Welcome to MDS 3.0 Training 2025 Session #3

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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 GG- Functional Abilities and Goals

Review Section H- Bladder and Bowel

Review Section I- Active Diagnoses

Review Section J- Health Conditions

Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 7/23/25:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107app_pp_guidelines_ltcf.pdf

Section GG

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

Section GG: Functional Abilities and Goals

- Completed for PPS 5-day, IPA, PPS Discharge, and OBRA Admission, Quarterly, Annual, SCSA, SCPC and SCPQ assessments.
- This section assesses the need for assistance with self-care and mobility activities at the beginning and end of a SNF PPS stay and OBRA assessments.
- 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 PPS functional score is be based on section GG.

Section GG: PPS assessments

- 5-day PPS MDS- Items focus on the resident's self-care/mobility performance at admission. This 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.
- The assessment period is days 1-3 of the SNF PPS stay starting with A2400B.

GG0100, GG0110 Prior Functioning:

PPS assessments only

- GG0100: Everyday Activities
  - Self-Care
  - Indoor Mobility (Ambulation)
  - Stairs *For the GG0100C stair activity, "by any safe means" may include a resident scooting up and down stairs on their buttocks.*
  - Functional Cognition
- GG0110: Prior Device Use
  - Manual wheelchair
  - Motorized wheelchair and/or scooter
  - Mechanical lift
  - Walker
  - Orthotics/prosthetics
  - None of the above

GG0100: Prior Functioning

- Ask the resident, their family or caregivers about their prior functioning with everyday activities
- Review the resident's medical records describing the resident’s prior functioning with everyday activities.

GG0100 Coding: Prior Functioning

- Code 3, Independent: if the resident completed the activities by themself, with or without an assistive device, with no assistance from a helper.
- Code 2, Needed Some Help: if the resident needed partial assistance from another person to complete the activities.
- Code 1, Dependent: if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.

GG0100 Coding: Prior Functioning (continued)

- Code 8, Unknown: if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- Code 9, Not Applicable: if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

- **Coding Tips**
- For **GG0110D**, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- **GG0110C**, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.
- *Clinical judgment may be used to determine whether other devices meet the definition provided.*

Section GG - Functional Abilities

GG0100. Prior Functioning: Everyday Activities

Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:	↓	Enter Codes in Boxes
3. **Independent** - Resident completed all the activities by themself, with or without an assistive device, with no assistance from a helper. 2. **Needed Some Help** - Resident needed partial assistance from another person to complete any activities. 1. **Dependent** - A helper completed all the activities for the resident. 8. **Unknown.** 9. **Not Applicable.**	☐	A. **Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	☐	B. **Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	☐	C. **Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	☐	D. **Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use

Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

↓	Check all that apply
☐	A. **Manual wheelchair**
☐	B. **Motorized wheelchair and/or scooter**
☐	C. **Mechanical lift**
☐	D. **Walker**
☐	E. **Orthotics/Prosthetics**
☐	Z. **None of the above**

GG0115 Functional Limitation in ROM

GG0120 Mobility Devices

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

Coding:	↓	Enter Codes in Boxes
0. No impairment 1. Impairment on one side 2. Impairment on both sides	☐	A. **Upper extremity** (shoulder, elbow, wrist, hand)
	☐	B. **Lower extremity** (hip, knee, ankle, foot)

GG0120. Mobility Devices

↓	Check all that were normally used in the last 7 days
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

GG0115
Functional Limitation in Range of Motion

- The intent of GG0115 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places them at risk of injury.
- When completing this item, staff members should refer to items in GG0130 and GG0170 and view the limitation in ROM, considering activities the resident is able to perform. RAI page GG-5
- Steps for assessment RAI pages GG 6-7

GG0115 Coding Tips

- *Do not look at limited ROM in isolation. You must determine whether the limited ROM has an impact on functional ability or places the resident at risk for injury.*
- *For example, if the resident has an amputation, it does not automatically mean that they are limited in function. A resident with an amputation may not have a particular joint in which a certain range of motion can be tested, however, that does not mean that the resident necessarily has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury.*
- *This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.*

RAI page GG-7

GG0120 Mobility Devices Coding Instructions

- **GG0120A, Cane/crutch:** *if the resident used a cane or crutch, including single-prong, tripod, quad cane, etc.*
- **GG0120B, Walker:** *if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.*
- **GG0120C, Wheelchair (manual or electric):** *if the resident normally sits in a wheelchair when moving about. Include wheelchairs that are 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.*
- **GG0120D, Limb prosthesis:** *if the resident used an artificial limb to replace a missing extremity.*
- **GG0120Z, None of the above:** *if the resident used none of the mobility devices listed in GG0120 or locomotion did not occur during the observation period.*

GG0130: Self-Care and GG0170: Mobility

- **General coding tips**
- *The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once.*
- *A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence.*
- *CMS does not provide an exhaustive list of assistive devices that may be used…*
- **Coding tips for coding the resident's usual performance**
- *If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent.*

GG0130: Self Care and GG0170: Mobility Coding

PPS and OBRA assessments

- Code 06, Independent: if the resident completes the activity by themself with no assistance from a helper.
- Code 05, Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).

GG0130 Self Care and GG0170 Mobility Coding

- Code 04, Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

GG0130 Self Care and GG0170 Mobility Coding

- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

GG0130 and GG0170 Coding Activity Was Not Attempted

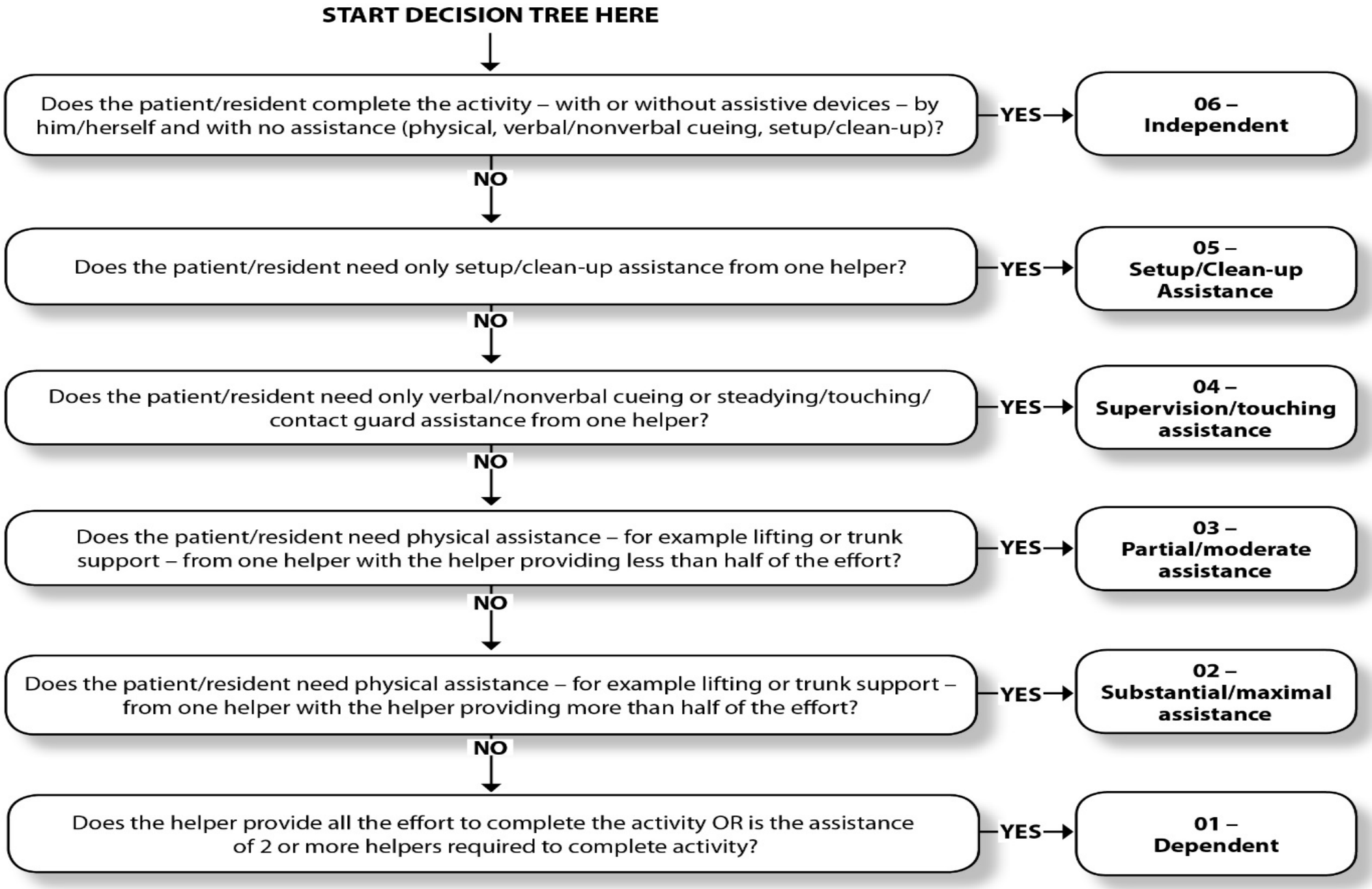
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 10, Not attempted due to environmental limitations: if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

GG0130 & GG0170
Steps for Assessment

- 1. Assess the resident's self-care and mobility performance based on direct observation, the resident's self-report, and reports from clinicians, care staff, or family reports, documented in the resident's medical record during the 3-day assessment period.
- 2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- 3. If helper assistance is required because resident's performance is unsafe or of poor quality, score according to the amount of assistance provided.
  - If 2 or more helpers are required for safety, code as 01, Dependent.
- Fastening, buttoning, tying shoes is touching assistance.

Decision Tree page GG-16

- Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.


START DECISION TREE HERE
Does the patient/resident complete the activity – with or without assistive devices – by him/herself and with no assistance (physical, verbal/nonverbal cueing, setup/clean-up)?
YES
06 – Independent
NO
Does the patient/resident need only setup/clean-up assistance from one helper?
YES
05 – Setup/Clean-up Assistance
NO
Does the patient/resident need only verbal/nonverbal cueing or steadying/touching/ contact guard assistance from one helper?
YES
04 – Supervision/touching assistance
NO
Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing less than half of the effort?
YES
03 – Partial/moderate assistance
NO
Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing more than half of the effort?
YES
02 – Substantial/maximal assistance
NO
Does the helper provide all the effort to complete the activity OR is the assistance of 2 or more helpers required to complete activity?
YES
01 – Dependent

GG0130 Functional Abilities and Goals- Admission Self-Care

Section GG - Functional Abilities - Admission

GG0130. Self-Care (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

- GG0130 Self-Care (Assessment period is the first 3 days of the stay) Complete if an Admission or 5-day PPS.
- If the 5-day PPS, the stay begins on A2400B.
- If not a PPS assessment, the stay begins on A1600
- Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

- **Performance Coding Tips**
- **General coding tips**
- *The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once.*
- *A dash (–) indicates "No information." CMS expects dash use to be a rare occurrence.*
- *CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.*
- *Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).*
- **Coding tips for coding the resident's usual performance**
- *If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent.*

- From GG-17

GG0130 Functional Abilities- Admission Self-Care

1. Admission Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	**I. Personal hygiene:** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0170 Functional Abilities- Admission Mobility

Section GG - Functional Abilities - Admission

GG0170. Mobility (Assessment period is the first 3 days of the stay)
Complete column 1 when A0310A = 01 or when A0310B = 01.
When A0310B = 01, the stay begins on A2400B. When A0310B = 99, the stay begins on A1600.

Code the resident's usual performance at the start of the stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the stay (admission), code the reason.

- GG0170 Mobility (Assessment period is the first 3 days of the stay) Complete if an Admission or 5-day PPS.
- If 5-day PPS the stay begins on A2400B
- If not a PPS assessment, the stay begins on A1600

GG0170 Functional Abilities-Admission Mobility

1. Admission Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170 Functional Abilities- Admission Mobility

1. Admission Performance	
Enter Codes in Boxes ↓	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q1. Does the resident use a wheelchair and/or scooter?
☐	0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR1. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS1. Indicate the type of wheelchair or scooter used.
☐	1. **Manual** 2. **Motorized**

Section GG: PPS Discharge or OBRA Discharge

- Part A PPS Discharge
- Completed when the Medicare 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 the day before the resident's discharge date (please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment).

GG0130 Functional Abilities- Discharge Self-Care

- Assessment period is the last 3 days of the stay.
- Complete only if A0310F=10 or 11 or A0310H=1.
  - OBRA Return Not Anticipated, OBRA Return anticipated, Planned, Unplanned,
  - or End of PPS
- If A0310G is **not**= 2 (unplanned) **and**
- A0310H= 1 (SNF Part A PPS DC Assessment) **and**
- A2400C (end date of most recent Medicare stay) minus A2400B (Start date of most recent Medicare stay) is greater than 2 **and**
- A2105 is not= 4 (Short-Term General Hospital), the stay ends on A2400C (end date of most recent Medicare stay)
- For all other Discharge assessments, the stay ends on A2000 (Discharge Date)
- Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

GG0130 Functional Abilities- Discharge Self-Care

Section GG - Functional Abilities - Discharge

GG0130. **Self-Care** (Assessment period is the last 3 days of the stay)
Complete column 3 when A0310F = 10 or 11 or when A0310H = 1.
When A0310H = 1 and A2400C minus A2400B is greater than 2 **and** A2105 is not = 04, the stay ends on A2400C.
For all other Discharge assessments, the stay ends on A2000.

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

GG0130 Functional Abilities- Discharge Self-Care

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	A. **Eating**: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	B. **Oral hygiene**: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting hygiene**: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self**: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing**: The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing**: The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear**: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	I. **Personal hygiene**: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0170 Functional Abilities- Discharge Mobility

- Assessment period is the last 3 days of the stay.
- Complete only if A0310F=10 or 11 or A0310H=1.
  - OBRA Discharge Return Not Anticipated, OBRA Discharge Return Anticipated, Planned, Unplanned,
  - or End of PPS
- If A0310G is **not**= 2 (unplanned) **and**
- A0310H= 1 (SNF Part A PPS DC Assessment) **and**
- A2400C (end date of most recent Medicare stay) minus A2400B (Start date of most recent Medicare stay) is greater than 2 **and**
- A2105 is not= 4 (Short-Term General Hospital), the stay ends on A2400C (end date of most recent Medicare stay)
- For all other Discharge assessments, the stay ends on A2000 (Discharge Date)
- Code the resident's usual performance at the end of the stay for each activity using the 6-point scale. If an activity was not attempted at the end of the stay, code the reason.

GG0170 Functional Abilities- Discharge Mobility

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right**: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying**: The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed**: The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	**D. Sit to stand**: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer**: The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer**: The ability to get on and off a toilet or commode.
☐☐	**FF. Tub/shower transfer**: The ability to get in and out of a tub/shower.
☐☐	**G. Car transfer**: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet**: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns**: Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet**: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170 Functional Abilities- Discharge Mobility

3. Discharge Performance

Enter Codes in Boxes ↓

L. **Walking 10 feet on uneven surfaces**: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

M. **1 step (curb)**: The ability to go up and down a curb and/or up and down one step.
If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object

N. **4 steps**: The ability to go up and down four steps with or without a rail.
If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object

O. **12 steps**: The ability to go up and down 12 steps with or without a rail.

P. **Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

Q3. Does the resident use a wheelchair and/or scooter?

0. **No** → Skip to H0100, Appliances
1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns

R. **Wheel 50 feet with two turns**: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

RR3. Indicate the type of wheelchair or scooter used.

1. **Manual**
2. **Motorized**

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

SS3. Indicate the type of wheelchair or scooter used.

1. **Manual**
2. **Motorized**

GG: Stand Alone OBRA Assessments

- Quarterly, Annual, Significant Change in Status, Significant Correction to prior assessment-Comprehensive or Quarterly.

- The look back is the ARD plus the 2 previous days (days 5, 6 and 7).
- Code the resident's usual performance. Use the 6-point scale or activity was not attempted codes.
- Complete only column 5.

GG IPA

- Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.
- For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident.
- The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.
- The IPA does not affect the variable per diem schedule.

GG0130 Functional Abilities OBRA/Interim Self-Care

Section GG - Functional Abilities - OBRA/Interim

GG0130. Self-Care (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

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

- Assessment period is the ARD plus 2 previous calendar days
- Complete only if A0310A= 02-06 and/or A0310B= 08
  - 02. Quarterly
  - 03. Annual
  - 04. Significant Change in Status
  - 05. Significant correction to prior comprehensive
  - 06. Significant correction to prior quarterly
  - 08. IPA- Interim Payment Assessment
- Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

GG0130 Functional Abilities-OBRA/Interim Self-Care

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	A. **Eating**: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	B. **Oral hygiene**: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C. **Toileting hygiene**: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E. **Shower/bathe self**: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F. **Upper body dressing**: The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G. **Lower body dressing**: The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H. **Putting on/taking off footwear**: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.
☐☐	I. **Personal hygiene**: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene).

GG0170 Functional Abilities-OBRA/Interim Mobility

Section GG - Functional Abilities - OBRA/Interim

GG0170. Mobility (Assessment period is the ARD plus 2 previous calendar days)

Complete column 5 when A0310A = 02 - 06 and A0310B = 99.

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

- Assessment period is the ARD plus 2 previous calendar days
- Complete only if A0310A= 02-06 and/or A0310B= 08
  - 02. Quarterly
  - 03. Annual
  - 04. Significant Change in Status
  - 05. Significant correction to prior comprehensive
  - 06. Significant correction to prior quarterly
  - 08. IPA- Interim Payment Assessment
- Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

GG0170 Functional Abilities-OBRA/Interim Mobility

5. OBRA/Interim Performance Enter Codes in Boxes ↓	
☐☐	A. **Roll left and right**: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying**: The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed**: The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand**: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer**: The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer**: The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer**: The ability to get in and out of a tub/shower.
☐☐	I. **Walk 10 feet**: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	J. **Walk 50 feet with two turns**: Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet**: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170 Functional Abilities-OBRA/Interim Mobility

5. OBRA/Interim Performance

Enter Codes in Boxes ↓

Q5. Does the resident use a wheelchair and/or scooter?

☐ 0. No → Skip to H0100, Appliances
1. Yes → Continue to GG0170R, Wheel 50 feet with two turns

☐☐ **R. Wheel 50 feet with two turns**: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

RR5. Indicate the type of wheelchair or scooter used.

☐ 1. Manual
2. Motorized

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

SS5. Indicate the type of wheelchair or scooter used.

☐ 1. Manual
2. Motorized

PPS 5-day, IPA or Discharge Performance and OBRA Admission, Quarterly, Annual, SCSA, SCPC, SCPQ

- Code the resident's usual performance for each activity using the 6-point scale.
- Start with the least assistance provided, then step through the levels until you reach one that matches the resident’s usual performance.
- If the activity was not attempted during the entire 3-day assessment period, indicate the reason. DO NOT DASH!
- Coding a dash (-) indicates “No information”
- Use of dashes in the Discharge Goals is allowed and does not affect the Annual Payment Update (APU), however, at least one discharge goal should be entered.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record.

CMS GG Training Videos

- Lesson 1: Importance of Section GG for Post-Acute Care
- Lesson 2: Section GG Assessment and Coding Principles
- Lesson 3: Coding GG0130.Self-Care Items
- Lesson 4: Coding GG0170.Mobility Items
- Coding GG0110. Prior Device Use with Information From Multiple Sources (3:58)
- Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility (11:56)
- Coding GG0130B. Oral Hygiene (4:25)
- Coding GG0170C. Lying to Sitting on side of bed (4:33)
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html
- https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/skilled-nursing-facility-quality-reporting-program/snf-quality-reporting-program-spotlights-and-announcements
- Accessed 3/23/23

F676 Activities of Daily Living/ Maintain Abilities

- **Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:**
- **A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section …**

F676 (continued)

- **The facility must provide care and services for the following activities of daily living:**
- **Hygiene –bathing, dressing, grooming, and oral care,**
- **Mobility—transfer and ambulation, including walking,**
- **Elimination-toileting,**
- **Dining-eating, including meals and snacks,**
- **Communication, including**
  - **Speech,**
  - **Language,**
  - **Other functional communication systems.**

F677 ADL Care Provided for Dependent Residents

- **A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene**

Updated to include the MDS Section GG Self-Care and Mobility coding definitions

- *Independent: if the resident completes the activity by themself with no assistance from a helper.*
- *Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).*
- *Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.*
- *Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.*
- *Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.*

Section H:
Bladder and Bowel

- H0100A: Indwelling Catheter: may code even if in only a brief time during the look back period.
- H0300 and H0400 Urinary and Bowel Continence: If a resident has a change from occasional incontinent to frequently incontinent, this is a significant difference and needs to be investigated.
  - Incontinence: any urine touching the skin, willful or not. Peeing in a brief is not continence.

Section H - Bladder and Bowel

H0100. Appliances

↓ **Check all that apply**

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ B. **External catheter**
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

A. **Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐

B. **Response** - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐

C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

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

H0300. Urinary Continence

Enter Code ☐

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

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated**, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

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

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

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

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

H0600. Bowel Patterns

Enter Code ☐

Constipation present?

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

Toileting Programs

- Toileting programs must include:
- Evidence it was used during the look back period.
- Must be individualized, resident specific, based on an assessment.
- Evidence it had been communicated to the staff and the resident.
- Would expect to see flow records, a care plan and written evaluations of the resident response.
- This would include toileting trials.
- Guidance found in Appendix C.

F690 Bowel/Bladder Incontinence, Catheter, UTI

- **The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.**

- **For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.**
- Surveyor guidance updated to observe for cues of psychological distress.

F691 Colostomy, Urostomy, or Ileostomy Care

- **The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.**

Section I:
Active Diagnoses

- The items in this section are intended to code diseases and conditions that have a direct relationship to current function, cognition, moods, behaviors, medical treatment, nursing monitoring, or risk of death.
- One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.
- This section identifies active diseases and infections that drive the current care plan.
- Diagnoses need to have been noted by the physician within the past 60 days and then narrow to the last 7 days if active (labs, monitoring, medications, therapy).

I0020 Indicate the Resident's Primary Medical Condition Category PPS 5-day Assessment and OBRA Assessments

- I0020: Indicate the resident's primary medical condition category is coded when A0310A= 01, 02, 03, 04, 05, 06, A0310B=01
- The *primary reason* for admission will determine the clinical grouping for each resident.
- Indicate the resident's primary medical condition category that best describes the primary reason for the stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
- This is an active diagnosis indicating the primary reason for the SNF stay. Examples start on RAI page I-3

Section I: Active Diagnoses

There are two look-back periods for this section:

• Diagnosis identification (Step 1) is a 60-day look-back period.

1. **Identify diagnoses:** The disease conditions in this section require a physician-documented diagnosis in the **last 60 days.**

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

• Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI).

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

Section I: Active Diagnoses

- I2300 Urinary Tract Infection (UTI) (Last 30 Days) includes Item I2300 Urinary tract infection (UTI): Code only if both of the following are met in the last 30 days:
  - 1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, AND
  - 2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
- If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable.

QSO-23-05-NH

Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System:

Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute

https://www.cms.gov/files/document/qso-23-05-nh.pdf

1/18/2023

Outcomes

- The 4 facilities which attested to having inaccurate schizophrenia documentation and agreed to implement a plan of correction:
  - Overall QM and Long-Stay QM rating was suppressed for 6 months
  - Short stay QM rating will be calculated and posted as normal
  - Long stay antipsychotic use QM was suppressed for 12 months

- The facility which underwent the CMS audit for schizophrenia resulted in:
  - Overall QM and long-stay QM ratings downgraded to one star for 6 months
  - Short stay QM ratings suppressed for 6 months
  - Long-stay antipsychotic QM suppressed for 12 months

I6000 Schizophrenia

Memorandum Summary Adjusting Quality Measure Ratings:

CMS will be conducting audits of schizophrenia coding in the Minimum Data Set data and based upon the results, adjust the Nursing Home Care Compare quality measure star ratings for facilities whose audits reveal inaccurate coding.

CMS is concerned that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use.

Facilities that have coding inaccuracies identified through the schizophrenia MDS audit will have their QM ratings adjusted as follows:

- The Overall QM and long stay QM ratings will be downgraded to one star for six months (this drops the facility's overall star rating by one star).
- The short stay QM rating will be suppressed for six months.
- The long stay antipsychotic QM will be suppressed for 12 months.

Section I: Active Diagnoses

- I5100 Quadriplegia. No functional use of all four limbs. Use only if spinal cord injury. Spinal cord injury must be a primary condition and not a result of another condition. DO NOT code functional quad here. If the resident has dementia or spastic quadriplegia due to cerebral palsy, stroke, contractures, brain disease the primary diagnosis should be coded and not the resulting paralysis or paresis from that condition.
- I5600 Malnutrition. Requires physician diagnosis documentation.
- I8000 Additional active diagnoses.

Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

This item is required by NC Medicaid/Myers and Stauffer

Active Diagnoses in the last 7 days

Check all that apply.

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

	Cancer
☐	**I0100. Cancer** (with or without metastasis)
	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
☐	**I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
☐	**I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Gastrointestinal
☐	**I1100. Cirrhosis**
☐	**I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
☐	**I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**
	Genitourinary
☐	**I1400. Benign Prostatic Hyperplasia (BPH)**
☐	**I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**

Active Diagnoses in the last 7 days - Continued

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)**
- ☐ I2000. **Pneumonia**
- ☐ I2100. **Septicemia**
- ☐ I2200. **Tuberculosis**
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ I2400. **Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ I2500. **Wound Infection** (other than foot)

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ I3400. **Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ I3700. **Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ I3800. **Osteoporosis**
- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I4000. **Other Fracture**

Neurological

- ☐ I4200. **Alzheimer's Disease**
- ☐ I4300. **Aphasia**
- ☐ I4400. **Cerebral Palsy**
- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ I4900. **Hemiplegia or Hemiparesis**
- ☐ I5000. **Paraplegia**
- ☐ I5100. **Quadriplegia**
- ☐ I5200. **Multiple Sclerosis (MS)**
- ☐ I5250. **Huntington's Disease**
- ☐ I5300. **Parkinson's Disease**
- ☐ I5350. **Tourette's Syndrome**
- ☐ I5400. **Seizure Disorder or Epilepsy**
- ☐ I5500. **Traumatic Brain Injury (TBI)**

Nutritional

- ☐ I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ I5700. **Anxiety Disorder**
- ☐ I5800. **Depression** (other than bipolar)
- ☐ I5900. **Bipolar Disorder**
- ☐ I5950. **Psychotic Disorder** (other than schizophrenia)
- ☐ I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ I6100. **Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ I6300. **Respiratory Failure**

Vision

- ☐ I6500. **Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ I7900. **None of the above active diagnoses** within the last 7 days

Other

I8000. **Additional active diagnoses**
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A.								
B.								
C.								
D.								
E.								
F.								
G.								
H.								
I.								
J.								

Section J: Health Conditions

- The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.
- Item J2100 Recent Surgery Requiring Active SNF Care- completed for 5-day PPS and OBRA assessments.
- J2300 – J5000 Surgical Procedures- complete only if J2100= Yes.
- Documentation is needed to justify answers.

J0100: Pain Management: Scheduled and PRN Pain Medication, Non-pharmacological Pain Interventions

- 5-day look back period
- Data to answer the 6 questions in this item come from the medical record review and interviews
- Interventions are included as part of a care plan
- There must be documentation that the intervention(s) were received, and results assessed
- Interventions do not have to be successful to be counted
- F697 SOM Appendix PP, Pain Management

Non-Medication Pain Interventions

- Scheduled and implemented non-pharmacological interventions include, but are not limited to, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture.
- Herbal or alternative medicine products are not included in this category.
- Alternatives need to be care planned and evaluated for effectiveness.

J0300-J0600: Resident Pain Interview

- The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
- Attempt to conduct the interview with all residents
- The Pain Interview is not contingent upon B0700.
- Use the resident's preferred language. If not verbal, offer writing, sign or cue cards.
- Use the resident's terminology for pain-such as hurting, aching, burning.
- Code for the presence or absence of pain regardless of main management efforts.
- The resident's reported pain scale is independent of the medication received during the look-back.

Pain Management

Section J - Health Conditions

J0100. Pain Management

Complete for all residents, regardless of current pain level

At any time in the last 5 days, has the resident:

Enter Code ☐

A. Received scheduled pain medication regimen?

0. No
1. Yes

Enter Code ☐

B. Received PRN pain medications OR was offered and declined?

0. No
1. Yes

Enter Code ☐

C. Received non-medication intervention for pain?

0. No
1. Yes

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐

0. No (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. Yes → Continue to J0300, Pain Presence

Pain Assessment Interview

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐

Ask resident: *"Have you had pain or hurting at any time in the last 5 days?"*

0. **No** → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** → Continue to J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐

Ask resident: *"How much of the time have you experienced pain or hurting over the last 5 days?"*

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
9. Unable to answer

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: *"Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?"*

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?"*

0. Does not apply - I have not received rehabilitation therapy in the past 5 days
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days, **how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

J0600. Pain Intensity

Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. **Numeric Rating Scale (00–10)**

Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00–10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

B. **Verbal Descriptor Scale**

Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

1. Mild
2. Moderate
3. Severe
4. Very severe, horrible
9. Unable to answer

Pain Frequency Resident Interview

F697 Pain Management

- **The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.**
- **Definitions of pain added:**
- *"**Acute Pain**" refers to pain that is usually sudden in onset and time-limited with a duration of less than 1 month and often is caused by injury, trauma, or medical treatments such as surgery. (From the Centers for Disease Control and Prevention (CDC)).*
- *"**Chronic Pain**" refers to pain that typically lasts greater than 3 months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause. (From the CDC).*
- *"**Subacute Pain**" refers to pain that has been present for 1–3 months. (From the CDC).*

J0700-J0850: Staff Assessment for pain

- Do not complete the Staff Interview if the resident interview should have been attempted and it was not attempted.

Staff Pain Assessment

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

☐	A. **Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
☐	B. **Vocal complaints of pain** (e.g., that hurts, ouch, stop)
☐	C. **Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
☐	D. **Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
☐	Z. **None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

J1100.	**Shortness of Breath (dyspnea)**
↓	**Check all that apply**
☐	**A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
☐	**B. Shortness of breath** or trouble breathing **when sitting at rest**
☐	**C. Shortness of breath** or trouble breathing **when lying flat**
☐	**Z. None of the above**
J1300.	**Current Tobacco Use**
Enter Code ☐	**0. No** **1. Yes**
J1400.	**Prognosis**
Enter Code ☐	Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation) **0. No** **1. Yes**
J1550.	**Problem Conditions**
↓	**Check all that apply**
☐	**A. Fever**
☐	**B. Vomiting**
☐	**C. Dehydrated**
☐	**D. Internal bleeding**
☐	**Z. None of the above**

J1100 Shortness of Breath

- **Item Rationale**
- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.
- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.
- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

J1100 Shortness of Breath

- **Steps for Assessment**
- Interview the resident about shortness of breath.
- If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.
- Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing.
- Observe the resident for shortness of breath or trouble breathing.
- If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

F689 Free of Accidents Hazards/ Supervision/Devices

- **The facility must ensure that –**
- **The resident environment remains as free of accident hazards as is possible; and**
- **Each resident receives adequate supervision and assistance devices to prevent accidents.**
- The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:
  - Identifying hazard(s) and risk(s);
  - Evaluating and analyzing hazard(s) and risk(s);
  - Implementing interventions to reduce hazard(s) and risk(s); and
  - Monitoring for effectiveness and modifying interventions when necessary.

J1300: Current Tobacco Use

- **Includes tobacco used in any form**
  - Does not include vaping, nicotine patches

- **Planning for Care**
- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.
- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.

J1400: Prognosis

- Coding Instructions
  - Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
  - Code 1, yes: if the medical record includes physician documentation:
    - that the resident is terminally ill; or
    - the resident is receiving hospice services.

J1550 Other Health Conditions

A. Fever

Defined as 2.4 degrees Fahrenheit higher than baseline. A temp of 100.4 F on admission is considered a fever. Important to obtain baseline temperature. Establishment of a baseline temperature is important.

B. Vomiting

C. Dehydrated ***Does require documentation of 2 or more of the 3 potential dehydration indicators listed:***

1) Usually takes in less than 1500 cc of fluid daily.

2) One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc.

3) Fluid loss that exceeds amount of fluids taken in.

D. Internal Bleeding

Do not include controlled nose bleeds, menses, UA with small blood. May include hematoma or ICH if can be proved it occurred during the lookback period.

Z. None of the above

- Documentation supports the coding decisions.
- Coding Tips J-28 through J-30

J1700: Fall History on Admission or Reentry

- Falls, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls,
- Ask the resident and family/significant other about falls in the last 6 months.
- Review inter-facility transfer information.
- Review all relevant medical records for evidence of one or more falls in the previous 6 months.

J1800: Falls Since Admission/Entry or Prior Assessment (OBRA or Scheduled PPS)

- If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
- If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the current ARD.
- Any fall since the last MDS, even if it occurred while out in the community, in an acute hospital, or in the nursing home.
- Review incident reports, fall logs and the medical record.
- Ask the resident and family about falls during the look-back period even if not documented in the medical record.

What are you calling a fall?

- Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) *or the result of an overwhelming external force (e.g., a resident pushes another resident).* An intercepted fall occurs is still considered a fall.
- A resident found of the floor or ground without knowledge of how they got there, is a fall.
- J1700: Fall History on Admission/Entry or Reentry (cont.)
- The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
- Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
- CMS understands that challenging a resident's balance and training them 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. *However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall. J-33*

J1900: Falls Since Admission or Most Recent MDS Without or With Injury

- J1900A-No injury
  - No evidence of injury seen; no c/o pain or injury, no change in resident behavior after the fall.
- J1900B-Injury (except major)
  - Includes*, but is not limited to*, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.
- J1900C-Major Injury
  - Includes*, but is not limited to, traumatic* bone fractures, joint dislocations/ *subluxations, internal organ injuries, amputations, spinal cord injuries,* head injuries, *and crush injuries*.

J1700. Fall History on Admission/Entry or Reentry

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?

- **0. No**
- **1. Yes**
- **9. Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2–6 months** prior to admission/entry or reentry?

- **0. No**
- **1. Yes**
- **9. Unable to determine**

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?

- **0. No**
- **1. Yes**
- **9. Unable to determine**

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

- **0. No** → Skip to J2000, Prior Surgery
- **1. Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:	↓	Enter Codes in Boxes
0. None 1. One 2. Two or more	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	**B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain
	☐	**C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Language at J1900

- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.
- Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results) and ensure that this information is used to code the assessment.
- **Coding Tips**
- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.
- *Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.*
- Examples updated

J2000-5000: Prior Surgery, Recent Surgery, and Surgical Procedures

- J2000: Only completed for 5-day PPS assessments
  - Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
  - 1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the SNF
  - 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.
- J2100: Recent Surgery Requiring Active SNF Care completed on PPS 5-day and OBRA assessments.
- Need to determine if this surgery requires active care during this stay.
- J2300 through J5000 Surgical Procedures, completed only if J2100= 1 (Yes). Documentation in the medical record is required to justify answers.

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code ☐

Did the resident have major surgery during the **100** days prior to admission?

0. No
1. Yes
8. Unknown

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Enter Code ☐

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

0. No
1. Yes
8. Unknown

This item is required by NC Medicaid/Myers and Stauffer

Section J: J2100
Recent Surgery Requiring Active SNF Care

- Complete only for PPS 5-day or OBRA assessments.
- For PPS: Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. Did that surgery require active care?
- For OBRA: Was the resident an inpatient in an acute care hospital for at least one day, and the surgery carried some degree of risk to the resident's life or the potential for severe disability within 30 days of the ARD. Did that surgery require active care? RAI page J-38
- Documentation is needed to justify answers.
- If 1. Yes, proceed to J2300-J5000.

Surgical Procedures

Complete only if J2100 = 1

↓	Check all that apply
	Major Joint Replacement
☐	**J2300. Knee Replacement** - partial or total
☐	**J2310. Hip Replacement** - partial or total
☐	**J2320. Ankle Replacement** - partial or total
☐	**J2330. Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400. Involving the spinal cord or major spinal nerves**
☐	**J2410. Involving fusion of spinal bones**
☐	**J2420. Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**

Complete only if J2100 = 1

↓	Check all that apply
	Other Orthopedic Surgery
☐	**J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520. Repair but not replace joints**
☐	**J2530. Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800. Involving genital systems** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐	**J2899. Other major genitourinary surgery**
	Other Major Surgery
☐	**J2900. Involving tendons, ligaments, or muscles**
☐	**J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐	**J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐	**J2930. Involving the breast**
☐	**J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐	**J5000. Other major surgery not listed above**