life

- Frequency of administration of medication via injection can be an indication of stability of a resident's health status and/or complexity of care needs.

Planning for Care

- Monitor for adverse effects of injected medications.
- Although antigens and vaccines are not considered to be medications per se, it is important to track when they are given to monitor for localized or systemic reactions.

Steps for Assessment

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care locations where the resident may have received injections while a resident of the nursing home (e.g., flu vaccine in a physician's office, in the emergency room – as long as the resident was not admitted).
3. Determine if any medications were received by the resident via injection. If received, determine the number of days during the look-back period they were received.

N0300: Injections (cont.)

Coding Instructions

Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by injection.

*Insulin injections **are** counted in this item as well as in Item N0350.*

- 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 (e.g., subcutaneous, intramuscular, or intradermal) was received in Item N0300.

Coding Tips and Special Populations

- For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on one day, and another vaccine is provided on the next day, the number of days the resident received injections would be **coded as 2 days.**
- If two injections were administered on the same day, the number of days the resident received injections would be **coded as 1 day.**

Examples

1. During the **7**-day look-back period, Mr. T. received an influenza shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B_{12} injection on Wednesday.

   Coding: N0300 would be coded **3.**
   Rationale: The resident received injections on 3 separate days during the **7**-day look-back period.

2. During the **7**-day look-back period, Miss C. received both an influenza shot and her vitamin B_{12} injection on Thursday.

   Coding: N0300 would be coded **1.**
   Rationale: The resident received injections on one day during the **7**-day look-back period.

N0350: Insulin

N0350. Insulin	
Enter Days ☐	A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days
Enter Days ☐	B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

Item Rationale

Health-related Quality of Life

- Insulin is a medication used to treat diabetes mellitus (DM).
- Individualized meal plans should be created with the resident's input to ensure appropriate meal intake. Residents are more likely to be compliant with their DM diet if they have input related to food choices.

Planning for Care

- Orders for insulin may have to change depending on the resident's condition (e.g., fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections take into account meals, activity, etc., based on individualized resident assessment.
- Monitor for adverse effects of insulin injections (e.g., hypoglycemia).
- Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.

Steps for Assessment

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or insulin orders changed.

Coding Instructions for N0350A

- Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

Coding Instructions for N0350B

- Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist **if allowable under state licensure laws**) changed the resident's insulin orders.

N0350: Insulin (cont.)

Coding Tips and Special Populations

- For sliding scale orders:
  - 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.
  - If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.
- For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

N0410: Medications Received

N0410. Medications Received	
Indicate the number of DAYS 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 ☐	**A. Antipsychotic**
Enter Days ☐	**B. Antianxiety**
Enter Days ☐	**C. Antidepressant**
Enter Days ☐	**D. Hypnotic**
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**
Enter Days ☐	**H. Opioid**

N0410: Medications Received (cont.)

Item Rationale

Health-related Quality of Life

- Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.
- As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications.

DEFINITIONS

ADVERSE CONSEQUENCE
An unpleasant symptom or event that is caused by or associated with a medication, impairment or decline in an individual's physical condition, mental, functional or psychosocial status. It may include various types of adverse drug reactions (ADR) and interactions (e.g., medication-medication, medication-food, and medication-disease).

NON-PHARMACOLOGICAL INTERVENTION
Approaches that do not involve the use of medication to address a medical condition.

N0410: Medications Received (cont.)

Planning for Care

- The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication.
- Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.
- Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects.
- Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

Steps for Assessment

1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).

DEFINITIONS

DOSE
The total amount/strength/ concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/ concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

MONITORING
The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or the treatments and support decisions about adding, modifying, continuing, or discontinuing any interventions.

Coding Instructions

- N0410A–H: Code medications according to the pharmacological classification, not how they are being used.
- N0410A, Antipsychotic: Record the number of days an antipsychotic 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).
- N0410B, Antianxiety: Record the number of days an anxiolytic 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).

N0410: Medications Received (cont.)

- N0410C, Antidepressant: Record the number of days an antidepressant 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).
- N0410D, Hypnotic: Record the number of days a hypnotic 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).
- N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant 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). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.
- N0410F, Antibiotic: Record the number of days an antibiotic 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).
- N0410G, Diuretic: Record the number of days a diuretic 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).
- 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

- Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.
- 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.
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- Code a medication even if it was given only once during the look-back period.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are given during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

N0410: Medications Received (cont.)

- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.
- 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.
- When residents are having difficulty sleeping, nursing home staff should explore non-pharmacological interventions (e.g., sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and prior customary routine) to try to improve sleep prior to initiating pharmacologic interventions. If residents are currently on sleep-enhancing medications, nursing home staff can try non-pharmacologic interventions to help reduce the need for these medications or eliminate them.
- Many psychoactive medications increase confusion, sedation, and falls. For those residents who are already at risk for these conditions, nursing home staff should develop plans of care that address these risks.
- Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

DEFINITION

SLEEP HYGIENE
Practices, habits and environmental factors that promote and/or improve sleep patterns.

DEFINITIONS

GRADUAL DOSE REDUCTION (GDR)
Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.

MEDICATION INTERACTION
The impact of medication or other substance (such as nutritional supplements including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

N0410: Medications Received (cont.)

- Doses of psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.
- During the first year in which a resident on a psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** (the **State Operations Manual** can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html).
- Prior to discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).
- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances and duration of use. Certain anticoagulants require monitoring via laboratory results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
  - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html]), which may
    - significantly increase PT/INR results to levels associated with life-threatening bleeding, or
    - decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant.

N0410: Medications Received (cont.)

- 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 currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.
- 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.

Example

1. The Medication Administration Record for Mrs. P. reflects the following:
   - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
   - Lorazepam 1 mg PO QAM: Received every day.
   - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

   Coding: Medications in N0410, would be coded as follows: A. Antipsychotic = 3, resperidone is an antipsychotic medication, B. Antianxiety = 7, lorazepam is an antianxiety medication, and D. Hypnotic = 2, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition** (**DSM-5**) (or subsequent editions) (https://www.psychiatry.org/psychiatrists/practice/dsm), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html)].

N0410: Medications Received (cont.)

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- GlobalRPh Drug Reference, http://globalrph.com/drug-A.htm
- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcare-professionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6. *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"
- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html
- The DrugLib.com Index of Drugs by Category, http://www.druglib.com/drugindex/category/

This list is not all-inclusive. CMS is not responsible for the content or accessibility of the pages found at these sites. URL addresses were current as of the date of this publication.

N0450: Antipsychotic Medication Review

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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.

N0450: Antipsychotic Medication Review (cont.)

- 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 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?

Coding Instructions for N0450B

- Code 0, no: if a GDR has not been attempted. Skip to N0450D, Physician documented GDR as clinically contraindicated.
- Code 1, yes: if a GDR has been attempted. Continue to N0450C, Date of last attempted GDR.

Coding Instructions for N0450C

- **Enter the date of the last attempted Gradual Dose Reduction.**

N0450: Antipsychotic Medication Review (cont.)

Coding Instructions for N0450D

- `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 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

- 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.
- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic 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.
- 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 N0450C, 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 N0450C, Date of last attempted GDR.
- Federal requirements regarding GDRs are found at 42 CFR §483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

O0100: Special Treatments, Procedures, and Programs (cont.)

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).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

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.

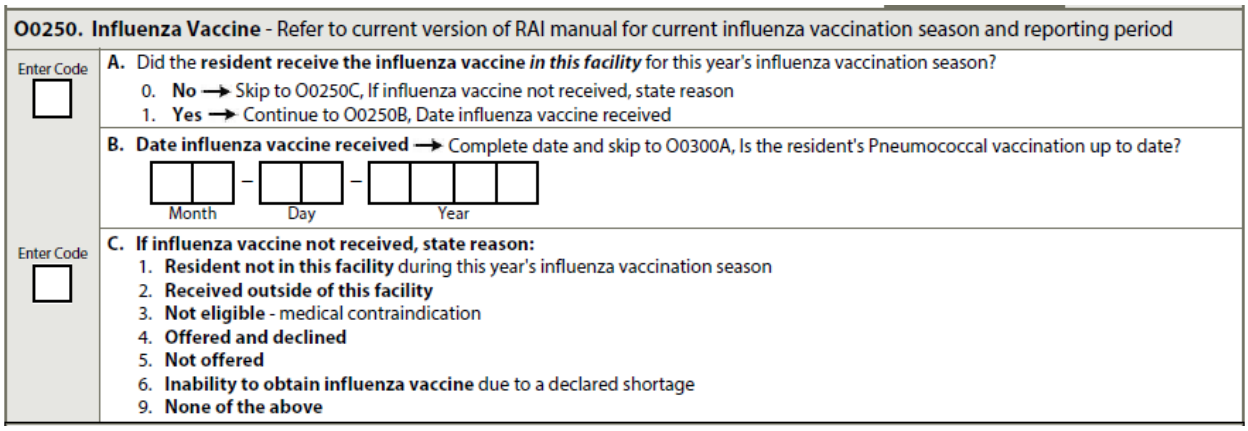
If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport 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



O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?
0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. **Date influenza vaccine received** → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. **If influenza vaccine not received, state reason:**
1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O0300: Pneumococcal Vaccine (cont.)

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

- 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.
- "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.

O0300: Pneumococcal Vaccine (cont.)

Examples

1. Mr. L., who is 72 years old, received the pneumococcal vaccine at his physician's office last year.

   Coding: O0300A would be coded 1, yes; skip to O0400, Therapies.
   Rationale: Mr. L is over 65 years old 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 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.

4. Mr. T. received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 65 years old and is being admitted to the nursing home for chemotherapy and respite care.

   Coding: O0300A would be coded 1, yes; skip to O0400, Therapies.
   Rationale: Mr. T. received his first dose of pneumococcal vaccine prior to the age of 65 due to him residing in congregate care at the age of 62. Even though Mr. T. is now immunocompromised, less than 5 years have lapsed since he originally received the vaccine. He would be considered up to date with his vaccination.

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 × 5) + (20 × 2) = 190]; concurrent minutes totaled 70 over the 7-day look-back period (35 × 2 = 70); and group minutes totaled 75 over the 7-day look-back period (25 × 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 × 2) + 23 + 18 + 12 = 113]; concurrent minutes totaled 0 over the 7-day look-back period (0 × 0 = 0); and group minutes totaled 80 over the 7-day look-back period (20 × 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 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 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 × 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.)

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes: 190

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 70

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

Enter Number of Minutes: 75

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 O0400A5, Therapy start date

Enter Number of Minutes: 65

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

Enter Number of Days: 5

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

Month: 10 – Day: 06 – Year: 2011

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month: - - – Day: - - – Year: - - - -

B. Occupational Therapy

Enter Number of Minutes: 113

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 0

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

Enter Number of Minutes: 80

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 O0400B5, Therapy start date

Enter Number of Minutes: 60

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

Enter Number of Days: 5

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

Month: 10 – Day: 09 – Year: 2011

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month: - - – Day: - - – Year: - - - -

O0400 continued on next page

O0400: Therapies (cont.)

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes: 287

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 100

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

Enter Number of Minutes: 0

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 O0400C5, Therapy start date

Enter Number of Minutes: 30

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

Enter Number of Days: 5

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

Month: 10 – Day: 07 – Year: 2011

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month: - - – Day: - - – Year: - - - -

D. Respiratory Therapy

Enter Number of Minutes: 50

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

Enter Number of Days: 0

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes: 0

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

Enter Number of Days:

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes: 90

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

Enter Number of Days: 5

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0420: Distinct Calendar Days of Therapy

O0420. Distinct Calendar Days of Therapy

Enter Number of Days:

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.

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:

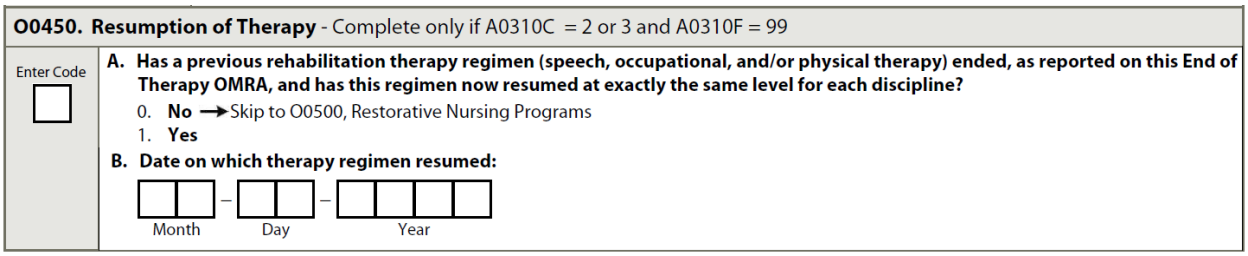
Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past

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 was 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

O0500. Restorative Nursing Programs	
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)	
Number of Days	**Technique**
☐	**A. Range of motion (passive)**
☐	**B. Range of motion (active)**
☐	**C. Splint or brace assistance**
Number of Days	**Training and Skill Practice In:**
☐	**D. Bed mobility**
☐	**E. Transfer**
☐	**F. Walking**
☐	**G. Dressing and/or grooming**
☐	**H. Eating and/or swallowing**
☐	**I. Amputation/prostheses care**
☐	**J. Communication**

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

O0600. Physician Examinations	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

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:
  - Chapter 15 of the ***Medicare Benefit Policy Manual*** (Pub. 100-2) and Chapter 12 of the ***Medicare Claims Processing Manual*** (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
- 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

O0700. Physician Orders	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's 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.

SECTION P: RESTRAINTS AND ALARMS

Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

Are Restraints Prohibited by CMS?

CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Retrieved December 18, 2012, from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf).

Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.10(e)(1) and 483.12). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use.

DEFINITION

PHYSICAL RESTRAINTS

Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP).

Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint. When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use.

While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule.

P0100: Physical Restraints (cont.)

resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR §§483.10(c)(6) and 483.21(b)(ii)(A)–(F) respectively. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.

— A resident who is injuring himself/herself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

Additional Information

- **Restraint reduction/elimination.** It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.
- **Restraints as a fall prevention approach.** Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- **Request for restraints.** While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.

  According to 42 CFR 483.10(e)(1) and 483.12, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of

P0100: Physical Restraints (cont.)

regulation solely based on a resident, legal surrogate or representative's request or approval." The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

P0200: Alarms

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

Item Rationale

Health-related Quality of Life

- An alarm is <u>any</u> physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

P0200: Alarms (cont.)

Planning for Care

- Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being.
- When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident.

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?

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.

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.

P0200: Alarms (cont.)

- **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.
- **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.
- Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the resident appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible.
- While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.
- Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200F Other alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. This is also a civil right for all residents. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code ☐	A. Resident participated in assessment 0. No 1. Yes
Enter Code ☐	B. Family or significant other participated in assessment 0. No 1. Yes 9. Resident has no family or significant other
Enter Code ☐	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process and in development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.24 Quality of Life).

DEFINITION

RESIDENT'S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspectives during assessment.

Q0100: Participation in Assessment (cont.)

- During the care planning meetings, the resident should be made comfortable and verbal communication should be directly with him or her.
- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.
- If the individual resident is unable to understand the process, his or her family member, significant other, and/or guardian/legally authorized representative, who represents the individual, should be invited to attend the assessment process whenever possible.
- When the resident is unable to participate in the assessment process, a family member or significant other, and/or guardian or legally authorized representatives can provide information about the resident's needs, goals, and priorities.

DEFINITIONS

FAMILY OR SIGNIFICANT OTHER
A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not include staff at the nursing home.

GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE
A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Steps for Assessment

1. Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.
2. Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.
3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

Coding Instructions for Q0100A, Resident Participated in Assessment

Record the participation of the resident in the assessment process.

- Code 0, No: if the resident did not actively participate in the assessment process.
- Code 1, Yes: if the resident actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- Code 0, No: if the family or significant other did not participate in the assessment process.

Q0100: Participation in Assessment (cont.)

- Code 1, Yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, Resident has no family or significant other: Resident has no family or significant other.

Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

Record the participation of a guardian or legally authorized representative in the assessment process.

- Code 0, No: if guardian or legally authorized representative did not participate in the assessment process.
- Code 1, Yes: if guardian or legally authorized representative did participate in the assessment process.
- Code 9, Resident has no guardian or legally authorized representative: Resident has no guardian or legally authorized representative.

Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.
- Significant other does not include nursing home staff.

Q0300: Resident's Overall Expectation

Complete only when A0310E=1. (First assessment on admission/entry or reentry).

Q0300. Resident's Overall Expectation Complete only if A0310E = 1	
Enter Code ☐	**A. Select one for resident's overall goal established during assessment process** 1. Expects to be **discharged to the community** 2. Expects to **remain in this facility** 3. Expects to be **discharged to another facility/institution** 9. **Unknown or uncertain**
Enter Code ☐	**B. Indicate information source for Q0300A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain**

Q0300: Resident's Overall Expectation (cont.)

Item Rationale

This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet his or her individual long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

Some residents have very clear and directed expectations that will change little prior to discharge. Other residents may be unsure or may be experiencing an evolution in their thinking as their clinical condition changes or stabilizes.

DEFINITION

DISCHARGE
To release from nursing home care. Can be to home, another community setting, or a healthcare setting.

Health-related Quality of Life

- Unless the resident's goals for care are understood, his or her needs, goals, and priorities are not likely to be met.

Planning for Care

- The resident's goals should be the basis for care planning.

Steps for Assessment

1. Ask the resident about his or her overall expectations to be sure that he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices such as returning home, or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting.
2. Ask the resident to consider his or her current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services and supports in the community.
3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community.
4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative, may also be recorded in the *clinical record*.
5. Because of a temporary (e.g., delirium) or permanent (e.g., profound dementia) condition, some residents may be unable to provide a clear response. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can be obtained from the family or significant other, as designated by the individual. If family or the significant other is not available, the information should be obtained from the guardian or legally authorized representative.

Q0300: Resident's Overall Expectation (cont.)

6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.
7. In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

Coding Instructions for Q0300A, Resident's Overall Goals Established during Assessment Process

Record the resident's expectations as expressed by him or her. It is important to document his or her expectations.

- Code 1, Expects to be discharged to the community: if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- Code 2, Expects to remain in this facility: if the resident indicates that he or she expects to remain in the nursing home.
- Code 3, Expects to be discharged to another facility/institution: if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- Code 9, Unknown or uncertain: if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.

Coding Tips

- This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations, not whether or not the staff considers them to be realistic. Coding other than the resident's stated expectation is a violation of the resident's civil rights.
- Q0300A, Code 1 "Expects to be discharged to the community" may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1).
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive, e.g., "do not resuscitate" (DNR).
- The resident should be provided options, as well as, access to information that allows him or her to make the decision and to be supported in directing his or her care planning.

Q0300: Resident's Overall Expectation (cont.)

Rationale: Mr. W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident's expressed goals.

3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs.

   Coding: Q0300A would be coded 2, Expects to remain in this facility.
   Q0300B would be coded 2, Family or significant other.

   Rationale: Ms. T is not able to respond, but her daughter has clear expectations that her mother will remain in the nursing home where she will be made comfortable for her remaining days.

4. Mrs. G., an 84-year-old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she "just needs to have a break." Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.

   Coding: Q0300A would be coded 1, Expects to be discharged to the community.
   Q0300B would be coded 2, Family or significant other.

   Rationale: Mrs. G. is not able to respond but her daughter has clear expectations that her mother will return home at the end of the 7-day respite visit.

5. Mrs. C. is a 72-year-old woman who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care. She has no living relatives and no significant other who is willing to participate in her care decisions. The court appointed a legal guardian to oversee her care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Mrs. C.'s best interest that she be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

   Coding: Q0300A would be coded 3, Expects to be discharged to another facility/institution.
   Q0300B would be coded 3, Guardian or legally authorized representative.

Q0300: Resident's Overall Expectation (cont.)

Rationale: Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions. A court-appointed legal guardian determined that it is in Mrs. C.'s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.

   Coding: Q0300A would be coded 1, Expects to be discharged to the community (small group homes are considered to be community setting).
   Q0300B would be coded 1, Resident

   Rationale: Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed that it is in Ms. K.'s best interest to be transferred to a group home. This information should also be recorded in the individual's clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)

Q0400: Discharge Plan

Q0400. Discharge Plan	
Enter Code ☐	**A. Is active discharge planning already occurring for the resident to return to the community?** 0. **No** 1. **Yes** → Skip to Q0600, Referral

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. Community resources and supports exist that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident's decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

Q0400: Discharge Plan (cont.)

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources.
- Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U.S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.
- The care plan should include the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative, arrangements for the durable medical equipment (if needed), formal and informal supports that will be available, the persons and provider(s) in the community who will meet the resident's needs, and the place the resident is going to be living.
- Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.
- Discharge instructions should include at a minimum:
  - the individuals preferences and needs for care and supports;
    - personal identification and contact information, including Advance Directives;
    - provider contact information of primary care physician, pharmacy, and community care agency including personal care services (if applicable) etc.;
    - brief medical history;
    - current medications, treatments, therapies, and allergies;
    - arrangements for durable medical equipment;
    - arrangements for housing;
    - arrangements for transportation to follow-up appointments; and
    - contact information at the nursing home if a problem arises during discharge
  - A follow-up appointment with the designated primary care provider in the community and other specialists (as appropriate).
  - Medication education.

Q0400: Discharge Plan (cont.)

- Prevention and disease management education, focusing especially on warning symptoms for when to call the doctor.
- Who to call in case of an emergency or if symptoms of decline occur.
- Nursing facility procedures and discharge planning for sub-acute and rehabilitation community discharges are most often well-defined and efficient.
- Section Q has broadened the scope of the traditional boundary of discharge planning for sub-acute residents to encompass long stay residents. In addition to home health and other medical services, discharge planning may include expanded resources such as assistance with locating housing, transportation, employment if desired, and social engagement opportunities.
  - Asking the resident and family about whether they want to talk to someone about a return to the community gives the resident voice and respects his or her wishes. This step in no way guarantees discharge but provides an opportunity for the resident to interact with LCA experts.
  - The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with providing information regarding community-based services and, when appropriate, transition services planning. The nursing facility interdisciplinary team and the LCA should work closely together. The LCA is the entity that does the community support planning, (e.g., housing, home modification, setting up a household, transportation, community inclusion planning, etc.). A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line/website or by other state-approved processes. Each state has a process for referral to an LCA, and it is vital to know the process in your state and for your facility. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.
  - Each NH needs to develop relationships with their LCAs to work with them to contact the resident and their family, guardian or significant others concerning a potential return to the community. A thorough review of medical, psychological, functional, and financial information is necessary in order to assess what each individual resident needs and whether or not there are sufficient community resources and finances to support a transition to the community.
  - Enriched transition resources including housing, in-home caretaking services and meals, home modifications, etc. are now more readily available. Resource availability and eligibility coverage varies across States and local communities.
  - Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions. However, a referral should not be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.

Q0400: Discharge Plan (cont.)

- Involve community mental health resources (as appropriate) to ensure that the resident has support and active coping skills that will help him or her to readjust to community living.
- Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge.
- For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf

Steps for Assessment

1. A review should be conducted of the care plan, the medical record, and clinician progress notes, including but not limited to nursing, physician, social services, and therapy to consider the resident's discharge planning needs.
2. If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other or guardian, as designated by the individual.
3. If a nursing facility has a discharge planning and referral and resource process for short stay residents that includes arranging for home health services, durable medical equipment, medical services, and appointments, etc., and the capability to address a resident's needs and arrange for that resident to discharge back to the community, a referral to the LCA may not be necessary. Additionally, some non-Medicare and Medicaid residents may have resources, informal and formal supports, and finances already in place that would not require referral to a local contact agency (LCA) to access them.
4. Record the resident's expectations as expressed/communicated, whether you assess that they are realistic or not realistic.
5. If the resident's discharge needs cannot be met by the nursing facility, an evaluation of the community living situation to evaluate whether it can meet the resident's needs should be conducted by the LCA, along with other community providers who will be providing the transition and other community based services to determine the need for assistive/adaptive devices, medical supplies, and equipment and other services.
6. The resident, his or her interdisciplinary team, and LCA (when a referral has been made to a local contact agency) should determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance).
7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.).
8. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is Active Discharge planning already occurring for the Resident to Return to the Community?

- Code 0, No: if there is not active discharge planning already occurring for the resident to return to the community.
- Code 1, Yes: if there is active discharge planning already occurring for the resident to return to the community; skip to **Referral** item (Q0600).

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

For Quarterly, Correction to Quarterly, and Not-OBRA Assessments. (A0310A=02, 06, 99)

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B Complete only if A0310A = 02, 06, or 99	
Enter Code ☐	**Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?** 0. **No** 1. **Yes** → Skip to Q0600, Referral

Item Rationale

This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, **Referral**. Q0500B is, however, mandatory on all comprehensive assessments.

Note: Let the resident know that they can change their mind about requesting information regarding possible return to the community at *any* time and should be referred to the LCA if they voice this request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.

Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

- Code 0, No: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again.

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (cont.)

- Code 1, Yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, **Referral**. If this is a comprehensive assessment, proceed to the next item, Q0500B.

Coding Tips

- Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded "No" to item Q0550.

If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

Examples

1. Ms. G is a 45-year old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.

   Coding: Q0490 would be coded 1, Yes, skip to Q0600; because this is a quarterly assessment.

   If this is a comprehensive assessment, then proceed to the next item Q0500B.

   Rationale: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widow with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

   Coding: Q0490 would be coded 1, Yes, skip to Q0600;

   Unless this is a comprehensive assessment, then proceed to the next item Q0500B.

   Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.

Q0500: Return to Community

For Admission, Quarterly, and Annual Assessments.

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**

Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in talking to someone about the possibility of leaving the facility and returning to live and receive services in the community. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living if it is the resident's desire. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Local contact agencies (LCAs) are experts in available home and community-based service (HCBS) and can provide both the resident and the facility with valuable information.

Health-related Quality of Life

- Returning home or to a non-institutional setting can be beneficial to the resident's health and quality of life.
- This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a civil right to receive services in the least restrictive and most integrated setting.
- Item Q0500B requires that the resident be asked the question directly and formalizes the opportunity for the resident to be informed of and consider his or her options to return to community living. This ensures that the resident's desire to learn about the possibility of returning to the community will be obtained and appropriate follow-up measures will be taken.
- The goal is to obtain the informed choice and preferences expressed by the resident and to provide information about available community supports and services.

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.

Q0500: Return to Community (cont.)

Steps for Assessment: Interview Instructions

1. At the initial admission assessment and in subsequent follow-up assessments (as applicable), make the resident comfortable by assuring him or her that this is a routine question that is asked of all residents.
2. Ask the resident if he or she would like to speak with someone about the possibility of returning to live and receive services in the community. Inform the resident that answering yes to this item signals the resident's request for more information and will initiate a contact by someone with more information about supports available for living in the community. A successful transition will depend on the resident's preferences and choices and the services, settings, and sometimes family supports that are available. In many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Answering yes *does not* commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at *any* time.
3. Explain that this item is meant to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input, if necessary. This step will help the resident clarify their discharge goals and identify important information for the LCA or, in some instances may indicate that the resident does not want to be referred to the LCA at this time. Also explain that the resident can change his/her mind at *any* time.
4. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others are not available, a guardian or legally authorized representative, if one exists, can provide the information.
5. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living. It is simply a request for information, not a request for discharge.

Coding Instructions for Q0500B, Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

Q0500: Return to Community (cont.)

A response code of 1, Yes, for this item indicates a request to learn about home and community based services, not a request for discharge.

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to live and receive services in the community.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to live and receive services in the community.
- Code 9, Unknown or uncertain: if the resident cannot understand or respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Coding Tips

- A "yes" response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency (LCA) about the resident's request within approximately 10 business days (or according to state policy) of a yes response being given. This code is intended to initiate contact with the LCA for follow-up as the resident desires.
- Follow-up is expected in a "reasonable" amount of time and 10 business days is a recommendation and not a requirement. Each state has its own policy for follow-up. It is important to know your state's policy. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face-to-face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.
- Some residents will have a very clear expectation and some may change their expectations over time. Residents may also be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a critical step. It is important to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually provides and can arrange, and obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24- hour care issues, etc.
- The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF and the resident can talk with the LCA to see what is available.

Q0500: Return to Community (cont.)

- Current return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian and/or legally appointed decision-maker for that individual should be asked the question.

Examples

1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local contact agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports.

   Coding: Q0500B would be coded 1, Yes.

   Rationale: Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local contact agency within approximately 10 business days, or according to state policy.

2. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in the Hope Nursing Home for the past 20 years. She once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Ms. C. was sent to the nursing home because she now required regular chest physical therapy and was told that she could no longer live in her previous group home because her needs were more intensive. No one had asked her about returning to the community until now. When administered the MDS assessment, she responded yes to item Q0500B.

   Coding: Q0500B would be coded 1, Yes.

   Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days, or according to state policy, for them to initiate discussions with Ms. C. about returning to community living.

Q0500: Return to Community (cont.)

3. Mr. D. is a 65-year-old man with a severe heart condition and interstitial pulmonary fibrosis. At the last quarterly assessment, Mr. D. had been asked about returning to the community and his response was no. He also responds no to item Q0500B. The assessor should ask why he responded no. Depending on the response, follow-up questions could include, "Is it that you think you cannot get the care you need in the community? Do you have a home to return to? Do you have any family or friends to assist you in any way?" Mr. D. responds no to the follow-up questions and does not want to offer any more information or talk about it.

   Coding: Q0500B would be coded 0, No.

   Rationale: During this assessment, he was asked about returning to the community and he responded no.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code ☐	**A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 9. **None of the above**

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B Again (cont.)

Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.
- Code 8, Information not available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Coding Instructions for Q0550B, Indicate information source for Q0550A

- Code 1, Resident: if resident responded to Q0550A.
- Code 2, If not resident, then family or significant other.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative.
- Code 9, None of the above.

Example

1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her and she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.

   Coding: Q0550A would be coded 1, Yes.
   Q0550B would be coded 1, Resident.

   Rationale: Ms. W. needs longer term restorative nursing care to recover from her injuries before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

Q0600: Referral

Q0600. Referral	
Enter Code ☐	**Has a referral been made to the Local Contact Agency?** (Document reasons in resident's clinical record) 0. **No** - referral not needed 1. **No** - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. **Yes** - referral made

Item Rationale

Health-related Quality of Life

- Returning home or transitioning to a non-institutional setting can be very important to the resident's health and quality of life.

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Steps for Assessment: Interview Instructions

1. If Item Q0400A is coded 1, yes, then complete this item.
2. If Item Q0490B is coded 1, yes, then complete this item,
3. If Item Q0500B is coded 1, yes, then complete this item.

Coding Instructions

- Code 0, No - referral not needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family, etc. responded no to Q0500B.
- Code 1, No - referral is or may be needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.

DEFINITION

DESIGNATED LOCAL CONTACT AGENCY (LCA)
Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

Q0600: Referral (cont.)

- Code 2, Yes - referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

Coding Tips

- State Medicaid Agencies (SMAs) are required to have designated Local Contact Agencies (LCA) and a State point of contact (POC) to coordinate efforts to implement Section Q and designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate. LCAs have a Data Use Agreement (DUA) with the SMA to allow them access to MDS data. It is important that each facility know who their LCA and POC are and how to contact them.
- Several resources are available on the Return to Community web site at: https://www.medicaid.gov/medicaid/ltss/community-living/index.html.
  - MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues.
  - The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q.
  - Videos of Section Q sessions and discussions at the 2010 RAI Coordinators Conference.
- Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some residents to return to their community. The nursing home and local contact agency staff members should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
- Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.
- The LCA can provide information to the SNF/NF on the available community living situations, and options for community based supports and services including the levels and scope of what is possible.
- The local contact agency team will explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.

Q0600: Referral (cont.)

- When Q0600 is answered 1, No, a care area trigger requires a return to community care area assessment (CAA) and CAA 20 provides a step-by-step process for the facility to use in order to provide the resident an opportunity to discuss returning to the community.

Examples

1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was "Yes" to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son's school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops, appliances, doorways, etc.

   Coding: Q0500B would be coded 1, Yes.
   Q0600 would be coded 2, Yes.
   Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes, because a referral to the designated LCA was made.

2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns due to falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V. to return to the community.

   Coding: Q0600 would be coded 1, No.
   Rationale: Ms. V. indicated that she wanted to have an opportunity to talk to someone about return to community. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600 would be coded as no- "referral is or may be needed." The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated local contact agency.

CHAPTER 4: CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING

4.1 Background and Rationale

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that nursing facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

4.2 Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)

As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.

The MDS is a starting point. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. For example, assessing a resident's orientation and recall helps staff complete portions of the MDS that relate to cognition (Section C), and weighing a resident and identifying his or her food intake helps staff complete portions

of the MDS related to nutritional status (Section K). When it is completed, the MDS provides a foundation for a more thorough assessment and the development of an individualized care plan. The MDS 3.0 manual explains in detail how to complete the MDS.

The information in the MDS constitutes the core of the required CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.

The CAA process framework. The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

When implemented properly, the CAA process should help staff:

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
- Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

4.3 What Are the Care Area Assessments (CAAs)?

The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. Specific "CAT logic" for each care area is identified under section 4.10 (The Twenty Care Areas). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas. Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative.

By statute, the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame. While a workup cannot always be completed within 14 days, it is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.

CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.

4.4 What Does the CAA Process Involve?

Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying

4.5 Other Considerations Regarding Use of the CAAs

Assigning responsibility for completing the MDS and CAAs. Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals. It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered). The proper assessment and management of CAAs that are triggered for a given resident may involve aspects of diagnosis and treatment selection that exceed the scope of training or practice of any one discipline involved in the care (for example, identifying specific medical conditions or medication side effects that cause anorexia leading to a resident's weight loss). It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice. For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.

Identifying policies and practices related to the assessment and care planning processes. Under the OBRA regulations, 42 CFR 483.70(h)(1) identifies the medical director as being responsible for overseeing the "implementation of resident care policies" in each facility, "and the coordination of medical care in the facility." Therefore, it is recommended that the facility's IDT members collaborate with the medical director to identify current evidence-based or expert-endorsed resources and standards of practice that they will use for the expanded assessments and analyses that may be needed to adequately address triggered areas. The facility should be able to provide surveyors the resources that they have used upon request as part of the survey review process.[1]

CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

- Relevant documentation for each triggered CAA describes: causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

[1] In Appendix C, CMS has provided CAA resources that facilities may choose to use but that are neither mandatory nor endorsed by the government. Please note that Appendix C does not provide an all-inclusive list.

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM).

If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.

Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

4.6 When Is the RAI Not Enough?

Federal requirements support a nursing home's ongoing responsibility to assess residents. The Quality of Care regulation requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 CFR 483.25).

Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.70(b), the facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Furthermore, surveyor guidance within OBRA (e.g., 42 CFR 483.25(b)(1) Pressure Ulcers and 42 CFR 483.45(d) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

Therefore, facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

Limitations of the RAI-related instruments. The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs are triggered, and a framework for the CAA process. However, the process of completing the MDS and related portions of the

RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents.

Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents. By themselves, neither the MDS nor the CAA process provide sufficient information to determine if the findings from the MDS are problematic or merely incidental, or if there are multiple causes of a single trigger or multiple triggers related to one or several causes. Although a detailed history is often essential to correctly identify and address causes of symptoms, the RAI was not designed to capture a history (chronology) of a resident's symptoms and impairments. Thus, it can potentially be misleading or problematic to care plan individual MDS findings or CAAs without any additional thought or investigation.

- The MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- The MDS is not a diagnostic tool or treatment selection guide
- The MDS does not identify causation or history of problems

Although facilities have the latitude to choose approaches to the CAA process, compliance with various OBRA requirements can be enhanced by using additional relevant clinical problem solving and decision making processes to analyze and address MDS findings and CAAs. Table 2 provides a framework for a more complete approach to clinical problem solving and decision making essential to the appropriate care of individuals with multiple and/or complex illnesses and impairments.

4.7 The RAI and Care Planning

As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(b)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html.

Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see 42 CFR 483.21(b), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.

assessment, effective clinical decision making, and is compatible with current standards of clinical practice can provide a strong basis for optimal approaches to quality of care and quality of life needs of individual residents. A well developed and executed assessment and care plan:

- Looks at each resident as a whole human being with unique characteristics and strengths;
- Views the resident in distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS);
- Gives the IDT a common understanding of the resident;
- Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers);
- Provides additional clarity of potential issues and/or conditions by looking at possible causes and risks (CAA process);
- Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up;
- Reflects the resident's/resident representative's input, goals, and desired outcomes;
- Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning);
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the individualized care plan as appropriate and necessary.

Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently:

- Review and revise the current care plan, as needed; and
- Communicate with the resident or his/her family or representative regarding the resident, care plans, and their wishes.

The overall care plan should be oriented towards:

1. Assisting the resident in achieving his/her goals.
2. Individualized interventions that honor the resident's preferences.
3. Addressing ways to try to preserve and build upon resident strengths.
4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).
5. Managing risk factors to the extent possible or indicating the limits of such interventions.
6. Applying current standards of practice in the care planning process.
7. Evaluating treatment of measurable objectives, timetables and outcomes of care.
8. Respecting the resident's right to decline treatment.
9. Offering alternative treatments, as applicable.

10. Using an interdisciplinary approach to care plan development to improve the resident's abilities.
11. Involving resident, resident's family and other resident representatives as appropriate.
12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.
13. Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes.

4.8 CAA Tips and Clarifications

Care planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment:

1) Care Plan goals should be measurable. The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate goal(s) and objectives must be pertinent to the resident's goals, preferences, condition, and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.
2) Care plan goal statements should include the **subject (first or third person),** the **verb,** the **modifiers,** the **time frame, and the goal(s)**.

Example:

Subject	***Verb***	***Modifiers***	***Time frame***	***Goal***
Mr. Jones **OR** I	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area

3) A separate care plan is not necessarily required for each area that triggers a CAA. Since a single trigger can have multiple causes and contributing factors and multiple items can have a common cause or related risk factors, it is acceptable and may sometimes be more appropriate to address multiple issues within a single care plan segment or to cross reference related interventions from several care plan segments. For example, if impaired ADL function, mood state, falls and altered nutritional status are all determined to be caused by an infection and medication-related adverse consequences, it may be appropriate to have a single care plan that addresses these issues in relation to the common causes.
4) The RN coordinator is required to sign and date the Care Area Assessment (CAA) Summary after all triggered CAAs have been reviewed to certify completion of the comprehensive assessment (CAAs Completion Date, V0200B2). Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days).
5) The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does

not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment.

6) The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

7) Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

8) If the RAI (MDS and CAAs) is not completed until the last possible date (the end of calendar day 14 of the stay), many of the appropriate care area issues, risk factors, or conditions may have already been identified, causes may have been considered, and a preliminary care plan and related interventions may have been initiated. A complete care plan is required no later than 7 days after the RAI is completed.

9) Review of the CAAs after completing the MDS may raise questions about the need to modify or continue services. Conditions that originally triggered the CAA may no longer be present because they resolved, or consideration of alternative causes may be necessary because the initial approach to an issue, risk, or condition did not work or was not fully implemented.

10) On the Annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again. Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care. The IDT with the input of the resident, family or resident's representative determines when a problem or potential problem needs to be addressed in the care plan.

11) The RN Coordinator for the CAA process (V0200B1) does not need to be the same RN as the RN Assessment Coordinator who verifies completion of the MDS assessment (Z0500). The date entered in V0200B2 on the CAA Summary is the date on which the RN Coordinator for the CAA process verified completion of the CAAs, which includes assessment of each triggered care area and completion of the location and date of the CAA assessment documentation section. See Chapter 2 for detailed instructions on the RAI completion schedule.

12) The Signature of Person Completing Care Plan Decision (V0200C1) can be that of any person(s) who facilitates the care plan decision making. It is an interdisciplinary process. The date entered in V0200C2 is the day the RN certifies that the CAAs have been completed and the day V0200C1 is signed.

4.9 Using the Care Area Assessment (CAA) Resources

Based on the preceding discussions in this Chapter, the following summarizes the steps involved in the CAA process, for those facilities that choose to use the CAA resources in this manual.

Please note: **Because MDS 3.0 trigger logic is complex, please refer to the CAT Logic tables within each CAA description (Section 4.10) for detailed information on triggers.**

Step 1: Identification of Triggered CAAs. After completing the MDS, identify triggered care areas. Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified. CMS has developed test files for facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly.

It is prudent to consider whether or not the software has triggered relevant CAAs for individual residents. For example, did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

For nursing homes that do not use an automated system, the CAT logic will provide the information necessary to manually identify triggered CAAs. The CAT logic is found within the CAT logic tables of each care area's description in section 4.10. These tables provide the MDS items that trigger the 20 (twenty) care areas. Facilities are not required to use this information or to maintain it in the resident's clinical record. Rather, the information is a resource that may be used by the IDT members to determine which CAAs are triggered from a completed MDS.

To identify the triggered CAAs manually using the CAT logic tables in section 4.10:

1. Compare the completed MDS with the CAT logic tables to determine which CAAs have been triggered for review.
2. The CAT logic table will list the MDS item numbers and specific codes that will trigger the particular CAA. To identify a triggered CAA, match the resident's MDS item responses with the MDS item number(s) and code(s) for each care area as listed in the CAT logic tables within section 4.10. If a particular item response matches a code in the CAT logic table for a particular care area, read through the logic statement and qualifiers (i.e., 'IF', 'AND', and 'OR') for that particular care area to determine if that care area is triggered. This means that further assessment using the CAA process is required for that particular care area.
3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.
4. Continue through the CAT logic tables for each of the 20 (twenty) care areas matching recorded MDS item responses with trigger indicators until all triggered CAAs have been identified.
5. When the CAT logic review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Step 2: Analysis of Triggered CAAs. Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps

staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

- Warrant intervention;
- Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
- Can help to minimize the onset or progression of impairments and disabilities; and
- Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions.

Example:

Chief Complaint: New onset of falls

Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after she stood up and started walking; a few falls occurred while attempting to stand up from a sitting or lying position.

It is clear that the problem statement reflects assessment findings from which the investigation may continue and relevant conclusions drawn.

While the CAAs can help the IDT identify conditions or findings that could potentially be a problem or risk for the resident, additional thought is needed to define these issues and determine whether and to what extent the care area issue and/or condition is a problem or issue needing an intervention (assessment, testing, treatment, etc.) or simply a minor or inconsequential finding that does not need additional care planning. For example, a resident may exhibit sadness without being depressed or may appear to be underweight despite having a stable nutritional status consistent with their past history. The IDT should identify and document the functional and behavioral implications of identified problematic issues/conditions, limitations, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident; how the condition limits or impairs the resident's ability to complete activities of daily living; or how the condition affects the resident's well-being in some way).

Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately. The IDT may find during their discussions that several problematic issues and/or conditions have a related cause, or they might identify that those issues and/or conditions stand alone and are unrelated. Goals and approaches for each problematic issue

and/or condition may overlap, and consequently the IDT may decide to address the problematic issues and/or conditions collectively in the care plan.

For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments. Thus, the following CATs naturally coexist and could be combined, assessed through the CAA process, and care planned together as a starting point for any resident: Delirium (CAA #1), Cognitive Loss/Dementia (CAA #2), Communication (CAA #4), Psychosocial Well-Being (CAA #7), Mood State (CAA #8) Behavioral Symptoms (CAA #9), and Psychotropic Drug Use (CAA #17).

Usually, illnesses and impairments happen in sequence (i.e., one thing leads to another, which leads to another, and so on). The symptom or trigger often represents only the most recent or most apparent finding in a series of complications or related impairments. Thus, a detailed history is often essential to identifying causes and selecting the most beneficial interventions, e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia. While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history. For example, knowing that the Behavioral Symptoms CAA (#9) is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.

It is the facility's responsibility to refer to sources as needed to help with clinical problem solving and decision making that is consistent with professional standards of practice. It is often necessary to involve the attending physician to identify specific underlying causes of problems, including multiple causes of a single problem or multiple problems or complications related to one or more underlying causes.

Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, goals, preferences, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.

Key components of the care plan may include, but are not limited to the following:

- Resident goals and preferences
- Measureable objective with established timeframes
- Specific interventions, including those that address common causes of multiple issues
- Additional follow-up and clarification
- Items needing additional assessment, testing, and review with the practitioner
- Items that may require additional monitoring but do not require other interventions

- The resident's preference and potential for future discharge and discharge plan

Staff who have participated in the assessment and who have provided pertinent information about the resident's status for triggered care areas should be a part of the IDT that develops the resident's care plan. In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented. **See Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives.**

Documentation related to CAAs should include the items previously discussed in Section 4.5.

4.10 The Twenty Care Areas

NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not checked. Example: "I4800=0" means that a check mark has not been placed in the check box item I4800.

1. Delirium

Delirium is acute brain failure caused by medical conditions, which presents with psychiatric symptoms, acute confusion, and fluctuations in levels of consciousness. It is a serious condition that can be caused by medical issues/conditions such as medication-related adverse consequences, infections, or dehydration. It can easily be mistaken for the onset or progression of dementia, particularly in individuals with more advanced pre-existing dementia.

Unlike dementia, delirium typically has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness periodically during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusions), seeing or feeling things that are not there (hallucinations), or a fixed false belief (delusions).

Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Symptoms of delirium are indicated by the presence of an acute mental status change and/or the presence of inattention, disorganized thinking or altered mental status on the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) as indicated by:

(a)

C1310A = 1

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

(b)

C1310B, C1310C or C1310D = 2

AND

C1310B = 1 or 2

AND EITHER

C1310C = 1 or 2 OR C1310D = 1 or 2

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. Staff who are closely involved with residents should report promptly any new onset or worsening of cognitive impairment and the other aforementioned symptoms in that resident.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting an acute change in mental status and/or the presence of inattention, disorganized thinking or altered mental status.

The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s) and/or condition(s), as well as to identify related underlying causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process (e.g., treating infections, addressing dehydration, identifying and treating hypo- or hyperthyroidism, relieving pain and depression, managing medications, and promoting adaptation and a comfortable environment for the resident to function. Other simple preventive measures that can be applied in all settings

include addressing hearing and visual impairments to the extent possible (e.g., with the use of glasses and hearing aids) and minimizing the use of indwelling urinary catheters.

2. Cognitive Loss/Dementia

Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has evidence of cognitive loss.

Cognitive Loss/Dementia CAT Logic Table

Triggering Conditions (any of the following):

1. BIMS summary score is less than 13 as indicated by:

   C0500 >= 00 AND C0500 < 13

2. BIMS summary score has a missing value and there is a problem with short-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0700 = 1)

3. BIMS summary score has a missing value and there is a problem with long-term memory as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C0800 = 1)

4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by:

   (C0500 = 99, -, OR ^) AND

   (C1000 >= 1 AND C1000 <= 3)

5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking or altered level of consciousness as indicated by:

   (C1310B = 1 OR C1310B = 2) OR

Cognitive Loss/Dementia CAT Logic Table

(C1310C = 1 OR C1310C = 2) OR

(C1310D = 1 OR C1310D = 2)

6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:

(E0200A >= 1 AND E0200A <= 3) OR

(E0200B >= 1 AND E0200B <= 3) OR

(E0200C >= 1 AND E0200C <= 3)

7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:

E0800 >= 1 AND E0800 <= 3

8. Wandering occurred at least 1 day in the past 7 days as indicated by:

E0900 >= 1 AND E0900 <= 3

The information gleaned from the assessment should be used to evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. It is important to define the nature of the impairment, e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue and/or condition is apparently not related to reversible causes, assessment should focus on the details of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss, to facilitate care planning specific to the resident's needs, issues and/or conditions, and strengths. The focus of the care plan should be to optimize remaining function by addressing underlying issues identified through this assessment process, such as relieving pain, optimizing medication use, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

The aging process leads to a decline in visual acuity, for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has a diagnosis of glaucoma, macular degeneration or cataracts or B1000 is coded 1-4.

Visual Function CAT Logic Table

Triggering Conditions (any of the following):

1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:

   I6500 = 1

2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:

   B1000 >= 1 AND B1000 <= 4

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves related activities, including expressive communication (making oneself understood to others, both verbally and via non-verbal exchange) and receptive communication (comprehending or understanding the verbal, written, or visual communication of others). Typical expressive issues and/or conditions include disruptions in language, speech, and voice production. Typical receptive communication issues and/or conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

   B0200 >= 1 AND B0200 <= 3

2. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

   B0700 >= 1 AND B0700 <= 3

3. Impaired ability to understand others through verbal content as indicated by:

   B0800 >= 1 AND B0800 <= 3

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet use, bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving or maintaining function when possible, and preventing

additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:

   (G0110B1 >= 1 AND G0110B1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:

   (G0110C1 >= 1 AND G0110C1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:

   (G0110D1 >= 1 AND G0110D1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

5. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion on unit (including with wheel chair, if applicable) was needed as indicated by:

   (G0110E1 >= 1 AND G0110E1 <= 4) AND

   ((C1000 >= 0 AND C1000 <= 2) OR

   (C0500 >= 5 AND C0500 <= 15))

6. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for locomotion off unit (including with wheel chair, if applicable) was needed as indicated by:

(G0110F1 >= 1 AND G0110F1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

7. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for dressing was needed as indicated by:

(G0110G1 >= 1 AND G0110G1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

8. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for eating was needed as indicated by:

(G0110H1 >= 1 AND G0110H1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

9. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for toilet use was needed as indicated by:

(G0110I1 >= 1 AND G0110I1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

10. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for grooming/personal hygiene was needed as indicated by:

(G0110J1 >= 1 AND G0110J1 <= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

11. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for self-performance bathing (excluding washing of back and hair) has a value of 1 through 4 as indicated by:

(G0120A>= 1 AND G0120A<= 4) AND

((C1000 >= 0 AND C1000 <= 2) OR

(C0500 >= 5 AND C0500 <= 15))

12. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while balance during transition has a value of 1 or 2 for any item as indicated by:

((G0300A = 1 OR G0300A = 2) OR
(G0300B = 1 OR G0300B = 2) OR
(G0300C = 1 OR G0300C = 2) OR
(G0300D = 1 OR G0300D = 2) OR
(G0300E = 1 OR G0300E = 2)) AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

13. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while resident believes he/she is capable of increased independence as indicated by:

G0900A = 1 AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

14. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while direct care staff believe resident is capable of increased independence as indicated by:

G0900B = 1 AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))

6. Urinary Incontinence and Indwelling Catheter

Urinary incontinence is the involuntary loss or leakage of urine or the inability to urinate in a socially acceptable manner. There are several types of urinary incontinence (e.g., functional, overflow, stress, and urge) and the individual resident may experience more than one type at a time (mixed incontinence).

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence itself is not a normal part of aging. Urinary incontinence can be a risk factor for various complications, including skin rashes, falls, and social isolation. Often, it is at least partially correctable. Incontinence may affect a resident's psychological well-being and social interactions. Incontinence also may lead to the potentially troubling use of indwelling catheters, which can increase the risk of life threatening infections.

This CAA is triggered if the resident is incontinent of urine or uses a urinary catheter. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Urinary Incontinence and Indwelling Catheter CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for toileting was needed as indicated by:

   (G0110I1 >= 2 AND G0110I1 <= 4)

2. Resident requires a indwelling catheter as indicated by:

   H0100A = 1

3. Resident requires an external catheter as indicated by:

   H0100B = 1

4. Resident requires intermittent catheterization as indicated by:

   H0100D = 1

5. Urinary incontinence has a value of 1 through 3 as indicated by:

   H0300 >= 1 AND H0300 <= 3

6. Resident has moisture associated skin damage as indicated by:

   M1040H = 1

Successful management will depend on accurately identifying the underlying cause(s) of the incontinence or the reason for the indwelling catheter. Some of the causes can be successfully treated to reduce or eliminate incontinence episodes or the reason for catheter use. Even when incontinence cannot be reduced or resolved, effective incontinence management strategies can prevent complications related to incontinence. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be used for appropriate indications and when no other viable options exist. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter, the potential for removal of the catheter, and consideration of complications resulting from the use of an indwelling catheter (e.g., urethral erosion, pain, discomfort, and bleeding). The next step is to develop an individualized care plan based directly on these conclusions.

7. Psychosocial Well-Being

Involvement in social relationships is a vital aspect of life, with most adults having meaningful relationships with family, friends, and neighbors. When these relationships are challenged, it can cloud other aspects of life. Decreases in a person's social relationships may affect psychological well-being and have an impact on mood, behavior, and physical activity. Similarly, declines in physical functioning or cognition or a new onset or worsening of pain or other health or mental health issues/conditions may affect both social relationships and mood. Psychosocial well-being may also be negatively impacted when a person has significant life changes such as the death of a loved one. Thus, other contributing factors also must be considered as a part of this assessment.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident exhibits minimal interest in social involvement.

Psychosocial Well-Being CAT Logic Table

Triggering Conditions (any of the following):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 or 4 as indicated by:

   F0500F = 3 OR F0500F = 4

4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities:

   F0800Q = 0

5. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

   (E0200A >= 1 AND E0200A <= 3) AND

   (I4800 = 0 OR I4800 = -) AND

   (I4200 = 0 OR I4200 = -)

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

   (E0200B >=1 AND E0200B <= 3) AND

   (I4800 = 0 OR I4800 = -) AND

   (I4200 = 0 OR I4200 = -)

7. Any six items for interview for activity preferences has the value of 4 and resident is primary respondent for daily and activity preferences as indicated by:

   (Any 6 of F0500A through F0500H = 4) AND

   (F0600 = 1)

The information gleaned from the assessment should be used to identify whether their minimal involvement is typical or customary for that person or a possible indication of a problem. If it is problematic, then address the underlying cause(s) of the resident's minimal social involvement and factors associated with reduced social relationships and engagement, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes in order to stimulate and facilitate social engagement.

8. Mood State

Sadness and anxiety are normal human emotions, and fluctuations in mood are also normal. But mood states (which reflect more enduring patterns of emotions) may become as extreme or overwhelming as to impair personal and psychosocial function. Mood disorders such as depression reflect a problematic extreme and should not be confused with normal sadness or mood fluctuation.

The mood section of the MDS screens for—but is not intended to definitively diagnose—any mood disorder, including depression. Mood disorders may be expressed by sad mood, feelings of emptiness, anxiety, or uneasiness. They may also result in a wide range of bodily complaints and dysfunctions, including weight loss, tearfulness, agitation, aches, and pains. However, because none of these symptoms is specific for a mood disorder, diagnosis of mood disorders requires additional assessment and confirmation of findings. In addition, other problems (e.g., lethargy, fatigue, weakness, or apathy) with different causes, which require a very different approach, can be easily confused with depression.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the Resident Mood Interview, Staff Assessment of Mood, or certain other specific issues indicate a mood issue and/or condition may be present.

Mood State CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has had thoughts he/she would be better off dead, or thoughts of hurting him/herself as indicated by:

   D0200I1 = 1

2. Staff assessment of resident mood suggests resident states life isn't worth living, wishes for death, or attempts to harm self as indicated by:

   D0500I1 = 1

3. The resident mood interview total severity score has a non-missing value (0 to 27) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the resident interview summary score on the current non-admission comprehensive assessment (D0300) is greater than the prior assessment (V0100E) as indicated by:

   ((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND
   ((D0300 >= 00) AND (D0300 <= 27)) AND
   ((V0100E >= 00) AND (V0100E <= 27)) AND
   (D0300 > V0100E)

4. The resident mood interview is not successfully completed (missing value on D0300), the staff assessment of resident mood has a non-missing value (0 to 30) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the staff assessment current total severity score on the current non-admission comprehensive assessment (D0600) is greater than the prior assessment (V0100F) as indicated by:

((A0310A = 03) OR (A0310A = 04) OR (A0310A = 05)) AND

((D0300 < 00) OR (D0300 > 27)) AND

((D0600 >= 00) AND (D0600 <= 30)) AND

((V0100F >= 00) AND (V0100F <= 30)) AND

(D0600 > V0100F)

5. The resident mood interview is successfully completed and the current total severity score has a value of 10 through 27 as indicated by:

D0300 >= 10 AND D0300 <= 27

6. The staff assessment of resident mood is recorded and the current total severity score has a value of 10 through 30 as indicated by:

D0600 >= 10 AND D0600 <= 30

The information gleaned from the assessment should be used as a starting point to assess further in order to confirm a mood disorder and get enough detail of the situation to consider whether treatment is warranted. If a mood disorder is confirmed, the individualized care plan should, in part, focus on identifying and addressing underlying causes, to the extent possible.

9. Behavioral Symptoms

In the world at large, human behavior varies widely and is often dysfunctional and problematic. While behavior may sometimes be related to or caused by illness, behavior itself is only a symptom and not a disease. The MDS only identifies certain behaviors, but is not intended to determine the significance of behaviors, including whether they are problematic and need an intervention.

Therefore, it is essential to assess behavior symptoms carefully and in detail in order to determine whether, and why, behavior is problematic and to identify underlying causes. The behavior CAA focuses on potentially problematic behaviors in the following areas: wandering (e.g., moving with no rational purpose, seemingly being oblivious to needs or safety), verbal abuse (e.g., threatening, screaming at, or cursing others), physical abuse (e.g., hitting, shoving, kicking, scratching, or sexually abusing others), other behavioral symptoms not directed at others (e.g., making disruptive sounds or noises, screaming out, smearing or throwing food or feces, hoarding, rummaging through other's belongings), inappropriate public sexual behavior or public disrobing, and rejection of care (e.g., verbal or physical resistance to taking medications, taking injections, completing a variety of activities of daily living or eating). Understanding the nature

of the issue/condition and addressing the underlying causes have the potential to improve the quality of the resident's life and the quality of the lives of those with whom the resident interacts.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident is identified as exhibiting certain troubling behavioral symptoms.

Behavioral Symptoms CAT Logic Table

Triggering Conditions (any of the following):

1. Rejection of care has a value of 1 through 3 indicating resident has rejected evaluation or care necessary to achieve his/her goals for health and well-being as indicated by:

   E0800 >= 1 AND E0800 <= 3

2. Wandering has a value of 1 through 3 as indicated by:

   E0900 >= 1 AND E0900 <= 3

3. Change in behavior indicates behavior, care rejection or wandering has gotten worse since prior assessment as indicated by:

   E1100 = 2

4. Presence of at least one behavioral symptom as indicated by:

   E0300 = 1

The information gleaned from the assessment should be used to determine why the resident's behavioral symptoms are problematic in contrast to a variant of normal, whether and to what extent the behavior places the resident or others at risk for harm, and any related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, reduce the frequency of truly problematic behaviors, and minimize any resultant harm.

10. Activities

The capabilities of residents vary, especially as abilities and expectations change, illness intervenes, opportunities become less frequent, and/or extended social relationships become less common. The purpose of the activities CAA is to identify strategies to help residents become more involved in relevant activities, including those that have interested and stimulated them in the past and/or new or modified ones that are consistent with their current functional and cognitive capabilities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident may have evidence of decreased involvement in social activities.

Activities CAT Logic Table

Triggering Conditions (any of the following):

1. Resident has little interest or pleasure in doing things as indicated by:

   D0200A1 = 1

2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:

   D0500A1 = 1

3. Any 6 items for interview for activity preferences has the value of 4 (not important at all) or 5 (important, but cannot do or no choice) as indicated by:

   Any 6 of F0500A through F0500H = 4 or 5

4. Any 6 items for staff assessment of activity preference item L through T are not checked as indicated by:

   Any 6 of F0800L through F0800T = 0

The information gleaned from the assessment should be used to identify residents who have either withdrawn from recreational activities or who are uneasy entering into activities and social relationships, to identify the resident's interests, and to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The care plan should focus on addressing the underlying cause(s) of activity limitations and the development or inclusion of activity programs tailored to the resident's interests and to his or her cognitive, physical/functional, and social abilities and improve quality of life.

11. Falls

A "fall" refers to unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an external force (e.g., being pushed by another resident). A fall without injury is still a fall. Falls are a leading cause of morbidity and mortality among the elderly, including nursing home residents. Falls may indicate functional decline and/or the development of other serious conditions, such as delirium, adverse medication reactions, dehydration, and infections. A potential fall is an episode in which a resident lost his/her balance and would have fallen without staff intervention.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has had recent history of falls and balance problems.

Falls CAT Logic Table

Triggering Conditions (any of the following):

1. Wandering occurs as indicated by a value of 1 through 3 as follows:

   E0900 >= 1 AND E0900 <= 3

2. Balance problems during transition indicated by a value of 1 or 2 for any item as follows:

   (G0300A = 1 OR G0300A = 2) OR

   (G0300B = 1 OR G0300B = 2) OR

   (G0300C = 1 OR G0300C = 2) OR

   (G0300D = 1 OR G0300D = 2) OR

   (G0300E = 1 OR G0300E = 2)

3. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last month prior to admission as indicated by:

   If A0310A = 01 AND J1700A = 1

4. For OBRA admission assessment: fall history at admission indicates resident fell anytime in the last 2 to 6 months prior to admission as indicated by:

   If A0310A = 01 AND J1700B = 1

5. Resident has fallen at least one time since admission or the prior assessment as indicated by:

   J1800 = 1

6. Resident received antianxiety medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

7. Resident received antidepressant medication on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C> = 1 AND N0410C<=7

8. Trunk restraint used in bed as indicated by a value of 1 or 2 as follows:

   P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed as indicated by a value of 1 or 2 as follows:

   P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's fall(s), as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based

directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

2. Body mass index (BMI) is too low or too high as indicated by:

   BMI < 18.5000 OR BMI > 24.9000

3. Any weight loss as indicated by a value of 1 or 2 as follows:

   K0300 = 1 OR K0300 = 2

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

   K0310 = 1 OR K0310 = 2

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510A1 = 1 OR K0510A2 = 1

6. Mechanically altered diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510C1 = 1 OR K0510C2 = 1

7. Therapeutic diet while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510D1 = 1 OR K0510D2 = 1

8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

((M0300B1 > 0 AND M0300B1 <= 9) OR
(M0300C1 > 0 AND M0300C1 <= 9) OR
(M0300D1 > 0 AND M0300D1 <= 9) OR
(M0300E1 > 0 AND M0300E1 <= 9) OR
(M0300F1 > 0 AND M0300F1 <= 9) OR
(M0300G1 > 0 AND M0300G1 <= 9))

13. Feeding Tubes

This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510B1 = 1 OR K0510B2 = 1

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s), including any reversible issues and conditions that led to using a feeding tube.

14. Dehydration/Fluid Maintenance

Dehydration is a condition in which there is an imbalance of water and related electrolytes in the body. As a result, the body may become less able to maintain adequate blood pressure and electrolyte balance, deliver sufficient oxygen and nutrients to the cells, and rid itself of wastes. In older persons, diagnosing dehydration is accomplished primarily by a detailed history, laboratory testing (e.g., electrolytes, BUN, creatinine, serum osmolality, urinary sodium), and to a lesser degree by a physical examination. Abnormal vital signs, such as falling blood pressure and an increase in the pulse rate, may sometimes be meaningful symptoms of dehydration in the elderly.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Dehydration/Fluid Maintenance CAT Logic Table

Triggering Conditions (any of the following):

1. Fever is selected as a problem health condition as indicated by:

   J1550A = 1

2. Vomiting is selected as a problem health condition as indicated by:

   J1550B = 1

3. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

4. Internal bleeding is selected as a problem health condition as indicated by:

   J1550D = 1

5. Infection present as indicated by:

   (I1700 = 1) OR
   (I2000 = 1) OR
   (I2100 = 1) OR
   (I2200 = 1) OR
   (I2300 = 1) OR
   (I2400 = 1) OR
   (I2500 = 1) OR
   ((M1040A = 1))

6. Constipation present as indicated by:

   H0600 = 1

7. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510A1 = 1 OR K0510A2 = 1

8. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510B1 = 1 OR K0510B2 = 1

The information gleaned from the assessment should be used to identify whether the resident is dehydrated or at risk for dehydration, as well as to identify any related possible causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration.

15. Dental Care

The ability to chew food is important for adequate oral nutrition. Having clean and attractive teeth or dentures can promote a resident's positive self-image and personal appearance, thereby enhancing social interactions. Medical illnesses and medication-related adverse consequences may increase a resident's risk for related complications such as impaired nutrition and communication deficits. The dental care CAA addresses a resident's risk of oral disease, discomfort, and complications.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has indicators of an oral/dental issue and/or condition.

Dental Care CAT Logic Table

Triggering Conditions (any of the following):

1. Any dental problem indicated by:

(L0200A = 1) OR
(L0200B = 1) OR
(L0200C = 1) OR
(L0200D = 1) OR
(L0200E = 1) OR
(L0200F = 1)

The information gleaned from the assessment should be used to identify the oral/dental issues and/or conditions and to identify any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes of the resident's issues and/or conditions.

16. Pressure Ulcer

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Pressure Ulcer CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) OR

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

   H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

   K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

   M0150 = 1

6. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

   M0300A > 0 AND M0300A <= 9

8. Resident has one or more pressure ulcer(s) that has gotten worse since prior assessment as indicated by:

(M0800A > 0 AND M0800A <= 9) OR

(M0800B > 0 AND M0800B <= 9) OR

(M0800C > 0 AND M0800C <= 9)

9. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

10. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications, prescribed primarily to affect cognition, mood, or behavior, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication, in consultation with the physician and the consultant pharmacist, and to identify any adverse consequences, as well as any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.

Psychotropic Medication Use CAT Logic Table

Triggering Conditions (any of the following):

1. Antipsychotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410A>= 1 AND N0410A<=7

2. Antianxiety medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410B>= 1 AND N0410B<=7

3. Antidepressant medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410C>= 1 AND N0410C<=7

4. Hypnotic medication administered to resident on one or more of the last 7 days or since admission/entry or reentry as indicated by:

   N0410D>= 1 AND N0410D<=7

18. Physical Restraints

A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. This category also includes the use of passive restraints such as chairs that prevent rising.

Physical restraints are only rarely indicated, and at most, should be used only as a short-term, temporary intervention to treat a resident's medical symptoms. They should not be used for purposes of discipline or convenience. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Restraints are often associated with negative physical and psychosocial outcomes (e.g., loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence). Adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation.

The physical restraint CAA identifies residents who are physically restrained during the look-back period. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Physical Restraints CAT Logic Table

Triggering Conditions (any of the following):

1. Bed rail restraint used in bed has value of 1 or 2 as indicated by:

   P0100A = 1 OR P0100A = 2

2. Trunk restraint used in bed has value of 1 or 2 as indicated by:

   P0100B = 1 OR P0100B = 2

3. Limb restraint used in bed has value of 1 or 2 as indicated by:

   P0100C = 1 OR P0100C = 2

4. Other restraint used in bed has value of 1 or 2 as indicated by:

   P0100D = 1 OR P0100D = 2

5. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100E = 1 OR P0100E = 2

6. Limb restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100F = 1 OR P0100F = 2

7. Chair restraint that prevents rising used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100G = 1 OR P0100G = 2

8. Other restraint used in chair or out of bed has value of 1 or 2 as indicated by:

   P0100H = 1 OR P0100H = 2

The information gleaned from the assessment should be used to identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by or risks related to restraint use.

The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or psychological condition(s) that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The ultimate goal is to eliminate restraint use by employing alternatives. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

19. Pain

Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage." Pain can be affected by damage to various organ systems and tissues, for example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain

can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep.

As with all symptoms, pain symptoms are subjective and require a detailed history and additional physical examination, and sometimes additional testing, in order to clarify pain characteristics and causes and identify appropriate interventions. This investigation typically requires coordination between nursing staff and a health care practitioner.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has active symptoms of pain.

Pain CAT Logic Table

Triggering Conditions (any of the following):

1. Pain has made it hard for resident to sleep at night over the past 5 nights as indicated by:

   J0500A = 1

2. Resident has limited day-to-day activity because of pain over past 5 days as indicated by:

   J0500B = 1

3. Pain numeric intensity rating has a value from 7 to 10 as indicated by:

   J0600A >= 07 AND J0600A <=10

4. Verbal descriptor of pain is severe or very severe as indicated by a value of 3 or 4 as follows:

   J0600B = 3 OR J0600B = 4

5. Pain is frequent as indicated by a value of 1 or 2 and numeric pain intensity rating has a value of 4 through 10 or verbal descriptor of pain has a value of 2 through 4 as indicated by:

   (J0400 = 1 OR J0400 = 2) AND

   ((J0600A >= 04 AND J0600A <= 10) OR

   (J0600B >= 2 AND J0600B <= 4))

6. Staff assessment reports resident indicates pain or possible pain in body language as indicated by:

   (J0800A = 1) OR

   (J0800B = 1) OR

   (J0800C = 1) OR

   (J0800D = 1)

The information gleaned from the assessment should be used to identify the characteristics and possible causes, contributing factors, and risk factors related to the pain. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to alleviate symptoms and, to the extent possible, address the underlying condition(s) that cause the pain.

Management of pain may include various interventions, including medications and other treatments that focus on improving the person's quality of life and ability to function. Therefore, it is important to tailor an individualized care plan related to pain to the characteristics, causes, and consequences of pain in the context of a resident's whole picture, including medical conditions, cognitive capabilities, goals, wishes, and personal and psychosocial function.

20. Return to Community Referral

All individuals have the right to choose the services they receive and the settings in which they receive those services. This right became law under the Americans with Disabilities Act (1990) and with further interpretation by the U.S. Supreme Court in the Olmstead vs. L.C. decision in 1999. This ruling stated that individuals have a right to receive care in the least restrictive (most integrated) setting and that governments (Federal and State) have a responsibility to enforce and support these choices.

An individual in a nursing home with adequate decision making capacity can choose to leave the facility and/or request to talk to someone about returning to the community at any time. The return to community referral portion of MDS 3.0 uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long-term care in the last restrictive setting possible. The CAA associated with this portion of MDS 3.0 focuses on residents who want to talk to someone about returning to the community and promotes opening the discussion about the individual's preferences for settings for receipt of services.

Individual choices related to returning to community living will vary, e.g., returning to a former home or a different community home, or, the individual may choose to stay in the nursing home. The discharge assessment process requires nursing home staff to apply a systematic and objective protocol so that every individual has the opportunity to access meaningful information about community living options and community service alternatives, with the goal being to assist the individual in maintaining or achieving the highest level of functioning and integration possible. This includes ensuring that the individual or surrogate is fully informed and involved, identifying individual strengths, assessing risk factors, implementing a comprehensive plan of care, coordinating interdisciplinary care providers, fostering independent functioning, and using rehabilitation programs and community referrals.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident expresses interest in returning to the community.

Return to Community Referral CAT Logic Table
Triggering Conditions (any of the following): 1. Referral is or may be needed but has not been made to local contact agency as indicated by: **Q0600 = 1**

The information gleaned from the assessment should be used to assess the resident's situation and begin appropriate care planning, discharge planning, and other follow-up measures. The next step is to develop an individualized care plan based directly on these findings.

The goal of care planning is to initiate and maintain collaboration between the nursing facility and the local contact agency (LCA) to support the individual's expressed interest in being transitioned to community living. The nursing home staff is responsible for making referrals to the LCAs under the process that the State has established. The LCA is, in turn, responsible for contacting referred residents and assisting with transition services planning. This includes facility support for the individual in achieving his or her highest level of functioning and the involvement of the designated contact agency providing informed choices for community living. The LCA is the entity that does the necessary community support planning (e.g. housing, home modification, setting up a household, transportation, community inclusion planning, arranging of care support, etc.). This collaboration will enable the State-designated local contact agency to initiate communication by telephone or visit with the individual (and his or her family or significant others, if the individual so chooses) to talk about opportunities for returning to community living.

4.11 Reserved

SNF must bill the default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

Under all situations other than exceptions 1-5, the following apply when the SNF failed to set the ARD prior to the end of the last day of the ARD window, including grace days, or later and the resident was already discharged from Medicare Part A when this was discovered:

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

In the case of an unscheduled assessment if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a scheduled PPS assessment, unless that scheduled PPS assessment is combined with an OBRA Discharge Assessment (see Section 2.12). For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.

A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections 2.5 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency

Term	Abbreviation	Definition
Inattention		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli.
Indwelling Catheter		A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
Intermittent Catheterization		Insertion and removal of a catheter through the urethra into the bladder for bladder drainage.
Internal Assessment ID		A sequential numeric identifier assigned to each record submitted to QIES ASAP.
International Classification of Diseases – Clinical Modification	**ICD-CM**	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries, and a classification system for surgical, diagnostic, and therapeutic procedures.
Invalid Record		As defined by the MDS Correction Policy, a record that was accepted into QIES ASAP that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.
Item Set Code	**ISC**	A code based upon combinations of reasons for assessment (A0310 items) that determines which items are active on a particular type of MDS assessment or tracking record.
Java-Based Resident Assessment Validation and Entry System	**jRAVEN**	Data entry software supplied by CMS for nursing facilities and hospital swing beds to use to enter MDS assessment data.
Legal Name		Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a government-issued document (i.e., driver's license, birth certificate, social security card).

(continued)

Term	Abbreviation	Definition
Respiratory Therapy		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.
Respite		Short-term, temporary care provided to residents to allow family members to take a break from the daily routine of care giving.
Significant Error		An error in an assessment where the resident's clinical status is not accurately represented (i.e. miscoded) on the erroneous assessment and the error has not been corrected via submission of a more recent assessment.
Skilled Nursing Facility	**SNF**	A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation services of injured, disabled, or sick persons.
Sleep Hygiene		Practices, habits, and environmental factors that promote and/or improve sleep patterns.
Social Security Number		A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

(continued)

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 Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version): http://www.eatrightpro.org/resource/practice/position-and-practice-papers/position-papers/individualized-nutrition-approaches-for-older-adults;
- American Geriatrics Society Clinical Practice Guidelines and Tools: http://www.americangeriatrics.org/publications-tools;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: http://www.paltc.org/product-store;
- 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;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf;
- 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/;
- Improving Nursing Home Culture (CMS Special Study): http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf;
  Institute for Safe Medication Practices: http://www.ismp.org/;

Track Changes
from Title Page v1.14
to Title Page v1.15

Chapter	Section	Page	Change
—	—	1	Version 1.14~~4~~5
—	—	1	October 2016~~7~~7
—	—	2	**Centers for Medicare & Medicaid Services'** **Long-Term Care Facility** **Resident Assessment Instrument (RAI)** **User's Manual** **October 2017** **For Use Effective October 1, 2017**

Track Changes
from Title Page v1.14
to Title Page v1.15

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>—</td><td>—</td><td>2</td><td>
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>
<tr><th>Item Set</th><th>Estimated response time</th></tr>
<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>
</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.
</td></tr>
</table>

Track Changes
from TOC v1.14
to TOC v1.15

Chapter	Section	Page	Change
—	—	i	2.2 ~~State~~CMS Designation of the RAI for Nursing Homes.....2-1
—	—	i	2.9 MDS Medicare Assessments for SNFs .....2-~~49~~50
—	—	i	2.10 Combining Medicare Scheduled and Unscheduled Assessments .....2-~~59~~60
—	—	i	2.11 Combining Medicare Assessments and OBRA Assessments .....2-~~64~~65
—	—	i	2.12 Medicare and OBRA Assessment Combinations .....2-~~66~~67
—	—	i	2.13 Factors Impacting the SNF Medicare Assessment Schedule .....2-~~78~~79
—	—	i	2.14 Expected Order of MDS Records.....2-~~83~~84
—	—	i	2.15 Determining the Item Set for an MDS Record .....2-~~86~~87
—	—	i	Section P Restraints and Alarms..... P-1
—	—	ii	4.11 (Reserved).....4-4~~1~~2

Track Changes
from Chapter 1 v1.14
to Chapter 1 v1.15

Chapter	Section	Page	Change
1	1.3	1-8	Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted an RN waiver under 42 CFR 483.3~~0 (c) or (d)~~5(e) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.
1	1.7	1-14	P | Restraints and Alarms | Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.
1	1.8	1-15	MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.~~75(l)(2)(3)~~70(i) and 483.75~~(l)(2)(4)(i)(ii)(iii)~~(i)(4), release of information from the resident's clinical record is permissible only when required by:
1	1.8	1-15	Providers~~,~~ who are part of a multi-facility corporation~~,~~ may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in ~~the~~ 42 CFR at 483.10~~(e)(3)~~(h)(3)(i)).

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.1	2-1	The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each ~~nursing home~~ resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA-required assessments will be described in detail in Section 2.6.
2	2.2	2-1	**2.2 CMS~~State~~ Designation of the RAI for Nursing Homes** Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by ~~the State and approved by~~ CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data. (Detailed submission requirements are located in Chapter 5.) While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items. ~~As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.~~

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.2	2-2	• CMS' ~~approval of a State's~~ specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI. • CMS' ~~approval of a State's~~ specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). • All comprehensive RAIs ~~authorized by States~~specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including CATs and the CAA Summary (Section V)). • If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS ~~approved State's~~specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer generated printouts. • Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates ~~the State's~~CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the ~~State~~ RAI specified by CMS).
2	2.2	2-2	Additional information about ~~State~~CMS specification of the RAI and~~,~~ variations in format ~~and CMS approval of a State's RAI~~ can be found in Sections 4145.1–~~–~~4145.7 of the CMS State Operations Manual (SOM). For more information about your State's assessment requirements, contact your State RAI coordinator (see Appendix B).

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.4	2-7	• Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the ~~long-term care~~ facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
2	2.4	2-8	• Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident. • Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a hand-written **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion date for all assessments and correction requests. ~~Either is equally acceptable.~~ This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility Tracking records and MDS Correction Requests (including signed attestation)~~(including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period~~. • All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified ~~long-term care~~ facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard. • In the future, ~~long-term care~~ facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.4–2.6	2-8–2-15	Page length changed due to revised content on 2-8.
2	2.5	2-11	**Interdisciplinary Team (IDT[1])** is a group of professional disciplines ~~clinicians from several medical fields~~ that combine~~s~~ knowledge, skills, and resources to provide the greatest benefit ~~care~~ to the resident.
2	2.5	2-11	1. 42 CFR 483.~~20(k)(2)~~21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).~~, the resident's family or the resident's legal representative;"~~
2	2.6	2-22	The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.
2	2.6	2-22	A **"significant change"** is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered ~~is not~~ "self-limiting"~~;~~ ~~(for declines only);~~

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.6	2-25–2-26	• **Decline in two or more of the following:** — Resident's decision-making ability has changed~~s~~; — Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior); — Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment; — Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning; — Resident's incontinence pattern changes or there was placement of an indwelling catheter; — Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); — Emergence of a new pressure ulcer at Stage 2~~II~~ or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status; — Resident begins to use ~~trunk~~ a restraint of any type ~~or a chair that prevents rising~~ when it was not used before; and/or — Emergence of a condition/disease in which a resident is judged to be unstable. ~~— Overall deterioration of resident's condition.~~

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.6	2-26	• **Improvement in two or more of the following:** — Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning; — Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; — Resident's decision making improves; ~~changes for the better;~~ — Resident's incontinence pattern improves. ~~changes for the better;~~ ~~— Overall improvement of resident's condition.~~
2	2.6	2-30	A **"significant error"** is an error in an assessment where: 1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2	2.6	2-32	• While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan. ~~determine if a revision to the resident's care plan is necessary, and make the applicable revision.~~ • The MDS must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).

Track Changes
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to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.7	2-41	• It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. 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 (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline ~~preliminary~~ care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
2	2.7	2-42	• Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. • After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).

Track Changes
from Chapter 2 v1.14
to Chapter 2 v1.15

Chapter	Section	Page	Change
2	2.7	2-42	• Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan. ~~Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly and SCQA assessment and modify the care plan on an ongoing basis, if appropriate.~~ • Detailed information regarding the care planning process appears in Chapter 4 of this manual.
2	2.7–2.15	2-42–2-88	Page length changed due to revised content on 2-42.
2	2.10	2-60	When combining assessments, the more stringent requirements must be met. For example, when a ~~nursing home~~ Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the PPS item set must be used. The PPS item set contains all the required items for the 14-Day Medicare-required assessment, whereas the Start of Therapy OMRA item set consists of fewer items, thus the provider would need to complete the PPS item set. The ARD window (including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.
2	2.13	2-80	***Resident Takes a Leave of Absence from the SNF*** If a resident is out of the facility for a Leave of Absence (LOA) as defined on page ~~2-12~~2-13 in this chapter, the Medicare assessment schedule may be adjusted for certain assessments.

Track Changes
from Chapter 3 Intro v1.14
to Chapter 3 Intro v1.15

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>3.3</td><td>3-3</td><td>With the exception of certain items (e.g., some items in Sections K and O), the look-back period <s>generally</s> <u>does not</u> extend into the preadmission period unless the item instructions state otherwise <s>include hospital stay</s>. In the case of reentry, the look-back period <u>does not</u> extend into time prior to the reentry, unless instructions state otherwise.</td></tr>
<tr><td>3</td><td>3.3</td><td>3-3–3-6</td><td>Page length changed due to revised content on 3-3.</td></tr>
<tr><td>3</td><td>3.3</td><td>3-6</td><td>
<table>
<tr><td>P</td><td>Restraints and Alarms</td><td>Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.</td></tr>
</table>
</td></tr>
</table>

Track Changes
from Chapter 3 Section A v1.14
to Chapter 3 Section A v1.15

Chapter	Section	Page	Change
3	A0600	A-11	• A0600B can only be a Medicare ~~(HIC)~~ number or a Railroad Retirement Board number.
3	A1500	A-18	• All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation" (MR) in federal regulation)/developmental disability (DD), or related conditions ~~regardless of the resident's method of payment~~ (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
3	A1500	A-19	• Please see ~~http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Preadmission-Screening-and-Resident-Review-PASRR.html~~https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html for CMS information on PASRR.

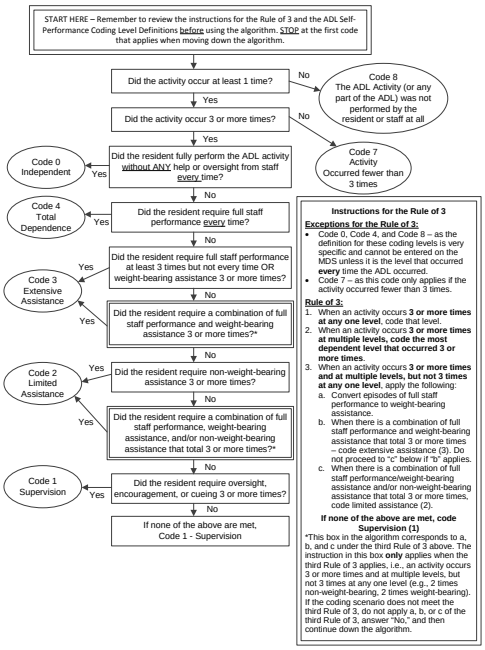
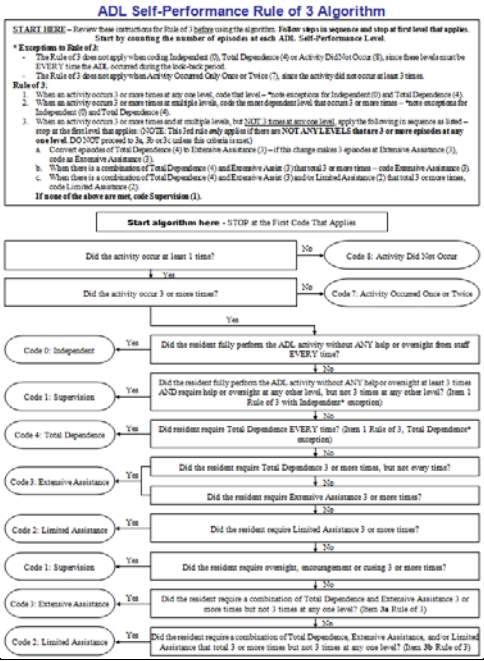
Track Changes
from Chapter 3 Section A v1.14
to Chapter 3 Section A v1.15

Chapter	Section	Page	Change
3	A2400	A-35	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: • A0310F = 11 • A0310G = 2 • A0310H = ~~0~~1 • A2000 = 10-20-2016 • A2100 = 03 • A2300 = 10-20-2016 • A2400A = 1 • A2400B = 10-15-2016 • A2400C = 10-20-2016 **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.

Track Changes
from Chapter 3 Section A v1.14
to Chapter 3 Section A v1.15

Chapter	Section	Page	Change
3	A2400	A-36	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: • A0310F = 11 • A0310G = 2 • A0310H = ~~0~~1 • A2000 = 11-26-2016 • A2100 = 03 • A2300 = 11-26-2016 • A2400A = 1 • A2400B = 11-15-2016 • A2400C = 11-25-2016 **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.

Track Changes
from Chapter 3 Section G v1.14
to Chapter 3 Section G v1.15

Chapter	Section	Page	Change
3	G0110	G-5	• To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-~~7~~8.
3	G0110	G-8	Replaced ADL Self-Performance Algorithm with ADL Self-Performance Rule of 3 Algorithm. OLD:  NEW: 

Track Changes
from Chapter 3 Section G v1.14
to Chapter 3 Section G v1.15

Chapter	Section	Page	Change
3	G0110	G-8	**~~ADL Self-Performance Algorithm~~ADL Self-Performance Rule of 3 Algorithm**
3	G0110	G-9–G10	• Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened. • 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. • 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.
3	G0110–G0900	G-9–G-42	Page length changed due to revised content on G-9.
3	G0110	G-24	The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels, and the third Rule of 3 does not apply because ~~even though~~ the ADL occurred three or more times, at the independent level. ~~it did not occur at multiple levels or three times at any one level.~~ Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, th~~ere is one~~ final instruction to the provider~~,~~ is that when ~~none of the ADL Self-Performance coding level definitions and the Rule of 3 do not~~ neither the Rule of 3 nor the ADL Self-Performance coding level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use the code Supervision (1) was entered.

Track Changes
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Chapter	Section	Page	Change
3	G0600	G-40	• 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.

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Chapter	Section	Page	Change
3	GG0130	GG-2	**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 ~~3-day~~ assessment period~~,~~. For Section GG, the admission assessment period is the first three days of the Part A stay ~~which is days 1 through 3,~~ 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	GG0130	GG-3	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 during the assessment period and the resident's performance varies, coding in Section GG~~Residents~~ should be ~~coded performing activities~~ based on the~~ir~~ resident's "usual performance~~,~~" ~~(or baseline performance on admission),~~ which is identified as the resident's usual activity/performance for any of the ~~s~~Self-~~c~~Care or ~~m~~Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's ~~s~~Self-~~c~~Care performance varies during the assessment period, report the resident's usual ~~status~~performance, **not** the resident's most independent performance and **not** the resident's most dependent ~~episode~~performance. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance.

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Chapter	Section	Page	Change
3	GG0130–GG0170	GG-3–GG-44	Page length changed due to revised content.
3	GG0130	GG-5	**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~~under~~ a SNF Part A stay. o For the 5-Day PPS~~Admission~~ assessment, code the resident's functional status based on a~~n~~ 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) ~~(days 1 through 3~~ of the Medicare Part A stay~~)~~, starting with the date in A2400B, Start of ~~m~~Most ~~r~~Recent Medicare ~~s~~Stay and the following two days, ending at 11:59 PM on day ~~3~~three. The assessment should occur, when possible, prior to the ~~start of~~resident benefitting from ~~therapeutic~~ treatment interventions in order to ~~capture~~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 ~~when the resident is discharged from the facility~~ on the day of, or one day ~~after~~before the resident's Discharge Date (A2000)~~Medicare Part A Stay ends. When this occurs, the OBRA Discharge assessment may be combined with the Part A PPS Discharge assessment.)~~. Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.

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Chapter	Section	Page	Change
3	GG0130	GG-5	o 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~~n~~ 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. ~~The discharge function scores are to reflect the resident's discharge status and are to be based on an assessment.~~ The~~is~~ functional assessment must be completed within the last three~~3~~ 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. • 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. • 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.

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Chapter	Section	Page	Change
3	GG0130	GG-6	• At admission, when coding for the resident's ~~d~~Discharge ~~g~~Goal(s), use the same 6-point scale. Instructions about coding ~~d~~Discharge ~~g~~Goals are provided below under Discharge Goal(s): Coding Tips. • 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. ~~• Record the resident's usual ability to perform each activity (e.g., eating). 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.~~
3	GG0130	GG-6	• 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, ~~c~~Code 07 if the resident refused to attempt the activity, ~~c~~Code 09 if the resident did not perform this activity prior to the current illness, exacerbation, or injury~~is not applicable for the resident~~, or ~~c~~Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns. • If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent. • To clarify your own understanding of the resident's performance of an activity, ask probing questions to 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. • 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.

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3	GG0130	GG-6–GG-7	• 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 ~~2%~~ reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (~~e~~Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation or injury (~~e~~Code 09), or the activity was not attempted due to medical condition or safety concerns (~~e~~Code 88), use these codes instead of a dash ("-"). Please note that **a dash may be used for GG0130 Discharge Goal items provided that <u>at least one</u> 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. • 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. • 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. • 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.

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Chapter	Section	Page	Change
3	GG0130	GG-7	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.
3	GG0130	GG-7	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, 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, t~~T~~he presence of a G-tube does not affect the eating score.
3	GG0130	GG-8	8. **Eating:** Mr. R is unable to eat by mouth ~~due to his medical condition~~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 th~~e~~is item ~~Eating~~.

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3	GG0130	GG-11	**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.
3	GG0130	GG-13	**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 ~~is~~ 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."

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3	GG0130	GG-14	**Discharge Goal(s): Coding Tips** • Use the 6-point scale to code the resident's ~~d~~Discharge ~~g~~Goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code ~~d~~Discharge ~~g~~Goal(s). Use a dash (-) to indicate that a specific activity is not a Discharge ~~g~~Goal. Of note, at least one Discharge ~~g~~Goal must be indicated for either ~~s~~Self-~~c~~Care or ~~m~~Mobility. Using the dash in this allowed instance does not affect APU determination. • Licensed clinicians can establish a resident's ~~d~~Discharge ~~g~~Goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgment, and the professional's standard of practice. 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 ~~s~~Self-~~c~~Care or ~~m~~Mobility Discharge ~~g~~Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one ~~d~~Discharge ~~g~~Goal is required, the facility may choose to code more than one ~~d~~Discharge ~~g~~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 ~~d~~Discharge ~~g~~Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

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3	GG0170	GG-19	**Steps for Assessment** 1. Assess the resident's mobility statusabilities based on direct observation, the resident's self-report, family and reports, and from the clinician,direct care staff reports, or family as documented in the resident's medical record during the 3-day assessment period,. For Section GG on admission, the assessment period is the first which is three days 1 through 3, of the Part A stay, starting with the date in A2400B, which is the Sstart 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. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
3	GG0170	GG-19	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.

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3	GG0170	GG-19–GG-20	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 during the assessment period and the resident's performance varies, coding in Section GG ~~Residents~~ should be ~~coded performing activities~~ based on the~~ir~~ resident's "usual performance," ~~(baseline performance on admission),~~ which is identified as the resident's usual activity/performance for any of the ~~s~~Self-~~c~~Care or ~~m~~Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's ~~m~~Mobility performance varies during the assessment period, report the resident's usual performance~~status~~, **not** the resident's most independent performance and **not** the resident's most dependent performance~~episode~~. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance. 8. 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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3	GG0170	GG-21	**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. o For the 5-Day PPS~~Admission~~ assessment, code the resident's functional status based on a~~n~~ 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~~3~~ days (calendar days) ~~(days 1 through 3~~ of the Medicare Part A stay~~)~~, starting with the date in A2400B, Start of ~~m~~Most ~~r~~Recent Medicare ~~s~~Stay and the following two days, ending at 11:59 PM on day ~~3~~three. The assessment should occur, when possible, prior to the resident benefitting from ~~start of therapeutic~~treatment interventions in order to determine~~capture~~ 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 ~~S~~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.

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Chapter	Section	Page	Change
3	GG0170	GG-21	o 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~~n~~ 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. ~~The discharge function scores are to reflect the resident's discharge status and are to be based on assessment.~~ The~~is~~ functional assessment must be completed within the last ~~3~~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. • When reviewing the ~~health~~medical record~~s~~, 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.

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3	GG0170	GG-22	• At admission, when coding ~~On the 5-Day PPS assessment, code the resident's "usual performance," or baseline performance, using the 6-point scale or code the reason an activity was not attempted, as well as~~ the resident's ~~d~~Discharge ~~g~~Goal(s), use~~ing~~ the same 6-point scale. **Instructions above related to coding Discharge Goals for the ~~m~~Mobility items (GG0170) are the same as those for coding Discharge Goals for the ~~s~~Self-~~c~~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.
3	GG0170	GG-22	~~• 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).~~ ~~• On the Part A PPS Discharge assessment, code the resident's usual performance using the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.~~ • ~~Record the resident's usual ability to perform each activity (e.g., sit to lying). 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.~~ • Do not record the staff's assessment of the resident's potential capability to perform the activity. • 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, ~~c~~Code 07 if the resident refused to attempt the activity, ~~c~~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 ~~c~~Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

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3	GG0170	GG-22	• 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). • 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 ~~2%~~ reduction in annual payment update. If the reason the item was not assessed~~that the activity was not attempted is~~was that the resident refused (~~e~~Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (~~e~~Code 09), or the activity was not attempted due to medical condition or safety concerns (~~e~~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.

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3	GG0170	GG-23	• 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 ~~s~~Self-~~c~~Care or ~~m~~Mobility goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one ~~d~~Discharge gGoal is required, the facility may choose to code more than one ~~d~~Discharge ~~g~~Goal for a resident. • 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. • 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.
3	GG0170	GG-23	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. 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 ~~Mrs. H does more~~ than half of the effort.

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3	GG0170	GG-24	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: 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~~Mrs. E~~ does less~~more~~ than half of the effort.
3	GG0170	GG-29	**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 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.
3	GG0170	GG-30	4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet~~ and lowers her underwear~~. 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.

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3	GG0170	GG-32	**Examples for GG0170H1, Does the resident walk?** 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, ~~so no~~ the admission performance ~~code is entered for the~~ walking items are skipped. However, a walking goal is clinically indicated and walking goals may be coded.
3	GG0170	GG-34	**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: GG0170QI, 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.

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Chapter	Section	Page	Change
3	GG0170	GG-35	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, Wheel 50 feet with two turns 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. ~~The resident provided more than half the effort.~~
3	GG0170	GG-36	7. **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. Coding: 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.
3	GG0170	GG-36	~~**Coding Tip for GG0170R, Wheel 50 feet with two turns**~~ • ~~Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair by discharge, even if the resident is anticipated to ambulate during the stay or by discharge.~~

Track Changes
from Chapter 3 Section GG v1.14
to Chapter 3 Section GG v1.15

Chapter	Section	Page	Change
3	GG0170	GG-37	6. **Indicate the type of wheelchair/scooter used:** ~~In the above example~~ Mr. L used a motorized wheelchair during the 3-day assessment period. Coding: GG0170SS, Indicate the type of wheelchair/scooter used would be coded 2, Motorized. Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.
3	GG0170	GG-38	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. 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. 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.

Chapter	Section	Page	Change
3	GG0170	GG-38	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.
3	GG0170	GG-38–GG-39	**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 stay, even if the resident is anticipated to ambulate during the stay or by discharge. 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.

Track Changes
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to Chapter 3 Section H v1.15

Chapter	Section	Page	Change
3	H0100	H-2	INTERMITTENT CATHETERIZATION ~~Sterile i~~Insertion and removal of a catheter through the urethra for bladder drainage.
3	H0100	H-2–H-3	• Do not include one-time catheterization for urine specimen during look-back period as intermittent catheterization. • 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.
3	H0100–H0600	H-3–H-14	Page length changed due to revised content on H-3.

Track Changes
from Chapter 3 Section I v1.14
to Chapter 3 Section I v1.15

Chapter	Section	Page	Change
3	I	I-4	• 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: ~~http://library.ahima.org/doc?oid=107574~~https://www.cms.gov/Medicare/Coding/ICD10/index.html.
3	I2300	I-8	— **Code only if ~~all~~ 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 ~~P~~physician documented UTI diagnosis~~,~~ (or by nurse practitioner, physician assistant, or clinical nurse specialist ~~or other authorized licensed staff as permitted by~~ if allowable under state licensure laws~~) diagnosis of a UTI~~ in the last 30 days, ~~2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g., pyuria),~~ ~~3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and~~ ~~4. Current medication or treatment for a UTI in the last 30 days.~~

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Chapter	Section	Page	Change
3	I2300	I-9	— 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.
3	I2300	I-9	— **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
3	I	I-8–I-11	Page length changed due to revised content.

Track Changes
from Chapter 3 Section J v1.14
to Chapter 3 Section J v1.15

Chapter	Section	Page	Change
3	J1700	J-27	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.

Track Changes
from Chapter 3 Section L v1.14
to Chapter 3 Section L v1.15

Chapter	Section	Page	Change
3	L0200	L-1	EDENTULOUS Having no natural permanent teeth in the mouth. Complete tooth loss.
3	L0200	L-2	• Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous ~~or~~ /lacks all natural teeth or parts of teeth.
3	L0200	L-3	• Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met. • 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. • 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.

Track Changes
from Chapter 3 Section M v1.14
to Chapter 3 Section M v1.15

Chapter	Section	Page	Change
3	—	M-1	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.
3	M0100–M1200	M-1–M-54	Page length changed due to revised content.
3	M0210	M-5–M-6	• 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~~the diabetic~~ has an ulcer that is caused by pressure or other factors. • If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer. • 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.

Track Changes
from Chapter 3 Section M v1.14
to Chapter 3 Section M v1.15

Chapter	Section	Page	Change
3	M0300	M-7	Added bold formatting to the following highlighted text. 4. If the pressure ulcer was unstageable on admission/entry or reentry, but 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 "present on admission."**
3	M0300A	M-9	3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers (see definition of suspected deep tissue injury on page M-21). The descriptors are similar for these two types of ulcers (e.g., temperature ~~(~~[warmth or coolness~~)~~]; tissue consistency ~~(~~[firm or boggy]).
3	M0300C	M-12	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-16).
3	M0300C	M-13	**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.

Track Changes
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to Chapter 3 Section M v1.15

Chapter	Section	Page	Change
3	M0300C	M-14	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 Code 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. This pressure ulcer worsened from a Stage 2 to a 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. This pressure ulcer would also be coded in M0800B as worsened.
3	M0300C	M-14	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~~one~~ that increased in numerical stage to a Stage 3 is coded in M0300C1 as 1 and in ~~cannot be coded 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.

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to Chapter 3 Section M v1.15

Chapter	Section	Page	Change
3	M0300G	M-22	**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-10).
3	M0800	M-27	**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.
3	M0800	M-27	DEFINITION WORSENING IN PRESSURE ULCER STATUS~~"WORSENING"~~ 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.

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Chapter	Section	Page	Change
3	M0800	M-28	**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 c~~C~~oding worsening of ~~unstageable~~ pressure ulcers: — If an unstageable pressure ulcer that was ~~unstageable~~ present on admission/entry or reentry~~,~~ is subsequently able to be numerically staged, do not consider it to be worsened because this would be ~~on~~ the first time ~~assessment~~ that the pressure ulcer was ~~it is~~ able to be numerically staged. However, if subsequent to this numerical staging, the pressure ulcer further deteriorates~~subsequently~~ and increases in numerical stage ~~after that assessment~~, the ulcer ~~it sh~~would be considered worsened.
3	M1040	M-36	M1040D, Open lesion(s) other than ulcers, rashes, cuts (e.g., ~~cancer lesion~~bullous pemphigoid)
3	M1040	M-36	• Do **not** code rashes 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, venous or arterial ulcers, diabetic foot ulcers or skin tears here. These conditions are coded in other items on the MDS.

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Chapter	Section	Page	Change
3	—	N-1	Intent: 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 ~~(subcutaneous, intramuscular or intradermal)~~, insulin, and/or select medications were received by the resident. In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications.
3	N0300–N0450	N-1–N-13	Page length changed due to revised content.
3	N0300	N-2	**Coding Instructions** *Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by ~~subcutaneous, intramuscular, or intradermal~~ injection.* *Insulin injections **are** counted in this item as well as in Item N0350.* • Count the number of days that **the resident received any type of injection ~~(subcutaneous, intramuscular, or intradermal)~~ while a resident of the nursing home.** • Record the number of days that any type of injection (e.g., subcutaneous, intramuscular, or intradermal) was received in Item N0300.

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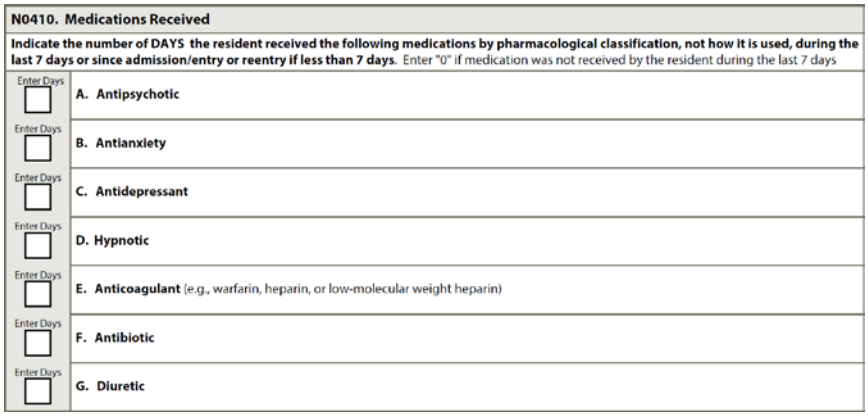
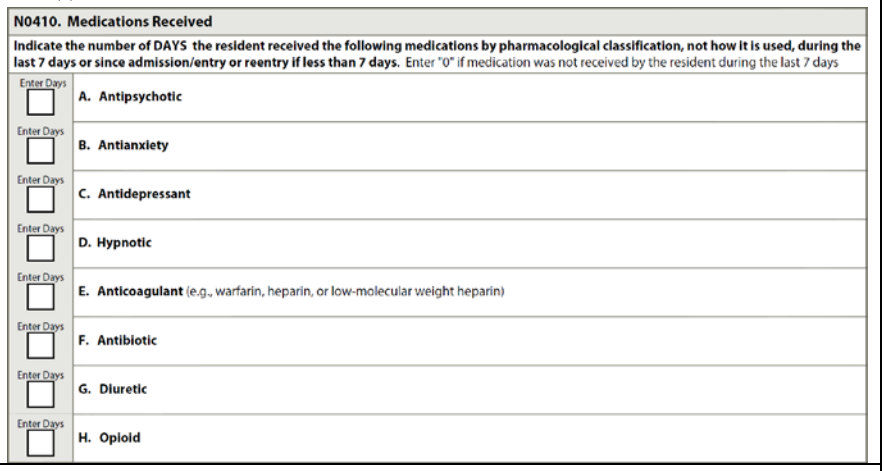
Chapter	Section	Page	Change
3	N0410	N-4	Updated N0410. Medications Received to include H. Opioid. Replaced screenshot. OLD  NEW 
3	N0410	N-6	**Coding Instructions** • N0410A–~~G~~H: Code medications according to the pharmacological classification, not how they are being used.
3	N0410	N-7	• N0410G, Diuretic: Record the number of days a diuretic 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). • 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).

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Chapter	Section	Page	Change
3	N0410	N-7	**Coding Tips and Special Populations** • Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic. • 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.
3	N0410	N-8	Added bold for emphasis on "both" in the following bullet: • Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.
3	N0410	N-8	• Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications. • 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.
3	N0410	N-9	• Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior. • Anticoagulants must be monitored with dosage frequency determined by clinical circumstances~~,~~ and duration of use.~~,~~ Certain anticoagulants require ~~and stability of~~ monitoring via laboratory results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).

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Chapter	Section	Page	Change
3	N0410	N-9–N-10	• 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 currently taking. For more information consult the FDA website http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/. • 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.
3	N0410	N-10	Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition** (**DSM-5**) (or subsequent editions) (~~http://www.psychiatry.org/practice/dsm~~https://www.psychiatry.org/psychiatrists/practice/dsm)

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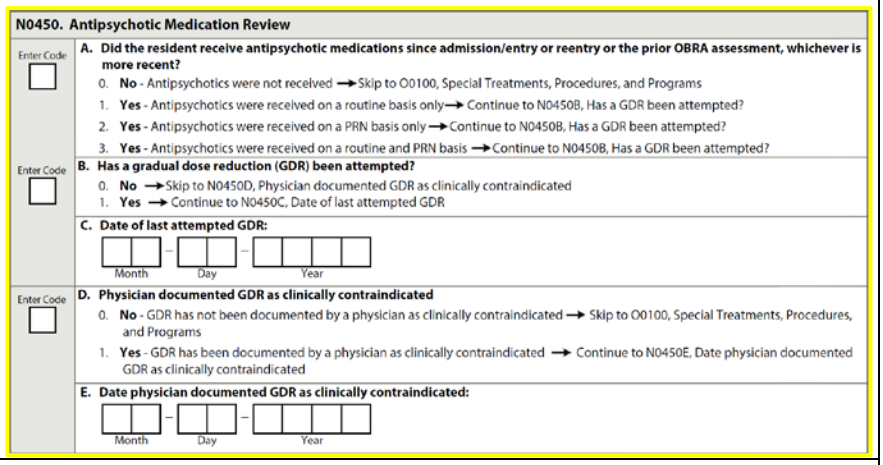
Chapter	Section	Page	Change
3	N0450	N-11	# N0450: Antipsychotic Medication Review  **N0450. Antipsychotic Medication Review** Enter Code ☐ **A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?** 0. **No** - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs 1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted? 2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted? 3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted? Enter Code ☐ **B. Has a gradual dose reduction (GDR) been attempted?** 0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated 1. **Yes** → Continue to N0450C, Date of last attempted GDR **C. Date of last attempted GDR:** ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) Enter Code ☐ **D. Physician documented GDR as clinically contraindicated** 0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs 1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated **E. Date physician documented GDR as clinically contraindicated:** ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)
3	N0450	N-11–N-12	## 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.
3	N0450	N-12	### 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.

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Chapter	Section	Page	Change
3	N0450	N-12	**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.
3	N0450	N-12	**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?
3	N0450	N-12	**Coding Instructions for N0450B** • Code 0, no: if a GDR has not been attempted. Skip to N0450D, Physician documented GDR as clinically contraindicated. • Code 1, yes: if a GDR has been attempted. Continue to N0450C, Date of last attempted GDR.
3	N0450	N-12	**Coding Instructions for N0450C** • **Enter the date of the last attempted Gradual Dose Reduction.**

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Chapter	Section	Page	Change
3	N0450	N-13	**Coding Instructions for N0450D** • 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 N0450E, Date physician documented GDR as clinically contraindicated.
3	N0450	N-13	**Coding Instructions for N0450E** • Enter date the physician documented GDR attempts as clinically contraindicated.

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Chapter	Section	Page	Change
3	N0450	N-13	**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. • Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic 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.

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Chapter	Section	Page	Change
3	N0450	N-13	• 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 N0450C, 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 N0450C, Date of last attempted GDR. • Federal requirements regarding GDRs are found at 42 CFR §483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

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Chapter	Section	Page	Change
3	O0100	O-5	• 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings ~~http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html~~https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
3	O0300	O-13	• 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. • "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.
3	O0300	O-13–O-14	Page length changed due to revised content on O-13.

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Chapter	Section	Page	Change
3	O0400	O-19	• 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.
3	O0400	O-19–O-46	Page length changed due to revised content on O-19.
3	O0600	O-43	**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.**
3	O0600	O-44	• 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, "-").
3	O0700	O-45	**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.**
3	O0700	O-45	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.**
3	O0700	O-45	• 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, "-").

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Chapter	Section	Page	Change
3	O0700	O-45	• Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, ~~or~~ clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law.

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Chapter	Section	Page	Change
3	—	P-1	**SECTION P: RESTRAINTS AND ALARMS**
3	—	P-1	Intent: The intent of this section is to record the frequency ~~over the 7-day look-back period~~ that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories ~~of Item P0100~~.
3	—	P-1	**Are Restraints Prohibited by CMS?** CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Retrieved December 18, 2012, from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf). ~~**Are Restraints Prohibited by CMS?**~~
3	—	P-1	Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.~~13(a)~~10(e)(1) and 483.12). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use.

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Chapter	Section	Page	Change
3	P0100	P-7	• **Restraints used in emergency situations.** If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR §§483.10~~(b)(4)~~(c)(6) and 483.~~20(k)(2)(ii)~~21(b)(ii)(A)–(F) respectively. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.
3	P0100	P-7	According to 42 CFR 483.~~13(a)~~10(e)(1) and 483.12, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience.
3	P0100	P-7–P-8	Page length changed due to revised content on P-7.

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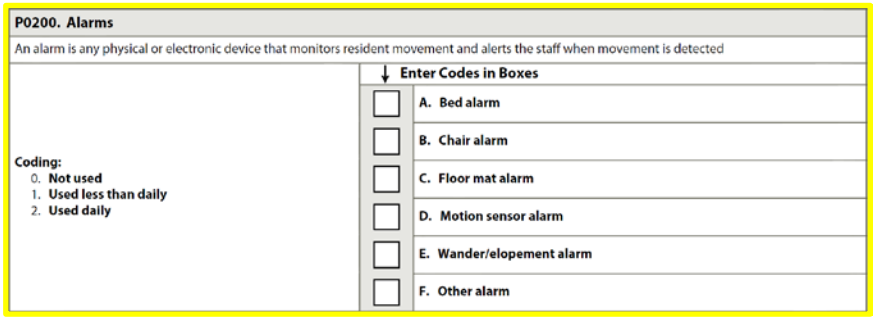
Chapter	Section	Page	Change
3	P0200	P-8	# P0200: Alarms  **P0200. Alarms** An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected Coding: 0. Not used 1. Used less than daily 2. Used daily Enter Codes in Boxes A. Bed alarm B. Chair alarm C. Floor mat alarm D. Motion sensor alarm E. Wander/elopement alarm F. Other alarm ## Item Rationale ### Health-related Quality of Life • An alarm is <u>any</u> physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices. • While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan. • The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning. • Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

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Chapter	Section	Page	Change
3	P0200	P-9	**Planning for Care** • Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being. • When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions. • There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident. **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?
3	P0200	P-9	**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.

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Chapter	Section	Page	Change
3	P0200	P-9	**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.

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Chapter	Section	Page	Change
3	P0200	P-10	• **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. • **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. • Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the resident appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response in a manner that addresses both safety issues and an evaluation to identify root causes to the degree possible. • While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision. • Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200F Other alarm, whether or not the device activates a sound. • Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.

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Chapter	Section	Page	Change
3	—	Q-1	Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.~~20 (i) (3)~~21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home and community-based services and to receive long term care in the least restrictive setting possible. This is also a civil right for all residents. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.
3	Q0100	Q-1	DEFINITION RESIDENT'S PARTICIPATION IN ASSESSMENT The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspectives during assessment.
3	Q0100	Q-1	**Health-related Quality of Life** • Residents who actively participate in the assessment process and in ~~developing~~ development of their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.
3	Q0100	Q-1	**Planning for Care** • Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved~~—~~—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.~~15~~24 Quality of Life).

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Chapter	Section	Page	Change
3	Q0100	Q-2	• During the care planning meetings, ~~he or she~~the resident should be made comfortable and verbal communication should be directly with him or her. • Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.
3	Q0100	Q-2	DEFINITION FAMILY OR SIGNIFICANT OTHER A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not~~, however,~~ include staff at the nursing home.
3	Q0100	Q-3	**Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment** *Record the participation of ~~the~~a guardian or legally authorized representative in the assessment process.*
3	Q0100	Q-3	**Coding Tips** • While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.
3	Q0300	Q-4	**Item Rationale** This item identifies the resident's general expectations and goals for nursing home stay. The resident should be asked about his or her own expectations regarding return to the community and goals for care. The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet his or her individual long-term care needs. Additional assessment information may be needed to determine whether the resident requires additional community services and supports.

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Chapter	Section	Page	Change
3	Q0300	Q-4	DEFINITION DISCHARGE To release from nursing home care. Can be to home, another community setting, or a healthcare setting.
3	Q0300	Q-4	**Steps for Assessment** 1. Ask the resident about his or her overall expectations to be sure that he or she has participated in the assessment process and has a better understanding of his or her current situation and the implications of alternative choices such as returning home, or moving to another appropriate community setting such as an assisted living facility or an alternative healthcare setting. 2. Ask the resident to consider his or her current health status, expectations regarding improvement or worsening, social supports and opportunities to obtain services and supports in the community. 3. If goals have not already been stated directly by the resident and documented since admission, ask the resident directly about what his or her expectation is regarding the outcome of this nursing home admission and expectations about returning to the community. 4. The resident's stated goals should be recorded here. The goals for the resident, as described by the family, significant other, guardian, or legally authorized representative, may also be recorded in the *clinical record*.
3	Q0300	Q-5	**Coding Tips** • This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations~~;~~, not whether or not the staff considers them to be realistic. Coding other than the resident's stated expectation is a violation of the resident's civil rights.

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Chapter	Section	Page	Change
3	Q0300	Q-7	3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days, in the nursing home, and that the family does not have the capacity to provide all the care the resident needs.
3	Q0400	Q-8	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be very important to a resident's health and quality of life. • For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. ~~There are improved c~~Community resources and supports exist that may benefit these residents and allow them to return to a community setting.
3	Q0400	Q-9	**Planning for Care** • Many nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to community resources. • Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the 1999 U.S. Supreme Court decision in Olmstead v. L.C., which states that residents needing long term services and supports have a civil right to receive services in the least restrictive and most integrated setting appropriate to their needs.

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Chapter	Section	Page	Change
3	Q0400	Q-9	• Each situation is unique to the resident, his/her family, and/or guardian/legally authorized representative. A referral to the Local Contact Agency (LCA) may be appropriate for many individuals, who could be maintained in the community homes of their choice for long periods of time, depending on the residential setting and support services available. For example, a referral to the LCA may be appropriate for some individuals with Alzheimer's disease. There are many individuals with this condition being maintained in their own homes for long periods of time, depending on the residential setting and support services available. The interdisciplinary team should not assume that any particular resident is unable to be discharged. A successful transition will depend on the services, settings, and sometimes family support services that are available.
3	Q0400	Q-10	— Who to call in case of an emergency or if symptoms of decline occur. — Nursing facility procedures and discharge planning for ~~subacute~~sub-acute and rehabilitation community discharges are most often well-defined and efficient.
3	Q0400	Q-10	o The NF is responsible for making referrals to the LCAs under the process that the State has set up. The LCA is responsible for contacting referred residents and assisting with providing information regarding community-based services and, when appropriate, transition services planning. They~~.~~ nursing facility interdisciplinary team and the LCA should work closely together. The LCA is the entity that does the community support planning, (e.g., housing, home modification, setting up a household, transportation, community inclusion planning, etc.). A referral to the LCA may come from the nursing facility by phone, by e-mails or by a state's on-line/website or by other state-approved processes. Each state has a process for referral to an LCA, and it is vital to know the process in your state and for your facility. In most cases, further screening and consultation with the resident, their family and the interdisciplinary team by the nursing home social worker or staff member would likely be an important step in the referral determination process.

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Chapter	Section	Page	Change
3	Q0400	Q-10	o Should a planned relocation not occur, it might create stress and disappointment for the resident and family that will require support and nursing home care planning interventions. However, a referral should not be avoided based upon facility staff judgment of potential discharge success or failure. It is the resident's right to be provided information if requested and to receive care in the most integrated setting.
3	Q0400	Q-10–Q-11	Page length changed due to revised content on Q-10.
3	Q0400	Q-11	• Use teach-back methods to ensure that the resident understands all of the factors associated with his or her discharge. • For additional guidance, see CMS' **Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting**. Available at ~~https://www.medicare.gov/Pubs/pdf/11376.pdf~~ https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf
3	Q0400	Q-11	7. Eligibility for financial assistance through various funding sources (e.g., private funds, family assistance, Medicaid, long-term care insurance) should be considered prior to discharge to identify the options available to the individual (e.g., home, assisted living, board and care, or group homes, etc.). 8. A determination of family involvement, capability and support after discharge should also be made. However, support from the family is not always necessary for a discharge to take place.

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Chapter	Section	Page	Change
3	Q0490	Q-12	**Item Rationale** This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, **Referral**. Q0500B is, however, mandatory on all comprehensive assessments. Note: Let the resident know that they can change their mind about requesting information regarding possible return to the community at *any* time and should be referred to the LCA if they voice ~~their~~this request, regardless of schedule of MDS assessment(s).
3	Q0490	Q-13	**Coding Tips** • Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded "No" to item Q0550.
3	Q0490	Q-13	2. Mrs. R is an 82-year-old widow~~ed woman~~ with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

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Chapter	Section	Page	Change
3	Q0500	Q-14	**Item Rationale** The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in ~~being transitioned to community living~~ talking to someone about the possibility of leaving the facility and returning to live and receive services in the community. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living if it is the resident's desire. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Local contact agencies (LCAs) are experts in available home and community-based service (HCBS) and can provide both the resident and the facility with valuable information.
3	Q0500	Q-14	**Health-related Quality of Life** • Returning home or to a non-institutional setting can be beneficial ~~very important~~ to the resident's health and quality of life. • This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a civil right to receive services in the least restrictive and most integrated setting.

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Chapter	Section	Page	Change
3	Q0500	Q-15	2. Ask the resident if he or she would like to speak with someone about the possibility of returning to live and receive services in the community. Inform the resident that answering yes to this item signals the resident's request for more information and will initiate a contact by someone with more information about supports available for living in the community. A successful transition will depend on the resident's preferences and choices and the services, settings, and sometimes family supports that are available. In many cases individuals requiring long term care services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations. Answering yes *does not* commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community. Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at *any* time.
3	Q0500	Q-15	3. Explain that this item is meant to provide the opportunity for the resident to get information and explore the possibility of different settings for receiving ongoing care. A viable and workable discharge plan requires that the nursing home social worker or staff talk with the resident before making a referral to a local contact agency to explore topics such as: what returning to the community means, i.e., a variety of settings based on preferences and needs; the arrangements and planning that the NF/SNF can make; and obtaining family or legal guardian input, if necessary. This step will help the resident clarify their discharge goals and identify important information for the LCA or, in some instances may indicate that the resident does not want to be referred to the LCA at this time. Also explain that the resident can change his/her mind at *any* time.

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Chapter	Section	Page	Change
3	Q0500	Q-15	4. If the resident is unable to communicate his or her preference either verbally or nonverbally, the information can then be obtained from family or a significant other, as designated by the individual. If family or significant others are not available, a guardian or legally authorized representative, if one exists, can provide the information. 5. Ask the resident if he or she wants information about different kinds of supports that may be available for community living. Responding yes will be a way for the individual—and his or her family, significant other, or guardian or legally authorized representative—to obtain additional information about services and supports that would be available to support community living. It is simply a request for information, not a request for discharge.
3	Q0500	Q-16	**Coding Instructions for Q0500B, Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** *A response code of 1, Yes, for this item indicates a request to learn about home and community based services, not a request for discharge.* • Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to live and receive services in the community. • Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to live and receive services in the community.

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Chapter	Section	Page	Change
3	Q0500	Q-16	**Coding Tips** • A "yes" response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency (LCA) about the resident's request within approximately 10 business days (or according to state policy) of a yes response being given. This code is intended to initiate contact with the ~~local agency~~ LCA for follow-up as the resident desires. • Follow-up is expected in a "reasonable" amount of time and 10 business days is a recommendation and not a requirement. Each state has its own policy for follow-up. It is important to know your state's policy. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face-to-face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.
3	Q0500	Q-16–Q-17	• The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF and the resident can talk with the LCA to see what is available~~ that does not require family support~~. • Current return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian and/or legally appointed decision-maker for that individual ~~could~~should be asked the question.
3	Q0500	Q-16–Q-22	Page length changed due to revised content.

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Chapter	Section	Page	Change
3	Q0500	Q-17	1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local contact agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports. Coding: Q0500B would be coded 1, Yes. Rationale: Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local contact agency within approximately 10 business days, or according to state policy.
3	Q0500	Q-17	Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days, or according to state policy, for them to initiate discussions with Ms. C. about returning to community living.
3	Q0550	Q-19	Rationale: Ms. W. needs longer term restorative nursing care to recover from her ~~falls~~injuries before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.
3	Q0600	Q-20	**Health-related Quality of Life** • Returning home or transitioning to a non-institutional setting can be very important to the resident's health and quality of life.

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Chapter	Section	Page	Change
3	Q0600	Q-20	**Planning for Care** • Some nursing home residents may be able to return to the community if they are provided ~~appropriate~~ assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.
3	Q0600	Q-20	DEFINITION DESIGNATED LOCAL CONTACT AGENCY (LCA)
3	Q0600	Q-21	• Code 2, Yes - referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency. ~~**Section Q Point of Contact list for Local Contact Agencies:** http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/downloads/state-by-state-poc-list.pdf~~
3	Q0600	Q-21	• State Medicaid Agencies (SMAs) are required to have designated Local Contact Agencies (LCA) and a State point of contact (POC) to coordinate efforts to implement Section Q and designate LCAs for their State's skilled nursing facilities and nursing facilities. These local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies on Aging, Independent Living Centers, or other entities the State may designate. LCAs have a Data Use Agreement (DUA) with the SMA to allow them access to MDS data. It is important that each facility know who their LCA and POC are and how to contact them.

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Chapter	Section	Page	Change
3	Q0600	Q-21	• Several resources are available ~~at~~ on the Return to Community web site at: ~~http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/community-living/community-living-initiative.html~~https://www.medicaid.gov/medicaid/ltss/community-living/index.html. ~~— The State-by-State list of Local Contact Agencies and POC Section Q Coordinator Information~~ — MDS 3.0 Section Q Implementation Solutions contains Section Q questions and answers that can help States with implementation issues. — The Section Q Pilot Test Results report describes the results of user testing of the new items in Section Q. — Videos of Section Q sessions and discussions at the 2010 RAI Coordinators Conference.
3	Q0600	Q-21	• Resource availability and eligibility coverage varies across States and local communities and may present barriers to allowing some resident~~'~~s to return to their community. The nursing home and local contact agency staff members should guard against raising the resident and their family members' expectations of what can occur until more information is obtained.
3	Q0600	Q-21	• The local contact agency team ~~must~~ will explore community care options/supports and conduct appropriate care planning to determine if transition~~s~~ back to the community is possible. • Resident support and interventions by the nursing home staff may be necessary if the LCA transition is not successful because of unanticipated changes to the resident's medical condition, ~~insufficient financial resources,~~ problems with caregiving supports, community resource gaps, etc. preventing discharge to the community.

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Chapter	Section	Page	Change
3	Q0600	Q-22	1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was "Yes" to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son's school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops~~, and~~ appliances, doorways, etc. Coding: Q0500B would be coded 1, Yes. Q0600 would be coded 2, Yes. Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes, because a referral to the designated LCA was made.
3	Q0600	Q-22	2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns ~~because of~~ due to falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V. to return to the community. Coding: Q0600 would be coded 1, No. Rationale: Ms. V. indicated that she wanted to have an opportunity to talk to someone about return to community.

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Chapter	Section	Page	Change
4	4.2	4-1	As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.~~20(k)~~21(b) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
4	4.2	4-2	The information in the MDS constitutes the core of the required ~~State~~CMS-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.
4	4.4	4-3	Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(~~b~~d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS.
4	4.5	4-6	**Identifying policies and practices related to the assessment and care planning processes.** Under the OBRA regulations, 42 CFR 483.~~75(i)~~70(h)(1) identifies the medical director as being responsible for overseeing the "implementation of resident care policies" in each facility, "and the coordination of medical care in the facility."

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Chapter	Section	Page	Change
4	4.6	4-7	Federal requirements support a nursing home's ongoing responsibility to assess residents. The Quality of Care regulation requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 CFR 483.25~~ [F 309]~~). Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.75~~0~~(b), the facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Furthermore, surveyor guidance within OBRA (e.g., ~~F314~~ 42 CFR 483.25~~(c)~~(b)(1) Pressure ~~Sores~~Ulcers and ~~F329~~ 42 CFR 483.~~25(l)~~45(d) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

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Chapter	Section	Page	Change
4	4.7	4-8	As required at 42 CFR 483.~~25~~21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care. Regulatory requirements related to care planning in nursing homes are located at 42 CFR 483.20(~~k~~b)(1) and (2) and are specified in the interpretive guidelines (F tags) in Appendix PP of the State Operations Manual (SOM). The SOM can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving (see~~.~~ 42 CFR 483.~~20(k)~~21(b), Comprehensive Care Plans). This Chapter does not specify a care plan structure or format.
4	4.7	4-10	• Develops and implements an interdisciplinary care plan based on the assessment information gathered throughout the RAI process, with necessary monitoring and follow-up; • Reflects the resident's/resident representative's input, ~~and~~ goals, and desired outcomes; ~~for health care;~~

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Chapter	Section	Page	Change
4	4.7	4-10–4-11	Revised the following bullets and updated numbering accordingly. **The overall care plan should be oriented towards:** 1. Assisting the resident in achieving his/her goals. 2. Individualized interventions that honor the resident's preferences. 3. Addressing ways to try to preserve and build upon resident strengths. 4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation). 5. Managing risk factors to the extent possible or indicating the limits of such interventions. ~~6. Addressing ways to try to preserve and build upon resident strengths.~~ 7. Applying current standards of practice in the care planning process. 8. Evaluating treatment of measurable objectives, timetables and outcomes of care. 9. Respecting the resident's right to decline treatment. 10. Offering alternative treatments, as applicable. 11. Using an ~~appropriate~~ interdisciplinary approach to care plan development to improve the resident's ~~functional~~ abilities. 12. Involving resident, resident's family and other resident representatives as appropriate. 13. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs. 14. Involving ~~the~~ direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes. ~~15. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.~~
4	4.7	4-10–4-11	Page length changed due to revised content on 4-10.

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Chapter	Section	Page	Change
4	4.8	4-11	Care planning is a process that has several steps that may occur at the same time or in sequence. The following key steps and considerations may help the IDT develop the care plan after completing the comprehensive assessment: 1) Care Plan goals should be measurable. The IDT may agree on intermediate goal(s) that will lead to outcome objectives. Intermediate goal(s) and objectives must be pertinent to the resident's goals, preferences, condition, and situation (i.e., not just automatically applied without regard for their individual relevance), measurable, and have a time frame for completion or evaluation.
4	4.8	4-11–4-12	Revised the following bullets and updated numbering accordingly. 5) The 7-day requirement for completion or modification of the care plan applies to the Admission, SCSA, SCPA, and/or Annual RAI assessments. A new care plan does not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. ~~Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed.~~ 6) The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. 7) Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
4	4.8–4.11	4-12–4-42	Page length changed due to revised content on 4-12.

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Chapter	Section	Page	Change
4	4.9	4-15	**Steps 3 and 4: Decision Making and CAA Documentation.** The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, goals, preferences, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.
4	4.9	4-15–4-16	Key components of the care plan may include, but are not limited to the following: • Resident goals and preferences • Measureable objective with established timeframes • Specific interventions, including those that address common causes of multiple issues • Additional follow-up and clarification • Items needing additional assessment, testing, and review with the practitioner • Items that may require additional monitoring but do not require other interventions • The resident's preference and potential for future discharge and discharge plan

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Chapter	Section	Page	Change
6	6.8	6-56	A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections ~~2.4~~2.5 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A.

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Chapter	Section	Page	Change
Ap. A	—	Ap. A-10	~~Sterile i~~Insertion and removal of a catheter through the urethra into the bladder for bladder drainage.
Ap. A	—	Ap. A-19	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, ~~heated~~ nebulizer~~s~~ treatments~~, aerosol 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.

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Chapter	Section	Page	Change
Ap. C	—	Ap. C-84	• American Geriatrics Society Clinical Practice Guidelines and Tools: ~~http://www.americangeriatrics.org/health_care_professionals/clinical_practice/featured_programs_products/~~http://www.americangeriatrics.org/publications-tools;
Ap. C	—	Ap. C-84	• American Society of Consultant Pharmacists Practice Resources: ~~https://ascp.com/practice-resources~~ https://www.ascp.com/page/prc;