

# MDS/RAI CHANGES FOR OCTOBER 1, 2017

## PUTTING IN PERSPECTIVE

- There is “only” 90 pages in the Change Tables
- For the most part we knew most of the changes already specifically in Section N and P
- Some changes are truly benign but some will make you stop and think a minute

# FROM THE TOP



- Our new manual is officially Version 1.15
- Is effective October 1, 2017
- On the slides if you see
  - ~~That the word or sentence has been marked through~~ It means CMS has removed it from the manual
  - ***If you see this print*** It means CMS has added this information

# CHAPTER 1

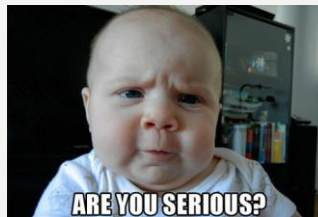
- Reminder that the MDS is a public document and can be copied freely
- Paperwork Reduction Act of 1995 (Seriously). Gives an estimated response time of each Item Set, including completion, encoding and transmission of the information collection. Please note this is just PPS assessments AND times are only an estimated per response

Item Set	Estimated Response Time
NP (PPS)	51 minutes
NOD (OMRA other + D/C)	39 minutes
NO/SO (OMRA other)	26.52 minutes
NSD (OMRA SOT)	34.17 minutes
NS/SS (OMRA SOT)	14.03 minutes

# REALITY CHECK



- The previous slide does not represent the reality of the actual assessment but just marking the response.
- This does not reflect the nursing assessment involved in each question



# CHAPTER 1

- CMS has changed several references to the regulations and the subsequent changes in the numbering system
- Nothing that changes the actual coding of the MDS
- In the overview of the different sections of the MDS it does show section P is now Restraints and Alarms (More on this later)



## CHAPTER 2

- Reminder that the MDS is a CMS Federal regulatory requirement
- Reminder that: 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
- The need to keep 15 months of CAA Summary, Quarterly assessment records, Entry and Death resident specific information must also be available to the individual resident.

## CHAPTER 2

- IDT: a group of professional disciplines that combines knowledge skills and resources to provide the greatest benefit to the resident.
- 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;"

## CHAPTER 2

- In the definition for a SCSA the word “major” has been added: resident meets the significant change guidelines for either **major** improvements or decline
- A “significant change” is a **major** decline or improvement in a residents that: Will not normally ... the decline is not considered “self- limiting”

## CHAPTER 2 SIGNIFICANT CHANGE



- **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;

## CHAPTER 2 SIGNIFICANT CHANGE



- 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 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~~

## CHAPTER 2 SIGNIFICANT CHANGE



- **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.~~

## CHAPTER 2 SIGNIFICANT ERROR



- 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



## CHAPTER 2

- 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).
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## CHAPTER 2 BASELINE CARE PLAN

- Page 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)).** (cont)

## CHAPTER 2 BASELINE CARE PLAN

- 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).



## CHAPTER 2

- 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).

## CHAPTER 2

- 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.

## CHAPTER 3 OVERVIEW

- With the exception of certain items (e.g., some items in Sections K and O), the look-back period ~~generally~~ **does not extend into the preadmission period unless the item instructions state otherwise include hospital stay.** In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise.
- Restraints **and Alarms: ...record the frequency that any of the listed alarms were used.** (more to follow)

## CHAPTER 3 SECTION A

- 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).
- 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.
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# PASRR

- Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that:
  - 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability;
  - 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
  - 3) receive the services they need in those settings.

# CHAPTER 3 SECTION A



- In a coding example regarding a PPS discharge that was unexpected page A35-36
- **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.**
- **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.**

# CHAPTER 3

## 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.

# CHAPTER 3

## SELF PERFORMANCE RULE OF 3 ALGORITHM

### 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).**

## ADL SELF PERFORMANCE RULE OF 3 ALGORITHM

Stop at the First code that Applies		
Did the activity occur at least a time	No	Code 8: Activity did not occur
Did the activity occur 3 or more times	No	Code 7 Activity occurred once or twice
Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?	Yes	Code 0; Independent
Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)	Yes	Code 1 Supervision
Did resident require Total Dependence EVERY time? (Item 1 Rule of 3, Total Dependence* exception)	Yes	Total Dependence

## ADL SELF PERFORMANCE RULE OF 3 ALGORITHM

Stop at the First code that Applies (cont.)		
Did the resident require Total Dependence 3 or more times, but not every time?	Yes	Code 3 Extensive Assistance
Did the resident require Extensive Assistance 3 or more times?	Yes	Code 3 Extensive Assistance
Did the resident require Limited Assistance 3 or more times?	Yes	Code 2 Limited Assistance
Did the resident require oversight, encouragement or cueing 3 or more times	Yes	Code 1 Supervision
Did the resident require a combination of total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level (Item 3a Rule of 3)	Yes	Code 3 Extensive Assistance
Did the resident require a combination of total Dependence, Extensive assistance and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3b Rule of 3)	Yes	Code 2 Limited Assistance

## CHAPTER 3 SECTION G

- 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.

## CHAPTER 3

- **Check G0600 Mobility Devices**
  - **C, 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.

## CHAPTER 3 SECTION GG 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).**
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.**

## CHAPTER 3 SECTION GG STEPS FOR ASSESSMENT



- *6. The admission functional assessment, when possible, should be conducted prior to the person benefiting 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 their **resident's "usual performance,"** (or ~~baseline performance on admission~~), 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 **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.**

## CHAPTER 3 SECTION GG

### 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 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 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 start of 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.

## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends when the resident is discharged from the facility on the day of, or one day 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.



## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- 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 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.~~ 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.



## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- ~~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.~~

## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

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

## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- *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.*



## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- Coding a dash ("-") in these items indicates "No information." CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation or injury (Code 09), or the activity was not attempted due to medical condition or safety concerns (Code 88), use these codes instead of a dash ("-"). Please note that a dash may be used for GG0130 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale. Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash ("-") for Discharge Goals is provided below under Discharge Goal(s): Coding Tips.



## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE 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.

## CHAPTER 3 SECTION GG

### ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- 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.

## CHAPTER 3 SECTION GG

### EATING

- **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.



## CHAPTER 3 SECTION GG EATING



- **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.

## CHAPTER 3 SECTION GG EATING

- **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 this item.

## CHAPTER 3 SECTION GG TOILETING HYGIENE



- **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: would be Supervision or touching assistance

## CHAPTER 3 SECTION GG EXAMPLES OF PROBING CONVERSATIONS WITH STAFF

- Under eating they have added not just food but food and liquid



## CHAPTER 3 SECTION GG DISCHARGE GOALS CODING TIP

- Reinforcement that using the dash in this allowed instance does not affect APU determination and a reminder that we need at least one Discharge Goal must be indicated for either Self Care or Mobility
- It also mentions that we can code more than one Discharge Goal
- Reminds us that goals may be determined based on resident's admission functional status, prior functioning, medical conditions etc. and that discussions with the resident and family concerning discharge goals and anticipated length of stay



## CHAPTER 3 SECTION GG STEPS FOR ASSESSMENT



- Reminds us that the resident' mobility status is based on direct observation, family reports, direct care staff reports
- Clarified the definition:
  - *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.*

## CHAPTER 3 SECTION GG STEPS FOR ASSESSMENT

- 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.
- 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.



## CHAPTER 3 SECTION GG STEPS FOR ASSESSMENT

- 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 their resident's "usual performance," (baseline performance on admission), which is identified as the resident's usual activity/performance for any of the Self-cCare 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 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.
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## CHAPTER 3 SECTION GG ADMISSION OR DISCHARGE PERFORMANCE

- Reminder with the 5 Day PPS assessment we will be doing section GG and that treatment should not be withheld in order to conduct the functional assessment
- Reminder on the 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.

## CHAPTER 3 SECTION GG ADMISSION OR DISCHARGE PERFORMANCE

- Reminding us to do the discharge functional status based on a clinical assessment
- 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.

## CHAPTER 3 SECTION GG

- Reminder for both the admission and discharge for Section GG we are to use the same 6 point scale or “activity was not attempted”
- On page 22 CMS removed 3 examples/discussions on coding the Discharge assessment. Reminder to use the usual performance or why the activity was not attempted
- Reminder that the turns with ambulation or w/c mobility the turns may be in the same direction
- Reminder that the Discharge Goal must be enter in at least one Self Care or Mobility Item

## CHAPTER 3 SECTION GG

- 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



## CHAPTER 3 SECTION GG CODING TIPS

- Chair/bed-to-chair:
  - 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.

Wheel chair/scooter **Example for GG0170Q1, Does the resident use a wheelchair/scooter?**

- **I. 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 I, Yes.
  - **Coding:** GG0170Q1, Does the resident use a wheelchair/scooter? would be coded I, 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 I, 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.

## CHAPTER 3 SECTION GG CODING TIPS

**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.

**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 I, Manual.

**Rationale:** Mr. M used a manual wheelchair during the 3-day assessment period.

**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.

**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 I, Manual.

**Rationale:** Mr. A is assisted using a manual wheelchair during the 3-day assessment period.

## CHAPTER 3 SECTION GG CODING TIPS



- **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.
- 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.

## CHAPTER 3 SECTION H

### • INTERMITTENT CATHETERIZATION

- ~~Sterile~~ insertion and removal of a catheter through the urethra for bladder drainage.
- 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.



# CHAPTER 3 SECTION I

- New web site for Z codes: <https://www.cms.gov/Medicare/Coding/ICD10/index.html>

# CHAPTER 3 SECTION I UTI'S



- **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 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.~~

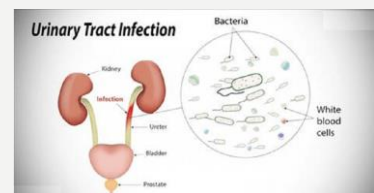
## CHAPTER 3 SECTION I UTI'S



- 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.

## CHAPTER 3 SECTION I UTI RESOURCES

- Work with your Medical Director to get this set up
- 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](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>



## CHAPTER 3 SECTION J FALLS

- Included now in the definition of 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.

## CHAPTER 3 SECTION L EDENTULOUS



- Definition: ***Having no natural permanent teeth in the mouth. Complete tooth loss.***
- Further discussion:
  - ***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.***

## CHAPTER 3 SECTION M SKIN INTEGRITY

- 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.

## CHAPTER 3 SECTION M PRESSURE ULCERS

- 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.
- 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 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.



## CHAPTER 3 SECTION M PRESSURE ULCERS

- Added emphasis to:
- 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.”**
- 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])).

## CHAPTER 3 SECTION M PRESSURE ULCERS

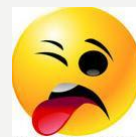
- A pressure ulcer described as a Stage 2 was noted and documented in the resident’s medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.
- **Coding:** The current Stage 3 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.*

## CHAPTER 3 SECTION M PRESSURE ULCERS

- 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 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.

## CHAPTER 3 SECTION M PRESSURE ULCERS

- Changed the emphasis in the wording:
- **WORSENING IN PRESSURE ULCER STATUS “~~WORSENING~~”**



## CHAPTER 3 SECTION M 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 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 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 and increases in numerical stage, the ulcer it would be considered worsened.

## CHAPTER 3 SECTION M PRESSURE ULCERS

- In M1040D Open lesions other than ulcers, rashes, cuts (*an example has bullous pemphigoid has been added and cancer lesion removed.*)
- In M1040 a general warning:
  - 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.



## CHAPTER 3 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 (~~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.***

## CHAPTER 3 SECTION N MEDICATIONS

- In the Coding Instructions for residents receiving any type of injections in several places they have either removed (~~subcutaneous, intramuscular or intradermal~~), or added (e.g. subcutaneous, intramuscular or intradermal),

## CHAPTER 3 SECTION N OPIOID

- Additional class has been included:
- **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).

## CHAPTER 3 SECTION N CODING TIPS

- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's website.
- 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]).
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant.

## CHAPTER 3 SECTION N

### CODING TIPS

- 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.
- 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>)
- 

## CHAPTER 3 SECTION N

### ANTIPSYCHOTIC MEDICATION REVIEW

- **Item Rationale**
- **Health-related Quality of Life**



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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.

## CHAPTER 3 SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

- **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.

## CHAPTER 3 SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

- **Steps for Assessment**

1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent.

2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction 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.

## CHAPTER 3 SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

- **Coding Instructions for N0450A**
- **Code 0, no:** if antipsychotics were not received: Skip to O0100, Special Treatments, Procedures, and Programs
- **Code 1, yes:** if antipsychotics were received on a routine basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 2, yes:** if antipsychotics were received on a PRN basis only: Continue to N0450B, Has a GDR been attempted?
- **Code 3, yes:** if antipsychotics were received on a routine and PRN basis: Continue to N0450B, Has a GDR been attempted?
- 

## CHAPTER 3 SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

- **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.**



## CHAPTER 3 SECTION N ANTIPSYCHOTIC MEDICATION REVIEW

- **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

## CHAPTER 3 SECTION N CODING TIPS

- **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).

## CHAPTER 3 SECTION N CODING TIPS

- 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.
- 

## CHAPTER 3 SECTION N CODING TIPS

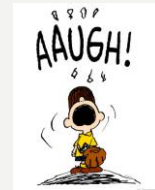
- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section.
- In cases where a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced 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.
-

## CHAPTER 3 SECTION 0 ISOLATION



- Isolation:
- ~~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>
- 

## CHAPTER 3 SECTION 0 VACCINES



- 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.

## CHAPTER 3 SECTION 0 THERAPIES

- 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.*

## SECTION 0 PHYSICIAN ORDERS AND VISITS

- O600 Physician visits and 0700 Physician visits both are captured in the last 14 days.
- In the new version of the manual it states: **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.**
- \*\*\*For MO we technically do not have any MDS specific items so we would not have to do this section since CMS does not require it

## SECTION P RESTRAINTS AND ALARMS

- Seven day look back for both restraints and alarms, Restraints are not prohibited by CMS but they are committed to reducing unnecessary physical restraints in nursing homes.
- In the opening section of Section P there are Federal rules numbering changes
- There is nothing else different in the restraint section.



## SECTION P ALARMS ITEM RATIONALE

- An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, 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.

## SECTION P ALARMS 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.

## SECTION P ALARMS: STEPS FOR ASSESSMENT

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

## SECTION P ALARMS: CODING INSTRUCTIONS

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

## SECTION P 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.

## SECTION P CODING TIPS

- **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.

## SECTION P CODING TIPS

- 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 INTENT

- In this section it does state: Discharge Planning is also a civil right for all residents



## SECTION Q 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.
- Coding other than the resident's stated expectation is a violation of the resident's civil rights

## SECTION Q

- 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.
- 

## SECTION Q

- 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.
- Missouri: <https://apps.dss.mo.gov/mfpnursinghome/Login.aspx>

## SECTION Q

- 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.
- It is simply a request for information, not a request for discharge

## SECTION Q RESOURCES

- 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>

## SECTION Q

- 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.**

## SECTION Q

- State Medicaid Agencies (**SMA**s) **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.**
- MO contact information
  - <https://www.medicaid.gov/medicaid/ltss/community-living/index.html>.

# CHAPTER 4 CARE PLANS

*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

# CHAPTER 4 CARE PLANS

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.~~

## CHAPTER 4 CARE PLANS

- 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.

## CHAPTER 4 CARE PLANS

- 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

# RESOURCES

- <https://downloads.cms.gov/files/MDS-30-RAI-Manual-v115-Replacement-Manual-Pages-and-Change-Tables-October-2017.pdf>
- QIPMO Team: [www.nursinghomehelp.org](http://www.nursinghomehelp.org)