Welcome to MDS 3.0 Training 2025 Session #2 part 2

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Disclaimer:

This presentation is not a substitute for reading and reviewing the

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

Version 1.20.1, October 2025

Item Sets Version 1.20.3 October 2025

or

State Operations Manual Appendix PP

Revised 7/23/25

Objectives:

Review Section C- Cognitive Patterns

Review Section D- Mood

Review Section E- Behavior

Review Section Q- Participation in Assessment and Goal Setting

Section C: Cognitive Patterns

- C0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's preferred language or primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the assessment should have been done during the look back period and *WAS NOT*, code C0100 as YES and dash (-) the information.
- C0500: Enter "99" if the resident was unable to complete the interview, do not dash.
- Score: 13- 15 cogitatively intact, 8-12 moderately impaired, 0-7 severely impaired.

*Need documentation of examples

Section C (continued)

- C0600: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.
- *DO NOT* complete a staff assessment if the resident interview *should have* been done and was not.
- C1310: Signs and Symptoms of Delirium: This may alert you to a problem. Probe and document what was said, then make a decision about notifying the physician.

Section C Coding Tips from page C-2

- Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments.
- As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS.
- In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

C0100. Should Brief Interview for Mental Status (C0200–C0500) be Conducted?

Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete C0700–C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed****. Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

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

Enter Code ☐

Ask resident: *"Please tell me what year it is right now."*

A. **Able to report correct year**

0. **Missed by > 5 years** or no answer
1. **Missed by 2–5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code ☐

Ask resident: *"What month are we in right now?"*

B. **Able to report correct month**

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code ☐

Ask resident: *"What day of the week is today?"*

C. **Able to report correct day of the week**

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code ☐

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (*something to wear; a color; a piece of furniture*) for that word.

A. **Able to recall "sock"**

0. **No** - could not recall
1. **Yes, after cueing** (*"something to wear"*)
2. **Yes, no cue required**

Enter Code ☐

B. **Able to recall "blue"**

0. **No** - could not recall
1. **Yes, after cueing** (*"a color"*)
2. **Yes, no cue required**

Enter Code ☐

C. **Able to recall "bed"**

0. **No** - could not recall
1. **Yes, after cueing** (*"a piece of furniture"*)
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score ☐☐

Add scores for questions C0200–C0400 and fill in total score (00–15)
Enter 99 if the resident was unable to complete the interview

C0600. Should the Staff Assessment for Mental Status (C0700–C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200–C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓	**Check all that the resident was normally able to recall**
☐	**A. Current season**
☐	**B. Location of own room**
☐	**C. Staff names and faces**
☐	**D. That they are in a nursing home/hospital swing bed**
☐	**Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1310. Signs and Symptoms of Delirium (from CAM®)

Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Enter Code ☐

A. Acute Onset Mental Status Change

Is there evidence of an acute change in mental status from the resident's baseline?

0. **No**
1. **Yes**

Coding:	↓	**Enter Codes in Boxes**
0. **Behavior not present**	☐	**B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
1. **Behavior continuously present, does not fluctuate**	☐	**C. Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
2. **Behavior present, fluctuates** (comes and goes, changes in severity)	☐	**D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** - startled easily to any sound or touch ▪ **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** - very difficult to arouse and keep aroused for the interview ▪ **comatose** - could not be aroused

Section D: Mood

- D0100 Should Resident Mood Interview be Conducted?
- D0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. DO NOT consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the resident refuses, make several attempts.
- If the assessment should have been done during the look back period and WAS NOT, code D0100 as YES and dash (-) the information.

Section D (PHQ-9)

- D0150: Symptom presence and frequency may alert you to a problem. Probe and document what was said during the interview. Then make a decision to notify the physician or not.
- D0150 I: Thoughts that would be better off dead- you must ask this question. If yes, find out why. Feeling ready to die is not the same as better off dead.
- D0160 Total Severity Score: 1-4 Minimal depression, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe depression.

Resident Mood Interview PHQ-2 to 9

- *Determine whether to ask the remaining seven questions Whether or not further evaluation of a resident's mood is needed depends on the resident's responses to the first two questions:*
- *If **both** D0150A1 and D0150B1 are coded 9, OR*
- ***both** D0150A2 and D0150B2 are coded 0 or 1, **end** the PHQ interview;*
- *otherwise continue.*
- *If **both** D0150A1 and D0150B1 are coded 9, leave D0150A2 and D0150B2 **blank,** then end the PHQ-2© and leave D0160, Total Severity Score blank.*
- *If **both** D0150A2 and D0150B2 are **coded 0 or 1**, then end the PHQ-2© and enter the total score from D0150A2 and D0150B2 in D0160, Total Severity Score.*

Section D (continued)

- D0500: Staff assessment should only be completed if the resident is rarely/never understood.
- DO NOT complete a staff assessment if the resident interview should have been done and was not.

D0100. Should Resident Mood Interview be Conducted?

Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500–D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9[e])

D0150. Resident Mood Interview (PHQ-2 to 9[e])

Say to resident: ***"Over the last 2 weeks, have you been bothered by any of the following problems?"***

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2)	0. **Never or 1 day**
1. **Yes** (enter 0–3 in column 2)	1. **2–6 days** (several days)
9. **No response** (leave column 2 blank)	2. **7–11 days** (half or more of the days)
	3. **12–14 days** (nearly every day)

	Enter Scores in Boxes	1. Symptom Presence	2. Symptom Frequency
A.	*Little interest or pleasure in doing things*	☐	☐
B.	*Feeling down, depressed, or hopeless*	☐	☐

If both D0150A1 and D0150B1 are coded 9, OR both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise, continue.

C.	*Trouble falling or staying asleep, or sleeping too much*	☐	☐
D.	*Feeling tired or having little energy*	☐	☐
E.	*Poor appetite or overeating*	☐	☐
F.	*Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G.	*Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H.	*Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I.	*Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

D0160. Total Severity Score

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

If D0150A2 or D0150B2 is coded 2 or 3, continue questions below.

If not, end the PHQ interview

D0600 Staff Assessment

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0150–D0160) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2)	0. **Never or 1 day**
1. **Yes** (enter 0–3 in column 2)	1. **2–6 days** (several days)
	2. **7–11 days** (half or more of the days)
	3. **12–14 days** (nearly every day)

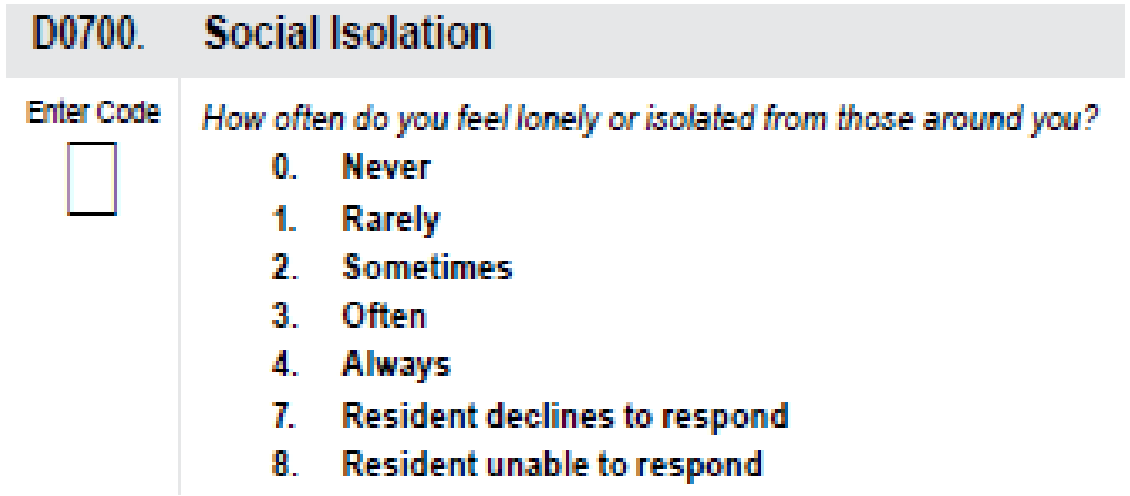
	Enter Scores in Boxes	1. Symptom Presence	2. Symptom Frequency
A.	**Little interest or pleasure in doing things**	☐	☐
B.	**Feeling or appearing down, depressed, or hopeless**	☐	☐
C.	**Trouble falling or staying asleep, or sleeping too much**	☐	☐
D.	**Feeling tired or having little energy**	☐	☐
E.	**Poor appetite or overeating**	☐	☐
F.	**Indicating that they feel bad about self, are a failure, or have let self or family down**	☐	☐
G.	**Trouble concentrating on things, such as reading the newspaper or watching television**	☐	☐
H.	**Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual**	☐	☐
I.	**States that life isn't worth living, wishes for death, or attempts to harm self**	☐	☐
J.	**Being short-tempered, easily annoyed**	☐	☐

D0600. Total Severity Score

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

D0700 Social Isolation



D0700. Social Isolation

Enter Code

How often do you feel lonely or isolated from those around you?

0. Never
1. Rarely
2. Sometimes
3. Often
4. Always
7. Resident declines to respond
8. Resident unable to respond

- Resident self-reported item
- A social determinant of health (SDOH)
- What other risks are associated with feeling isolated for this resident?
  - Nutrition?
  - Incontinence?
  - Accidents?
- Help the resident identify activities they enjoy and implement.
- Help connect them with others

Section E: Behavior

- This section is based on observations during the look back period.
- An increase in behaviors should be discussed with the physician, consider PASRR notification, or a possible SCSA.
- Should seek to understand why the behavior is being exhibited: lonely, meaningless, helpless, boredom.

*Need documentation of dates and behaviors.

Section E (continued)

- E0800 Rejection of Care: If the resident understands the ramifications of the lack of care, this would not be rejection.
- When surveyors look at ADL care, facial hair, long nails, the rejection of care section of the MDS is also reviewed.
- E0900 and E1000: Wandering. If the resident is out of the building without staff knowledge=elopement.
- Not talking about alert and oriented who have been assessed as safe to go outside. Or confused residents who are allowed to wander into an enclosed, secured area.
- If the resident has exit seeking behaviors, and this was prior knowledge, the facility is liable.

E0100. Potential Indicators of Psychosis

↓ **Check all that apply**

- ☐ **A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ **B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ **Z. None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence and Frequency

Note presence of symptoms and their frequency

Coding:

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

↓ **Enter Codes in Boxes**

- ☐ **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?

0. **No** → Skip to E0800, Rejection of Care - Presence and Frequency
1. **Yes** → Considering all of E0200, Behavioral Symptoms - Presence and Frequency, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐

A. Put the resident at significant risk for physical illness or injury?

0. **No**
1. **Yes**

Enter Code ☐

B. Significantly interfere with the resident's care?

0. **No**
1. **Yes**

Enter Code ☐

C. Significantly interfere with the resident's participation in activities or social interactions?

0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐

A. Put others at significant risk for physical injury?

0. **No**
1. **Yes**

Enter Code ☐

B. Significantly intrude on the privacy or activity of others?

0. **No**
1. **Yes**

Enter Code ☐

C. Significantly disrupt care or living environment?

0. **No**
1. **Yes**

E0800. Rejection of Care - Presence and Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence and Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside c the facility)?

0. **No**
1. **Yes**

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?

0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

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.
- Section Q ensures 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.

Section Q

- Language for Section Q
- *Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.*
- Puts emphasis on the resident's….
  - Civil rights
  - Right to request and receive information on community-based services
  - Request to learn about home and community-based services is not a request for discharge
  - Family support is not always necessary
- Section 504 of the Rehabilitation Act prohibits discrimination based on disability

Office of Civil Rights-
May 2016 Guidance to SNFs

- When coding Q0310 Resident's Overall Expectation, the response selected must reflect the resident's perspective if they are 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.
- Unjustified segregation can include nursing home placement when a resident could live in a more integrated setting. 3/12/25

Q0110. Participation in Assessment and Goal Setting
Identify all active participants in the assessment process

↓ Check all that apply

- ☐ A. Resident
- ☐ B. Family
- ☐ C. Significant other
- ☐ D. Legal guardian
- ☐ E. Other legally authorized representative
- ☐ Z. None of the above

Q0310. Resident's Overall Goal
Complete only if A0310E = 1

Enter Code ☐
A. Resident's overall goal for discharge established during the assessment process
1. Discharge to the community
2. Remain in this facility
3. Discharge to another facility/institution
9. Unknown or uncertain

Enter Code ☐
B. Indicate information source for Q0310A
1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

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 Q0610, Referral

Q0110, Q0310, Q0400

- Q0110 Participation in Assessment and Goal Setting
- Q0310 Resident's Overall Goal
- Q0400 Discharge Plan (within 3 months)

Q0310B, Q0500C, Q0550C Coding Instructions

- Code 1, Resident: if the resident is the source for completing this item.
- Code 2, Family: if a family member is the source for completing this item *because the resident is unable to respond*.
- Code 3, Significant other: if *a significant other of the resident* is the source for completing this item because the resident is unable to respond.
- Code 4, Legal guardian: *if a legal guardian of the resident is the source for completing this item because the resident is unable to respond.*
- Code 5, Other legally authorized representative: *if a legally authorized representative of the resident is the source for completing this item because the resident is unable to respond.*
- Code 9, None of the above: if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q03*1*0A = 9).

Q0400:
Discharge Plan

- Is active discharge planning already occurring for the resident to return to the community?
- The current care plan has goals specific to discharge
- DC is in the near future (within 3 months)
- Staff are taking active steps to accomplish discharge
- If special equipment, money, etc. is needed then a referral may still be necessary –or-
- Skip pattern if it is an uncomplicated/expected discharge

- Q0490 Resident's Preference to Avoid Being Asked Question Q0500B (must be documented in the resident's record)
  - Completed for quarterly, SCPQ or A0310A=99- none of the above
- Q0500B Return to Community
- Q0500C Indicate Information Source for Q0500B

Q0490. Resident's Documented Preference to Avoid Being Asked Question Q0500B

Complete only if A0310A = 02, 06, or 99

Enter Code ☐

Does resident's clinical record document a request that this question (Q0500B) be asked only on a comprehensive assessment?

0. No
1. Yes → Skip to Q0610, Referral

Q0500. Return to Community

Enter Code ☐

B. Ask the resident (or family or significant other or guardian or legally authorized representative only 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

Enter Code ☐

C. Indicate information source for Q0500B

1. Resident
2. Family
3. Significant other
4. Legal guardian
5. Other legally authorized representative
9. None of the above

Q0490 and Q0500

Q550

- Q0550A Does resident want to be asked about returning to the community on all assessments?

Q0550.	Resident's Preference to Avoid Being Asked Question Q0500B
Enter Code ☐	A. **Does resident** (or family or significant other or guardian or legally authorized representative **only** if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than on comprehensive assessments alone) 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 ☐	C. **Indicate information source for Q0550A** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

Section Q

Q0610. Referral

Enter Code ☐

A. Has a referral been made to the Local Contact Agency (LCA)?
0. No
1. Yes

Q0620. Reason Referral to Local Contact Agency (LCA) Not Made

Complete only if Q0610 = 0

Enter Code ☐

Indicate reason why referral to LCA was not made
1. LCA unknown
2. Referral previously made
3. Referral not wanted
4. Discharge date 3 or fewer months away
5. Discharge date more than 3 months away

- Q0610 Referral
- Q0620 Reason Referral to LCA Not Made
- Documentation in the record is necessary

Q0610: Referral

- Has a referral been made to the Local Contact Agency (LCA)?
- 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.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Discharge-Planning-Checklist.pdf

Q0620 Reason Referral to LCA Not Made

Discharge Planning Collaboration

- Nursing home staff are expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
- Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services.
- Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services.

The Office of Civil Rights Recommends…

- Review/Revise/Develop policies/procedures on Discharge Planning, MDS administration, and LCA referral process
- Train all members of the IDT on Section Q, and what the area LCA has to offer
- Invite the LCA and community-based service systems in to provide training

Discharge Planning Process should…

- Identify the needs and goals of ***this*** resident
- Include the resident as an active partner
- Emphasize value in moving back to the community
- Ensure a referral is made to the LCA if the resident indicates interest
- Include documentation if discharge to the community is not feasible
- ***Who decided and why***
- Be re-evaluated and updated as necessary

For NC statewide LCA questions:

Acentra Call Center

- 833-522-5429

Local Contact Agency

- **NC Medicaid Clinical Section**
  Phone: 919-855-4340
  NCLIFTSS 866-271-4894

Money Follows the Person

- MFPinfo@dhhs.nc.gov
- or call 855-761-9030

Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 7/23/25: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- Resident Rights
  - F550-F586
- Discharge Planning
  - F622 (transfer), F624 (preparation), F626 (return), F660 (DC plan) and F661 (DC summary) have been moved into NEW F627
- Behavioral Health
  - F740-F745

F552 Right to be Informed/ Make Treatment Decisions

- **The resident has the right to be informed of, and participate in, his or her treatment, including:**
- **The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.**
- **The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.**
- **The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.**

F561 Self Determination

- **The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice...**
- **The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions…**
- **The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.**
- **The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.**
- **The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.**

F561 Self Determination (continued)

During interviews with residents or their family and/or representative(s), determine if they are given the opportunity to choose and whether facility staff accommodate his or her preferences for:

- Activities that interest them;
- Their sleep cycles;
- Their bathing times and methods;
- Their eating schedule;
- Their health care options; and
- Any other area significant to the resident.

F578 Request/Refuse/Discontinue Treatment; Formulate Advanced Directive

- **The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**

- **These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.**

- **GUIDANCE**

Facility staff should periodically review with the resident and resident representative the decisions made regarding treatments, experimental research and any advance directive and its provisions, as preferences may change over time.

*Surveyors are looking for evidence of Residents/RP being given information and the opportunity to formulate an Advanced Directive.

F656 Comprehensive Care Plan

- **The facility must develop and implement a comprehensive person-centered care plan for each resident… The comprehensive care plan must describe the following —**
- **The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required**
- **Any services that would otherwise be but are not provided due to the resident's exercise of rights, <u>including the right to refuse treatment</u>.**
- **Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations.**

F656 Comprehensive Care Plan (continued)

- **In consultation with the resident and the resident's representative(s)—**
- **The resident's goals for admission and desired outcomes.**
- **The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.**
- **Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements.**

F627 Transfer and Discharge/Facility Requirements

A conglomeration of F622, F624, F626, F660 and F661

- **The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—**
- **(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
- **(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;**
- **(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;**
- **(D) The health of individuals in the facility would otherwise be endangered;**
- **(E) The resident has failed, after reasonable and appropriate notice, to pay… OR**
- **(F) The facility ceases to operate.**

F627 Appeals for Transfer

- **The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer, or discharge would pose.**

F627 DOCUMENTATION

- **When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.**
- **Documentation in the resident's medical record must include:**
  - **The basis for the transfer.**
  - **The specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).**
- **The documentation required for this section must be made by—**
  - **The resident's physician when transfer or discharge is necessary under paragraph (A) or (B) of this section;**
  - **A physician when transfer or discharge is necessary under paragraph (C) or (D) of this section.**

F627 Orientation for Transfer or Discharge

- **A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.**

F627 Permitting Residents to Return to Facility

- **A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.**
- **A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident—**
  - **Requires the services provided by the facility; and**
  - **Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.**
- **If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements as they apply to discharges.**

F627 Readmission

- **Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part, the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously.**
- **If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.**

F627 Discharge Planning Process

- **The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights as applicable and—**
  - **Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.**
  - **Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.**
  - **Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.**
  - **Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.**
  - **Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.**
  - **Address the resident's goals of care and treatment preferences.**
  - **Document that a resident has been asked about their interest in receiving information regarding returning to the community.**

F627 Discharge Planning Process

- **If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.**
- **Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.**
- **If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.**
- **For residents who are transferred to another SNF, HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.**
- **Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.**

F627 DISCHARGE SUMMARY

- **Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:**
  - **A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment.**
  - **The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.**

F627 Intent

- **INTENT** • *These regulations and guidance address inappropriate discharges and:*
- Specify the limited conditions under which a skilled nursing facility or nursing facility may transfer or discharge a resident,
- the documentation that must be included in the medical record, and who is responsible for making the documentation.
- *Ensure policies are developed and implemented which allow residents to return to the facility following hospitalization or therapeutic leave.*
- *Ensure a facility does not transfer or discharge a resident in an unsafe manner, such as a location that does not meet the resident's needs, does not provide needed support and resources, or does not meet the resident's preferences and, therefore, should not have occurred.*
- *Ensure the discharge planning process* addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan.

F740 Behavioral Health Services

- **Each resident must receive, and the facility must provide the necessary behavioral health 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.**
- **Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.**

F740 Behavioral Health Services (continued)

GUIDANCE

- Providing behavioral health care and services is an integral part of the person-centered environment.
- This involves an interdisciplinary approach to care, with qualified staff that demonstrate the competencies and skills necessary to provide appropriate services to the resident.
- Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress or loss of abilities.

F743 No Pattern of Behavioral Difficulties Unless Unavoidable

- **A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty, or a documented history of trauma and/or PTSD does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable…**

F743 No Pattern of Behavioral Difficulties Unless Unavoidable

Facility staff must:

- Monitor the resident closely for expressions or indications of distress;
- Assess and plan care for concerns identified in the resident's assessment;
- Accurately document the changes, including the frequency of occurrence and potential triggers in the resident's record;
- Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;
- Ensure appropriate follow-up assessment, if needed; and
- Discuss potential modifications to the care plan.