RAI MDS 3.0 Version 1.19.1 October 2024

Item Sets Version 1.19.1 October 2024

Presented by

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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 1.19.1, October 2024
- MDS Item Sets Version 1.19.1, October 2024

or

- State Operations Manual Appendix PP, Revised 3/24/25

Objectives
Participants will be able to:

- Recognize the impact of coding inaccuracies
- Define the key components of the Resident Assessment Instrument
- Review the Item Sets Version 1.19.1 effective October 1, 2024

The Importance of Accuracy

- The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis for:
  - The development of an individualized care plan
  - The Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - Quality monitoring activities, such as the quality measure reports
  - The data-driven survey and certification process
  - The quality measures used for public reporting
  - Research and policy development

Layout of the RAI Manual

- The layout of the RAI manual:
- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Coding Conventions, Overview to the Item-by-Item Guide to the MDS 3.0
- Chapter 4: Care Area Assessment (CAA) Process and Care Planning
- Chapter 5: Submission and Correction of the MDS Assessments
- Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

Layout of the RAI Manual Appendices

- Appendix A: Glossary and Common Acronyms
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (When Administered In Writing)
- Appendix F: MDS Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Item Sets

MDS RAI Manual Version 1.19.1 effective October 2024

- MDS RAI Manual version 1.19.1 and Item Sets available: https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

- Final Rule: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/administrative-information-memos-states-and-regions/fiscal-year-fy-2025-mission-priorities-document-mpd-action

Other helpful sites

CMS Nursing Home Resource Center

https://www.cms.gov/nursing-homes

CMS You-tube training videos June 2023

https://www.youtube.com/playlist?list=PLaV7m2-zFKphoXW6cc3NwUfxra0A1LYDi

Find the new MDS 3.0 Item Details

- SNF QRP Information webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation
- MDS 3.0 Technical Information: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation
- Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- Data submission specifications: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

Helpful Resource for Documentation

- Medicare Benefit Policy Chapter 8 Coverage of SNF Services:
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf
- NC Medicaid, Nursing Facility Services Clinical Coverage Policy:
- https://Medicaid.ncdhhs.gov/media/12254/open

- Myers and Stauffer:
- https://myersandstauffer.com/client-portal/north-carolina/

Choose “Spotlights and Announcements” for newest information for SNFs

Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 3/24/25:

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

- Resident Assessment
  - Regulations F635-F646
- Comprehensive Resident Centered Care Plans
  - Regulations F655-F661

CFR 483.20 Resident Assessments

- F635 Admission Physician Orders for Immediate Care
- F636 Comprehensive Assessments & Timing
- F637 Comprehensive Assessment After Significant Change (examples updated)
- F638 Quarterly Assessment At Least Every 3 Months
- F639 Maintain 15 Months of Resident Assessments
- F640 Encoding/Transmitting Resident Assessment
- F641 Accuracy of Assessments (F642 language incorporated)
- ~~F642 Coordination/Certification of Assessment~~
- F644 Coordination of PASARR and Assessments
- F645 PASARR Screening for MD & ID
- F646 MD/ID Significant Change Notification

CFR 483.21 Comprehensive Resident Centered Care Plans

- F655 Baseline Care Plan
- F656 Develop/Implement Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards (guidance, probes and deficiency categorization updated to include new schizophrenia and psychiatric diagnoses)
- F659 Qualified Persons
- ~~F660 Discharge Planning Process~~ Moved to F627 Transfer and Discharge
- ~~F661 Discharge Summary~~ Moved to F627 Transfer and Discharge

Regulation F636
Comprehensive Assessments & Timing

- *Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*
- *Comprehensive Assessments: Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's <u>needs, strengths, goals, life history and preferences</u>, using the resident assessment instrument (RAI) specified by CMS.*

Regulation F636
Comprehensive Assessments & Timing (continued)

- The assessment must include at least the following:
- (i) Identification and demographic information.
- (ii) Customary routine.
- (iii) Cognitive patterns.
- (iv) Communication.
- (v) Vision.
- (vi) Mood and behavior patterns.
- (vii) Psychological well-being.

Regulation F636
Comprehensive Assessments & Timing (cont.)

- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnosis and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin Conditions.
- (xiii) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures.

Regulation F636
Comprehensive Assessments & Timing (cont.)

- (xvi) Discharge planning.
- (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
- (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
- Not less than once every 12 months.

F636 Intent

- *INTENT: To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.*

F636 Guidance

- The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.
- The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, the resident's representative, family members, or outside consultants.

F636 Guidance (continued)

- At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.
- The facility must use the RAI process to develop a comprehensive care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

F640
Encoding/Transmitting Resident Assessment

- **INTENT**
- To ensure that facilities have provided resident specific information for payment and quality measure purposes.
- To enable a facility to better monitor each resident's decline and progress over time. Computer-aided data analysis facilitates a more efficient, comprehensive and sophisticated review of health data.

F640 Definitions, in part

- **"Accurate"** means that the encoded MDS data matches the MDS form in the clinical record. Also refer to guidance regarding accuracy at F641, and the information accurately reflects the resident's status as of the Assessment Reference Date (ARD).
- **"Capable of transmitting"** means that the facility has encoded and edited according to CMS specifications, the record accurately reflects the resident's overall clinical status as of the assessment reference date, and the record is ready for transmission.
- **"Complete"** means that all items required according to the record type, and in accordance with CMS' record specifications and State required edits are in effect at the time the record is completed.
- **"Discharge subset of items"** refers to the MDS Discharge assessment.
- **"Encoding"** means entering information into the facility MDS software in the computer.
- **"Transmitted"** means electronically transmitting to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, an MDS record that passes CMS' standard edits and is accepted into the system, within 14 days of the final completion date, or event date in the case of Entry and Death in Facility situations, of the record.

F640 Guidance

- Facilities are required to electronically transmit MDS data to the CMS System for each resident in the facility. The CMS System for MDS data is named the QIES ASAP System.
- For the subset of items required upon a resident's entry, transfer, discharge and death refer to Chapter 2 of the Long-Term Care Resident Assessment Instrument User's Manual for further information about these records.
  - For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- Submission must be according to State and Federal time frames. Electronically submit MDS information to the QIES ASAP system within 14 days:
- **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
- **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Regulation F641
Accuracy of Assessments

- **Accuracy of Assessments. The assessment must accurately reflect the resident's status.**
- ***Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.***
- ***Certification. A registered nurse must sign and certify that the assessment is completed.***
- ***Penalty for Falsification. Clinical disagreement does not constitute a material and false statement.***

F641 Intent

- *INTENT: To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.*

F641 Guidance

- Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.
- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

F641 Guidance (in part)

- ***Inaccurate MDS Diagnosis Coding*** *CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia.* For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment.
- This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

Regulation F655 Baseline Care Plans

- The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
- The baseline care plan must be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
  - (A) Initial goals based on admission orders. (B) Physician orders.
  - (C) Dietary orders. (D) Therapy services.
  - (E) Social services. (F) PASARR recommendation, if applicable.

F655 Intent

- Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

Regulation F656 Develop/Implement Comprehensive Care Plan

- *Comprehensive Care Plans: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.*
- *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.*
- *Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §483.10(c)(6).*

Regulation F656 (continued)

- *Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.*
- *In consultation with the resident and the resident's representative(s)— (A) The resident's goals for admission and desired outcomes. (B) 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. (C) Discharge plans in the comprehensive care plan, as appropriate.*

F656 Intent

- *INTENT: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.*

F656 Guidance

- GUIDANCE: Through the care planning process, facility staff must work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. If care planning is not complete, or is inadequate, the consequences may negatively impact the resident's quality of life, as well as the quality of care and services received.

Regulation F657 Care Plan Timing and Revision

- *A comprehensive care plan must be—*
- *Developed within 7 days after completion of the comprehensive assessment/CAA.*
- *Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.*
- *Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.*

F657 Intent

- *Intent: To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.*

F657 Guidance

- GUIDANCE: Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment. "After each assessment" means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS), except discharge assessments.
- For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.

Use of Dashes

- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system.
- A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
- Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
- There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
- QMs cannot be calculated, for example, when the use of a dash (-) indicates the SNF was unable to perform a pressure ulcer assessment. Left blank, it also means no assessment was done for that item.
- Coding Conventions RAI Page 3-4

Interim Payment Assessment (IPA)

- Optional
- Sets payment for remainder of the stay beginning on the ARD
- Too many IPAs may appear to CMS as you trying to manipulate the system
- Should have a plan to help determine when an IPA should be completed

IPA (continued)

- Look back period is 7 days unless otherwise indicated.
  - D0150 with a 14 day look back
  - GG0130 and GG0170 with 3 day look back
  - K0300 with 6 month look back
  - O0110 with a 14 day look back
- 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.

IPA (continued)

- 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.

Interviews

- Interview status should not be based on B0700, Makes Self Understood, rather, B0700 should be evaluated after all interviews have been attempted and coded.
- B0700 cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews as the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make self understood during the entire 7-day look-back.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

Interviews (continued)

- Use the resident's preferred language or method of communication.
- All residents capable of any communication should be asked about what is important in their care.
- DO NOT complete the staff interview if the resident interview should have been attempted and was not.

Interviews (continued)

- Basic approaches to make the interviews effective:
  - Introduce yourself and find a quiet, private area
  - Be sure the resident can hear you
  - Is an interpreter needed?
  - Sit where the resident can see you clearly
- See Appendix D for more techniques and tools.

Significant Change in Status Assessment

A SCSA is appropriate when:

— It is determined there has been a significant change (improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and

— The resident's condition is not expected to return to baseline within two weeks.

Hospice Services

- Electing Hospice or palliative care from an outside agency requires a SCSA to coordinate care and care plans.
- In-house palliative care services are not indicated on the MDS, a SCSA is not required but the resident should be evaluated for a SCSA and the care plans need to be updated to reflect palliative care.
- CMS does not differentiate between levels of Hospice services, only that they are received.
- O0110K indicates Hospice services for terminally ill persons. If a resident is receiving outside palliative services through a Hospice provider and is terminally ill, it should be counted here.
- J1400 should be marked when a resident has a life expectancy of 6 months or less and/or is receiving Hospice services marked at O0100K.
- Residents with non-terminal conditions receiving palliation services from a Hospice provider should not be marked.

Hospice then Discharges to Hospital

Example: A resident receiving hospice services was sent out and admitted to the hospital. The facility completed a Discharge return-anticipated and transmitted it.

If, upon return to the facility, the resident re-enrolls in hospice services, then a SCSA is required, *whether or not it is the same hospice provider.* This is to ensure a coordinated plan of care between the hospice and nursing home is in place.

- RAI Panel 1/23/2018

Review of the Optional State Assessment

- An OSA must be completed with each federally required OBRA and PPS assessment regardless of payer source.
- An OSA is not required with an IPA.
- An OSA is not required with discharge assessments unless the discharge assessment is combined with another OBRA or PPS assessment.
- The OSA is not required to be completed concurrent to a stand-alone Part A PPS Discharge.

Combining PPS Assessments and OBRA Assessments

- SNF providers are required to meet both OBRA and PPS standards in a Medicare certified nursing facility:

- When the OBRA and PPS assessment time frames coincide (except the IPA), one assessment may be used to satisfy both requirements.

- PPS and OBRA assessments (except the IPA) may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and PPS assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met, and all required items are completed. RAI page 2-48

RAI pages 2-17
through 2-19

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look-Back) Consists Of	14-day Observation Period (Look-Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day *and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)*
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day *and must be combined with a Part A PPS Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000)*

From RAI page 2-47

PPS Assessments, Tracking Records, and Discharge
Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or *is* combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Section A: Identification Information

- Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

Section A:
Identification Information

Remember:

The CMS Database

matching process includes:

- First Name
- Last Name
- Social Security Number
- Gender
- Date of Birth
- Please communicate with your business office regarding any changes to the resident’s demographic information

Section A

- A0310A: OBRA assessment schedule
- A0310B: PPS Assessment
  - PPS Scheduled Assessment for a Medicare Part A Stay
    - 01. 5-day scheduled assessment
  - PPS Unscheduled Assessment for a Medicare Part A Stay
    - 08. IPA- Interim payment Assessment
- A0310F: Entry/discharge reporting
- A0310G: Type of Discharge
- A0310G1: Is this a SNF Part A Interrupted Stay?
- A0310H: Is this a SNF Part A PPS Discharge Assessment?

OBRA Required Assessments - A310A

- 01. Admission (comprehensive)
- 02. Quarterly
- 03. Annual (comprehensive)
- 04. Significant Change in Status Assess (comprehensive)
- 05. Significant Correction to Prior Comprehensive (comprehensive)
- 06. Significant Correction to Prior Quarterly

OBRA Required Assessments

- Coding Instructions for A0310A, Federal OBRA Reason for Assessment
- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code “99”.
  - 01. Admission assessment (required by day 14)
  - 02. Quarterly review assessment
  - 03. Annual assessment
  - 04. Significant change in status assessment
  - 05. Significant correction to prior comprehensive assessment
  - 06. Significant correction to prior quarterly assessment
  - 99. None of the above

A0310: OBRA Required Assessments

- Certified beds (Title 18 and/or Title 19): OBRA schedule is required and transmitted regardless of the payer source.
- Licensed only beds are *not* transmitted.
- If you accidently transmit a record for a licensed only bed, you need to call me. A manual Correction/Deletion Request Form will need to be completed.

A0310B
PPS Assessments

- A0310B: PPS Scheduled Assessments include:
  - 01. 5-day scheduled assessment
- PPS Unscheduled Assessment include:
  - 08. IPA- Interim payment Assessment

- A0310H: PPS Part A Discharge

PPS 5-day
Factors Impacting Scheduling

- Resident Transfers, Discharges or Expires Before or On the Eighth Day of SNF Stay:
- If the resident is discharged from the SNF or the Medicare Part A stay ends before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required.
- If there is not a PPS assessment in the iQIES system, the provider must bill the default rate for any Medicare days. PPS and OBRA discharges and Death in facility Trackers continue to apply.

PPS 5-day
Factors Impacting Scheduling (continued)

- If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF to resume Part A coverage, the resident requires a new 5-Day assessment, unless it is an instance of an interrupted stay. If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form. An IPA may be completed, if deemed appropriate.
- RAI page 2-52

A0310F/A0310G/A0310G1/A0310H: Entry/Discharge Reporting Required for all residents

- A0310F
  - 01. Entry tracking record
  - 10. Discharge assessment- return not anticipated
  - 11. Discharge assessment- return anticipated
  - 12. Death in facility tracking
  - 99. None of the above
- A0310G Type of Discharge
  - 1. Planned, 2. Unplanned
- A0310G1 Is this a SNF Part A Interrupted Stay?
  - 0. No, 1. Yes
- A0310H Is this a SNF Part A PPS Discharge Assessment?
  - 0. No, 1. Yes

A0310F: Entry/Discharge Reporting

Entry Record

Completed within 7 days every time a person is **admitted or readmitted** into a nursing home (or swing bed facility)

Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)

Submit before the next assessment

Required in addition to the initial Admission assessment or other OBRA or PPS assessments

Cannot be combined with an assessment

Needs to be completed even if in the facility for a short period of time

Discharge Assessment and Record

Not associated with the bed hold status or opening and closing of the medical record

A0310H SNF PPS Part A Discharge (End of Stay) Assessment

- A Part A PPS Discharge assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility

- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000)
- Needs to be completed even if in the facility for a short period of time

Section A (continued) Interrupted Stay

- A0310G1: Is this a SNF Part A Interrupted Stay? Yes or No
- DEFINITIONS:
  - Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.
  - Interruption Window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the same SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

A0410

- A0410 Unit Certification or Licensure Designation

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State

2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State

3. Unit is Medicare and/or Medicaid certified

Section A (continued)

- A0500: Legal Name of Resident: First and Last Names: needs to be what Medicare has on file, match the Medicare/Medicaid card, the common working file.
- A0500 D: Suffix: *Please use!*
- A0600A Social Security Number
- A0700 Medicaid Number
- A0800 Gender: What it says on the Medicare card.
- A0900 Date of Birth
- Used in the CMS Database Matching Process!

- A2400 Medicare Stay: This is for traditional Medicare ONLY

A1005 Ethnicity

Section A	Identification Information

A1005. Ethnicity

Are you of Hispanic, Latino/a, or Spanish origin?

↓ **Check all that apply**

- ☐ **A.** No, not of Hispanic, Latino/a, or Spanish origin
- ☐ **B.** Yes, Mexican, Mexican American, Chicano/a
- ☐ **C.** Yes, Puerto Rican
- ☐ **D.** Yes, Cuban
- ☐ **E.** Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

A1005 Ethnicity Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- Code X, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, *including* X. Resident unable to respond.

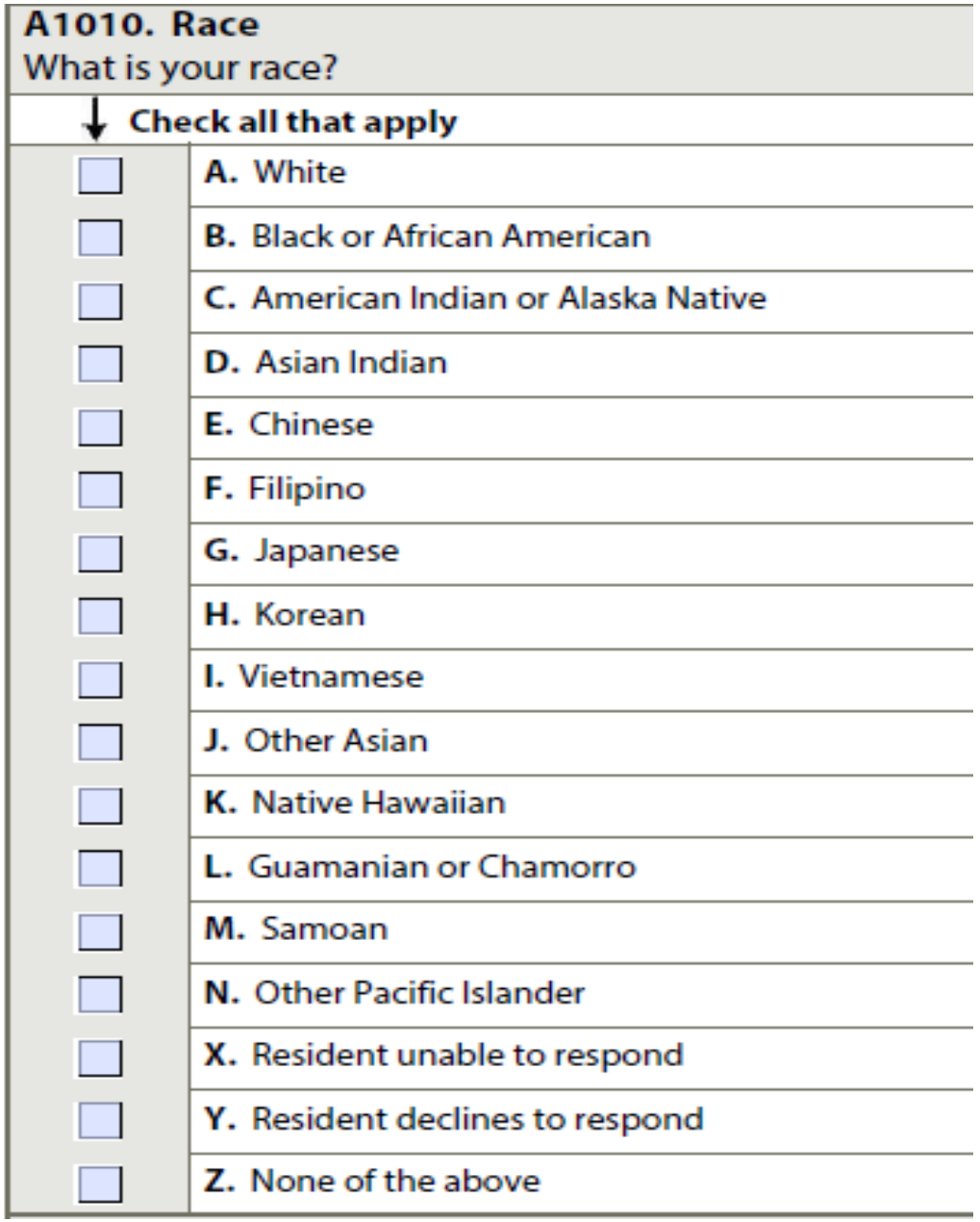
If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1005 as X. Resident unable to respond.

- Code Y, Resident declines to respond:

When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

RAI page A-15-A18



A1010. Race
What is your race?

↓ **Check all that apply**

- ☐ **A.** White
- ☐ **B.** Black or African American
- ☐ **C.** American Indian or Alaska Native
- ☐ **D.** Asian Indian
- ☐ **E.** Chinese
- ☐ **F.** Filipino
- ☐ **G.** Japanese
- ☐ **H.** Korean
- ☐ **I.** Vietnamese
- ☐ **J.** Other Asian
- ☐ **K.** Native Hawaiian
- ☐ **L.** Guamanian or Chamorro
- ☐ **M.** Samoan
- ☐ **N.** Other Pacific Islander
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond
- ☐ **Z.** None of the above

A1010 Race

- Race and Ethnicity will become Standardized Patient Assessment Data Elements (SPADEs) for SNF QRP starting 10/1/23.
- To aid in completing a culturally competent and trauma-informed comprehensive care plan.

A1010 Race Coding Instructions

If the resident provides a response, check the box(es) indicating the ethnic category or categories identified by the resident.

- **Code X**, Resident unable to respond:

In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply*, including* X. Resident unable to respond.

If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code A1010 as X. Resident unable to respond.

- **Code Y**, Resident declines to respond:

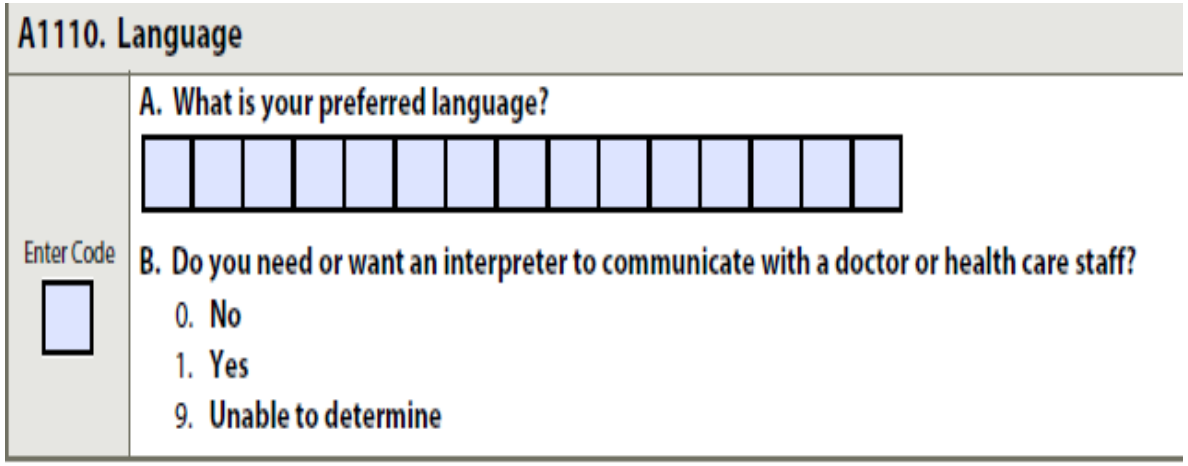
When the resident declines to respond, code only Y. Resident declines to respond.

When the resident declines to respond do not code based on other resources (family, significant other, or legally authorized representative or medical records).

- **Code Z**, None of the above: if the resident reports or it is determined from other resources that none of the listed races apply.

RAI page A-19 – A-22

A1110 Language


A1110. Language

Enter Code

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.

2. If the resident is unable to respond, a family member or significant other should be asked.

3. If neither source is available, review record for evidence of a need for an interpreter.

4. If an interpreter is wanted or needed, ask for preferred language.

5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Section A1250 Transportation

A1250. Transportation (from NACHC©)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

↓ **Check all that apply**

- ☐ **A.** Yes, it has kept me from medical appointments or from getting my medications
- ☐ **B.** Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
- ☐ **C.** No
- ☐ **X.** Resident unable to respond
- ☐ **Y.** Resident declines to respond

Only completed for

PPS 5-day

or

Planned + PPS discharge

*Assessing for transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

A1250 Transportation- Steps for Assessment

1. *Ask the resident:*

• *"In the past six months to a year, has lack of transportation kept you from medical appointments or from getting your medications?"*

• *"In the past six months to a year, has lack of transportation kept you from non-medical meetings, appointments, work, or from getting things that you need?"*

2. *Respondents should be offered the option of selecting more than one "yes" designation, if applicable.*

3. *If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.*

4. *Only if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative may provide a response for this item, use medical record documentation.*

5. *If the resident declines to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).* *RAI page A-26 to A-27*

A1500 –Preadmission Screening and Resident Review (PASRR)

- PASRR is a preadmission screening process.
- A positive screen indicates the resident has a mental illness, intellectual disability, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Reports on the results of the PASRR process.
- Only completed on the OBRA comprehensive MDS assessments.

PASRR Help Desk 888-245-0179, 919-813-5603

https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/pre-admission-screening-and-resident-review-pasrr

https://ncliftss.acentra.com/pasrr/

A1500: PASRR

- NCMUST (919) 816-3015, (888) 245-0179 or (919) 318-5550,
- Not everyone with MI is a Level II PASRR.
- Everyone with ID/DD should be a Level II PASRR.
- All known Level II PASRR residents need to have a referral completed for any significant change in status identified. Do not wait until the SCSA assessment has been completed to make this referral.
- Level I residents who experience a psychiatric episode, have a new psychiatric diagnosis or have been placed on antipsychotic medications should have a Level II PASRR referral made (RAI page 2-30 to 2-31).

PASRR Level II for Referral

- ***§483.20(e)(2) Refer all level II residents and all residents with newly evident or possible serious mental disorder (MI), intellectual disability (ID), or a related condition for level II resident review upon a significant change in status assessment***
- ***F644, F645, F646***

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month – Day – Year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1805. Entered From

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

A1900. Admission Date (Date this episode of care in this facility began)

Month – Day – Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A1805 Entered From

A2105. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements) → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
13. **Deceased**
99. **Not listed** → Skip to A2123, Provision of Current Reconciled Medication List to Resident at Discharge

A2105 Discharge Status

A2121 Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
Complete only if A0310H = 1

Enter Code ☐

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No** - Current reconciled medication list not provided to the subsequent provider → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the subsequent provider

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.
Complete only if A2121 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record**
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123. Provision of Current Reconciled Medication List to Resident at Discharge
Complete only if A0310H = 1

Enter Code ☐

At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

0. **No** - Current reconciled medication list not provided to the resident, family and/or caregiver → Skip to A2200, Previous Assessment Reference Date for Significant Correction
1. **Yes** - Current reconciled medication list provided to the resident, family and/or caregiver

A2121 Completed only on SNF Part A PPS DC and A2105= 02-12

A2122 Completed only if A2121= Yes

A2123 Completed only on SNF Part A PPS DC

SNF QRP will begin collecting data on Transfer of Health (TOH) Information to the provider and to the resident. Documentation supports the MDS.

*Need a process for documentation and communication of the reconciled medication list.

How does this get coded if staying in the facility?

In the case of a standalone Medicare Part A PPS Discharge assessment with the resident staying on the same unit and with the same team of interdisciplinary professionals, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge as 1, Yes.

In the case of a standalone Medicare Part A PPS Discharge assessment and the resident is moving to a different unit and/or IDT, code A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge based on whether a member of the resident's IDT transferred the resident's current reconciled medication list to the subsequent unit and/or IDT.

RAI pages A-44 to A-47

A2124 Route of Current Reconciled Medication List Transmission to Resident
Only completed if A2123=1 (Yes)

Section A	Identification Information

A2124. Route of Current Reconciled Medication List Transmission to Resident

Indicate the route(s) of transmission of the current reconciled medication list to the resident/family/caregiver.
Complete only if A2123 = 1

Check all that apply ↓	Route of Transmission
☐	**A. Electronic Health Record** (e.g., electronic access to patient portal)
☐	**B. Health Information Exchange**
☐	**C. Verbal** (e.g., in-person, telephone, video conferencing)
☐	**D. Paper-based** (e.g., fax, copies, printouts)
☐	**E. Other methods** (e.g., texting, email, CDs)

A2123 At the time of DC, did your facility provide the resident's current reconciled medication list to the resident, family and/or caregiver?

1.= Yes- Current reconciled medication list provided to the resident, family and/or caregiver.

Completed only on SNF Part A PPS DC

Assessment Reference Date

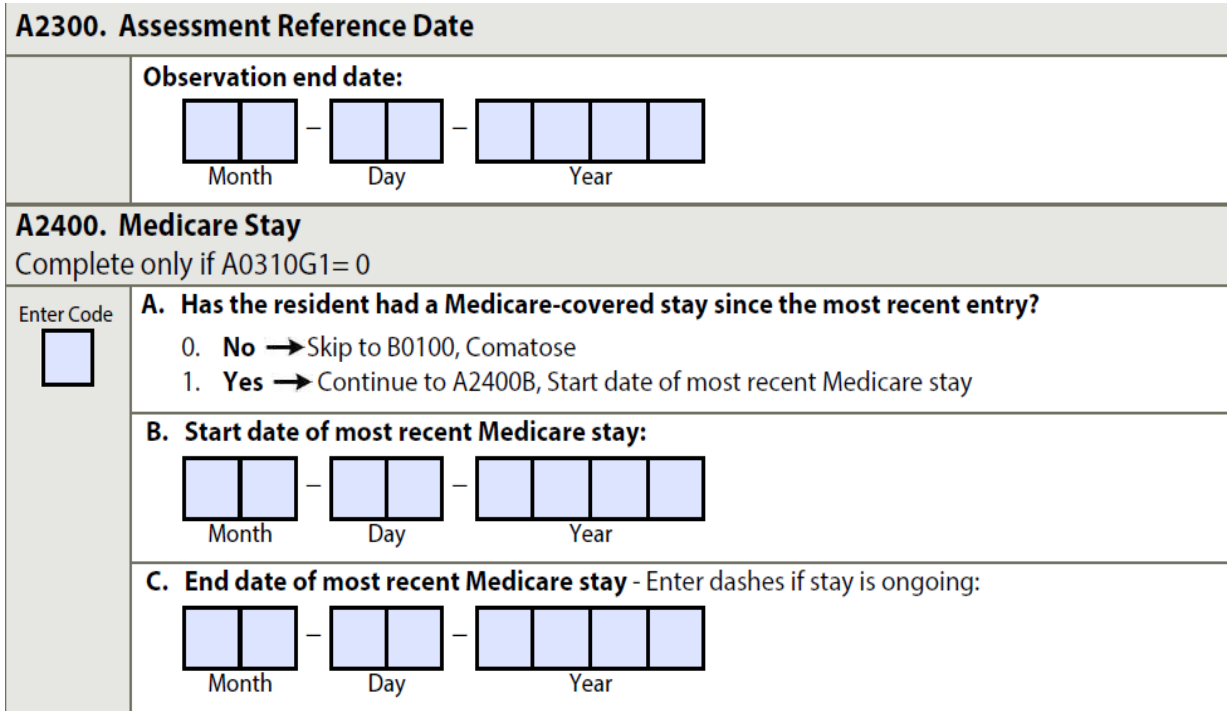
- **Assessment Reference Date (ARD)** refers to the *specific endpoint for* the observation (or "look-back") period*s in the MDS assessment process.* The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed.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

RAI page 2-9

Section A

- ITEMS WHICH DID NOT CHANGE:

- A2200 Previous Assessment Reference Date for Significant Correction
- A2300 Assessment Reference Date
- A2400 Medicare Stay



A2300. Assessment Reference Date

Observation end date:

Month – Day – Year

A2400. Medicare Stay

Complete only if A0310G1= 0

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

Month – Day – Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

Month – Day – Year

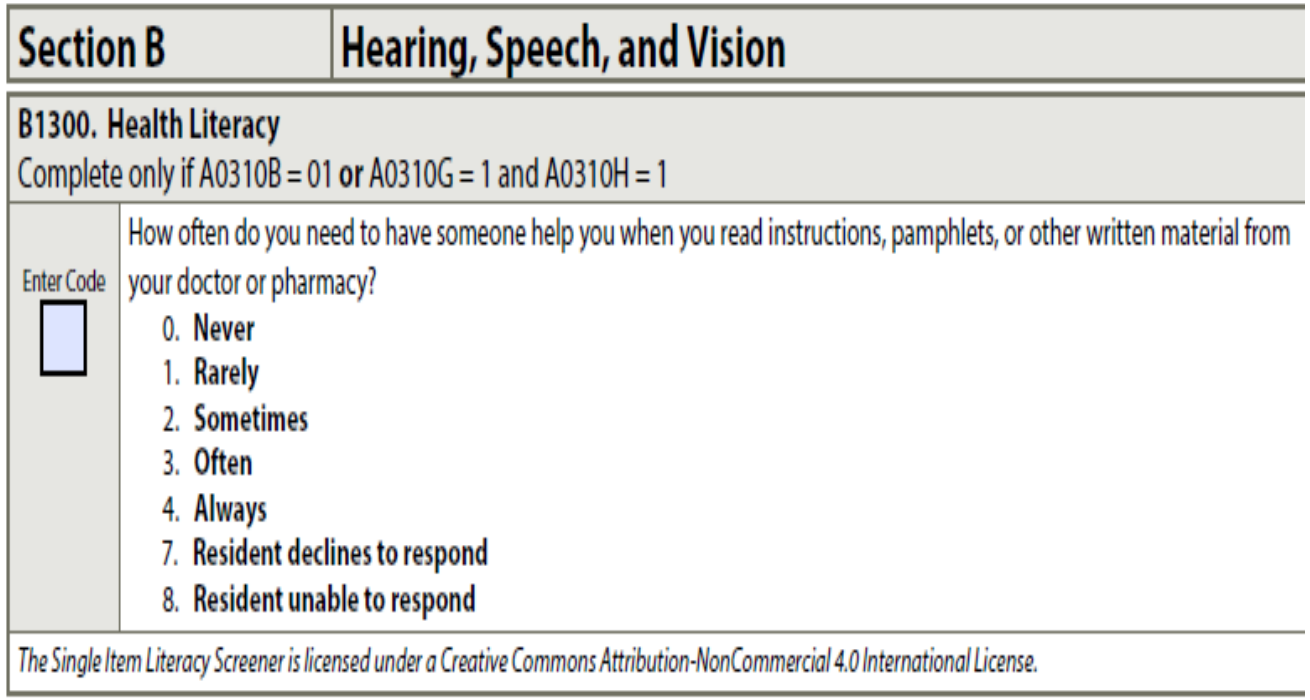
Section B:
Hearing, Vision, and Speech

Need examples and dates in documentation!

- B0100 Comatose: needs to be documented by a physician to count.
- B0200 Hearing: should be conducted in a private, quiet spot. The resident may need to use an amplifier. The resident does not need to own the device to use it for the assessment.
- B0600 Speech Clarity: if the resident is “aphasic” but is able to speak 1-2 words clearly, this should be coded as “clear speech.” It is about the clarity of the words, not the content or intended message.
- Section B0600 Speech Clarity and B0700 Makes Self Understood are assessing different things!

B0700: Makes Self Understood

- This item cannot be coded as Rarely/Never understood if the resident completed any of the resident interviews. As the interviews are conducted during the look-back period for this item and should be factored in when determining the resident's ability to make them self understood during the entire 7 day look back.
- This includes the ability to express or communicate requests, needs, opinions and to conduct social conversations in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood can included reduced voice volume and difficulty in producing sounds, finding the right word, making sentences, writing and/or gesturing.
- This should be coded after 11:59 PM of the ARD, taking into account all information.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.



Section B	Hearing, Speech, and Vision

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

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

The Single Item Literacy Screener is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License.

Glossary page A-10

Health Literacy *The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.*

Section B1300 Health Literacy

- Resident self-reported item
- Completed for 5-day PPS or Planned PPS Discharge
- Should include this information on the resident's care plan.
- F552 Right to be Informed/Make Treatment Decisions

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.
- If all the BIMS items are coded with a dash (-), then C0500, BIMS Summary Score must also be coded with a dash (-). RAI page C-17
- 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

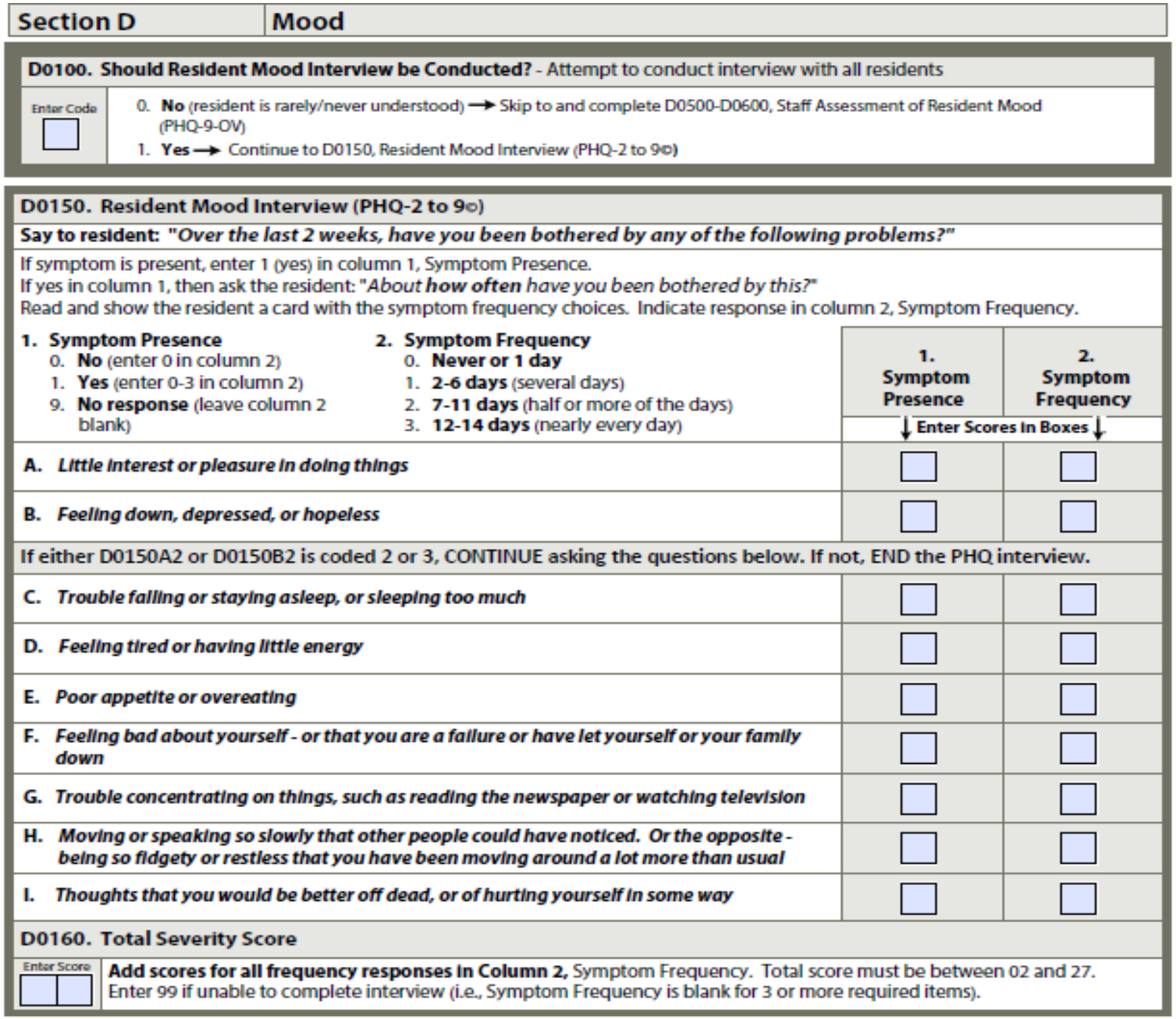
- C0600 Should the Staff Assessment for Mental Status be Conducted?
- C0700 Short-term Memory OK
- C0800 Long-term Memory OK
- C0900 Memory/Recall Ability
- C1000 Cognitive Skills for Daily Decision Making
- C1310 Signs and Symptoms of Delirium

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.

Section D: Mood

- 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	Mood

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©)

D0150. Resident Mood Interview (PHQ-2 to 9©)

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
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.		
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 02 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items).

MDS 1.18.11 Section D

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

If not, end the PHQ interview

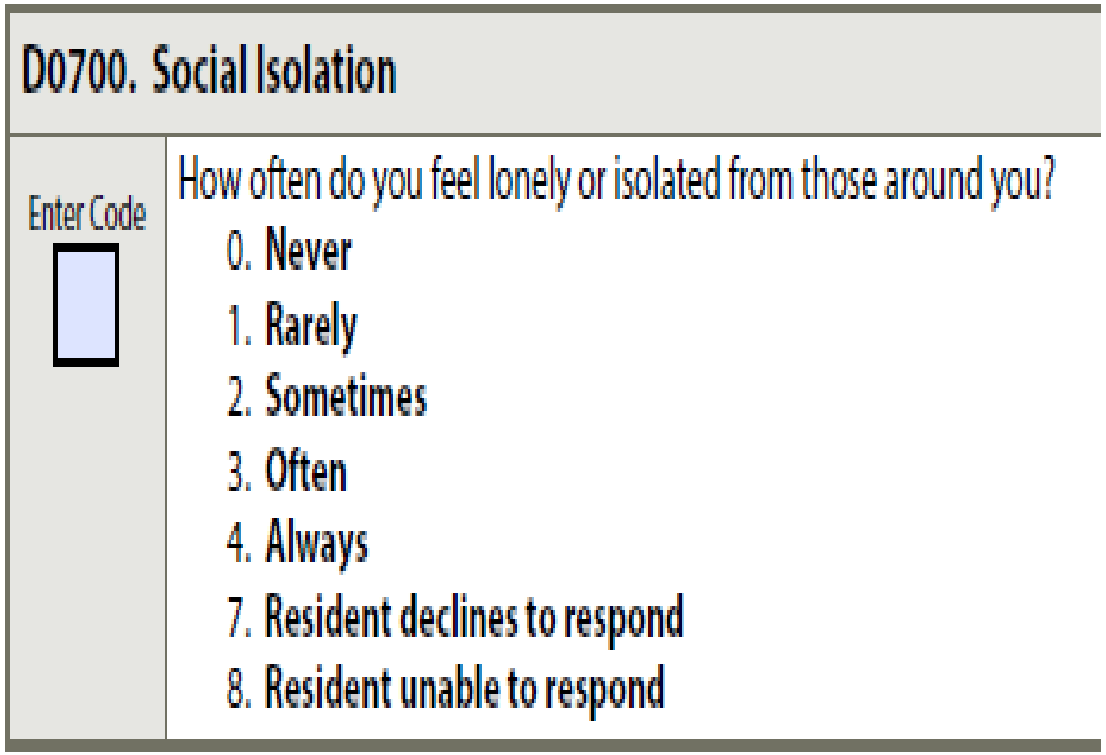
Section D (PHQ-9)

- 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.

Section D (continued)

- D0500: 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.

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.

Section E | Behavior

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 & 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
1. **Yes** → Considering all of E0200, Behavioral Symptoms, 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 & 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**

Section E | Behavior

E0900. Wandering - Presence & 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 of 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**

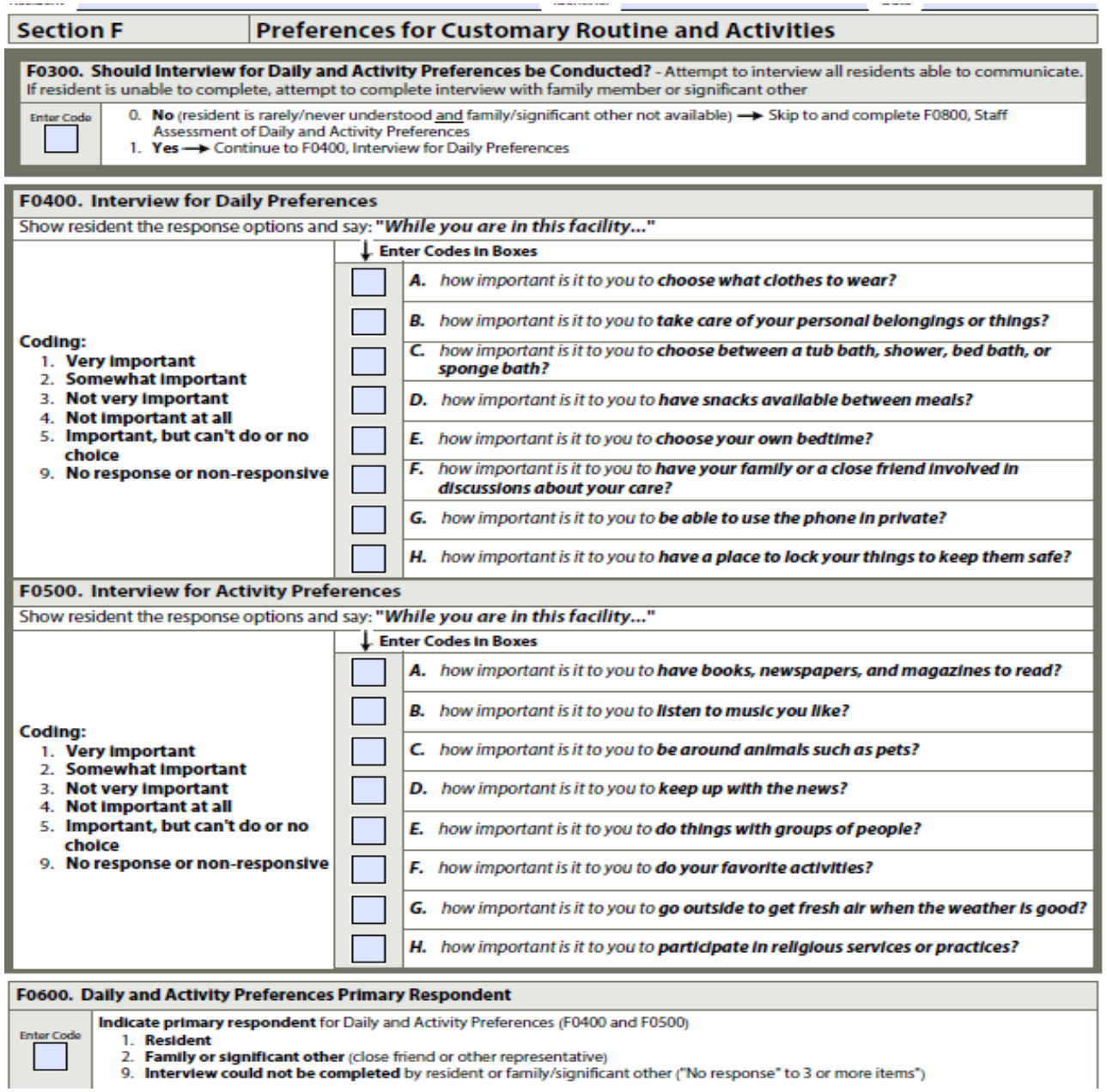
E1100. Change in Behavior or Other Symptoms

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

MDS 1.18.11 Section F



Section F | **Preferences for Customary Routine and Activities**

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes

- **A.** *how important is it to you to* ***choose what clothes to wear?***
- **B.** *how important is it to you to* ***take care of your personal belongings or things?***
- **C.** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
- **D.** *how important is it to you to* ***have snacks available between meals?***
- **E.** *how important is it to you to* ***choose your own bedtime?***
- **F.** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
- **G.** *how important is it to you to* ***be able to use the phone in private?***
- **H.** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes

- **A.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
- **B.** *how important is it to you to* ***listen to music you like?***
- **C.** *how important is it to you to* ***be around animals such as pets?***
- **D.** *how important is it to you to* ***keep up with the news?***
- **E.** *how important is it to you to* ***do things with groups of people?***
- **F.** *how important is it to you to* ***do your favorite activities?***
- **G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
- **H.** *how important is it to you to* ***participate in religious services or practices?***

F0600. Daily and Activity Preferences Primary Respondent

Enter Code

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

MDS 1.18.11 Section F

Section F	Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete GG0100, Prior Functioning: Everyday Activities
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

Check all that apply

☐	A. Choosing clothes to wear
☐	B. Caring for personal belongings
☐	C. Receiving tub bath
☐	D. Receiving shower
☐	E. Receiving bed bath
☐	F. Receiving sponge bath
☐	G. Snacks between meals
☐	H. Staying up past 8:00 p.m.
☐	I. Family or significant other involvement in care discussions
☐	J. Use of phone in private
☐	K. Place to lock personal belongings
☐	L. Reading books, newspapers, or magazines
☐	M. Listening to music
☐	N. Being around animals such as pets
☐	O. Keeping up with the news
☐	P. Doing things with groups of people
☐	Q. Participating in favorite activities
☐	R. Spending time away from the nursing home
☐	S. Spending time outdoors
☐	T. Participating in religious activities or practices
☐	Z. None of the above

Section F: Preferences for Customary Routine and Activities

- F0300: 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 conduct the interview with the family or significant other. If the interview could not be completed, then skip to the staff assessment.
- Documentation would be expected if the resident or family were not interviewed.
- If the assessment should have been done during the look back period and *WAS NOT*, code F0300 as YES and dash (-) the information.

Section F (continued)

- Section F is about the quality of their life. These questions are only asked on comprehensive assessments, but it is okay to ask these questions more frequently.
- Please include preferences in the care plan!
- Review and take into consideration how the resident answered D0700 Social Isolation.
- Surveyors ask many of these questions when interviewing residents.
  Get there before they do!

Section GG

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

Section GG: Functional Abilities

- 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
  - 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.

GG 0100 Coding: Prior Functioning

- Code 3, Independent: if the resident completed the activities by himself or herself, 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.

GG 0100 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.

GG0115 Functional Limitation in ROM- previously G0400

GG0120 Mobility Devices- previously G0600

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

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

GG0130: Self Care and GG0170: Mobility Coding

PPS and OBRA assessments

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

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

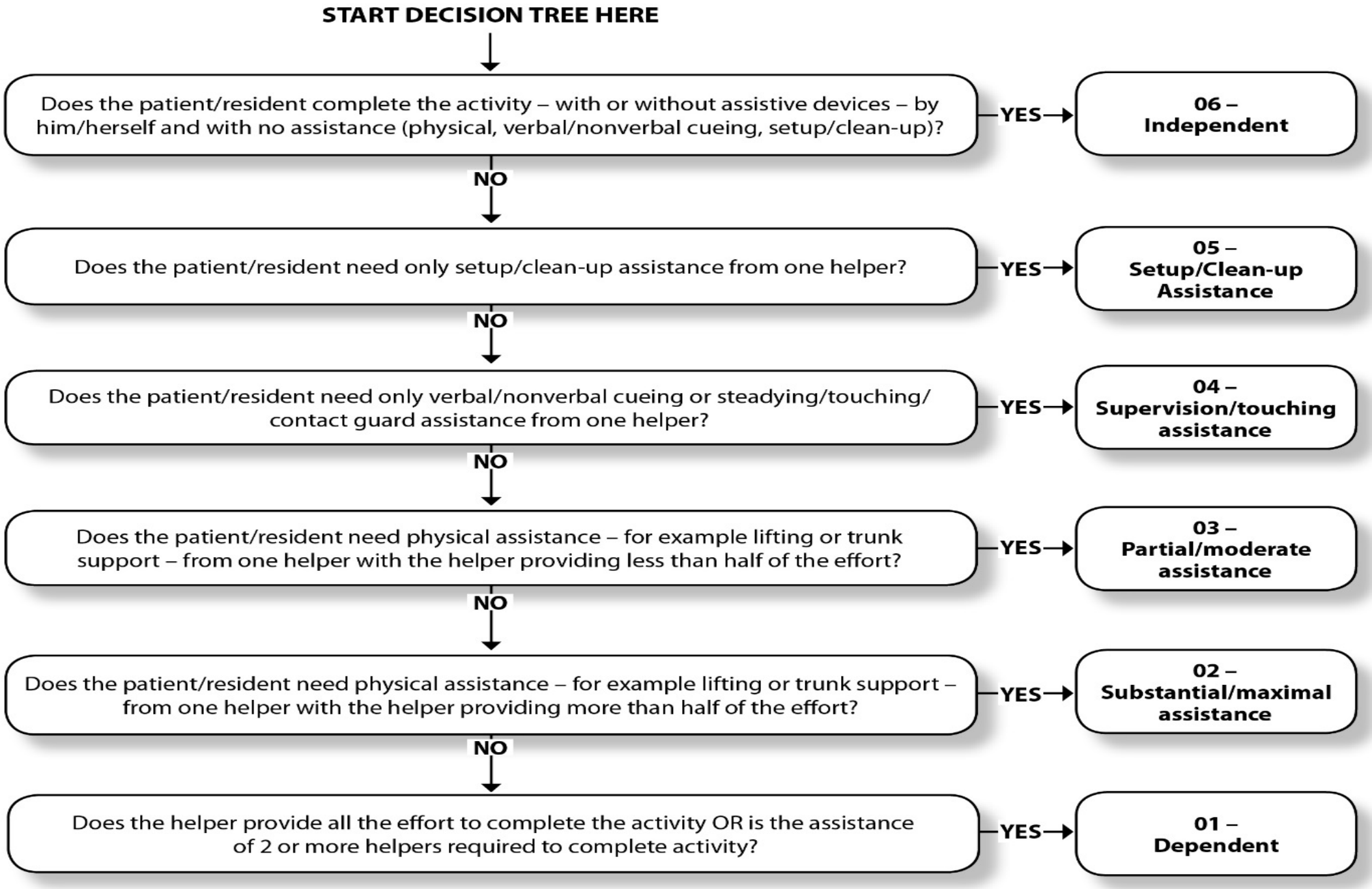
- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 10, Not attempted due to environmental limitations: 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-18

- 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 - Admission Self-Care

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.

- GG0130 Self-Care (Assessment period is the first 3 days of the stay) Complete if an Admission or 5-day PPS.
- The 5-day PPS 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.

GG0130 Functional Abilities
Self-Care Admission or 5-day PPS

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
Mobility Admission or 5-day PPS

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.
- The 5-day PPS stay begins on A2400B.
- If not a PPS assessment, the stay begins on A1600.

GG0170 Functional Abilities
Mobility Admission or 5-day PPS

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 and Goals Mobility Admission or 5-day PPS

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

- 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
Self-Care Discharge

- Assessment period is the last 3 days of the stay.
- Complete only if A0310F=10 or 11 or A0310H=1.
  - 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
Self-Care Discharge

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 Mobility Discharge

- Assessment period is the last 3 days of the stay.
- Complete only if A0310F=10 or 11 or A0310H=1.
  - 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 Mobility Discharge

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
Mobility Discharge

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.

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 Self-Care OBRA/Interim

- 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 Self-Care OBRA/Interim

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 Mobility OBRA/Interim

- 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
Mobility OBRA/Interim

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
Mobility OBRA/Interim

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

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**

Section H

- **DEFINITIONS**
  EXTERNAL CATHETER

Device attached to the shaft of the penis like a condom, *a female external catheter, or other non-invasive urine output management device or system that routes urine* to a drainage bag.

- **Coding Tips and Special Populations**

Female external catheters and other non-invasive urine output management devices or systems should be coded as external catheters (H0100B).

RAI pages H-2 and H-3

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.

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.

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

- The *primary reason* for admission will determine the clinical grouping for each resident.
- Many previously used diagnoses have been determined to be too vague to single out a clinical grouping. This may result in a "return to provider" claim status with the claim being sent back to the provider for proper coding and resubmission.
  - Examples include muscle weakness, dysphagia, difficulty walking, unsteadiness on feet, abnormalities of gait and mobility, unspecified convulsions, history of falls, hypotension, and other codes with unspecified sites, or unspecified diseases.
- Examples start on page I-3
- Myers & Stauffer require this item to be answered

I0020 Indicate the Resident's Primary Medical Condition Category OBRA Assessments

- I0020: Indicate the resident's primary medical condition category is coded when A0310A= 01, 02, 03, 04, 05, 06, A0310B=01
- 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.
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
- This is an active diagnosis indicating the primary reason for the SNF stay.

Section I: 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

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.

Clarification

- Item I2100 Septicemia:
- For sepsis to be considered septicemia, there needs to be inflammation due to sepsis and evidence of a microbial process.
- If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia.
- If the medical record does not reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses.

RAI page I-13

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.

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.
- I8000 Additional active diagnoses.

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.

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

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
1. **Yes** → Continue to J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

MDS 1.18.11 Section J

ITEMS WHICH DID NOT CHANGE:

J0100 Pain Management
J0200 Should Pain Assessment Interview be Conducted?
J0300 Pain Presence

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

Pain Frequency Resident Interview

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

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.

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.

J1300: Current Tobacco Use

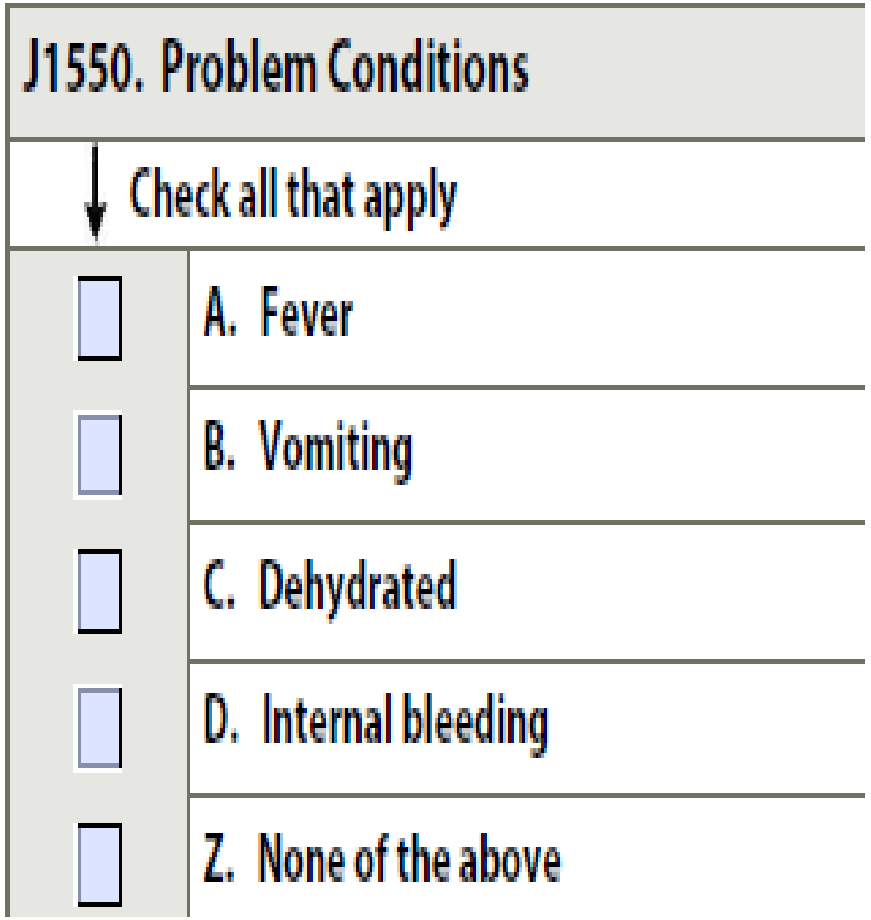
- **Includes tobacco used in any form**
  - Does not include vaping, nicotine patches

- **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: Problem Conditions



- Establishment of a baseline temperature is important.
- Documentation supports the coding decisions.
- Coding Tips J-29 to 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?

- An unintentional change in position coming to rest on the ground, floor or onto the next lower surface.
- Falls are not a result of an overwhelming external force.
- 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.
- CMS understands that challenging a resident's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

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)
  - 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
  - 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.
- 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 QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

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. M&S need this item answered
- 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.

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.

Section K: Swallowing/Nutritional Status

- The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

Section K: Swallowing/Nutritional Status

- K0100 Swallowing Disorder: need to observe the resident and ask staff who work with the resident if any of these signs and symptoms were present during the look back period.
- K)200A Height: Should be measured annually.
- K0200B Weight: Record the weight, on the most recent measure in the last 30 days, *closest* to the ARD.
- K0300 Weight Loss: Since this looks back 6 months, it may not capture weight loss from 3 months ago. If weight loss has been recognized and the resident has already regained some weight this would still need to be addressed. Explain in the CAA or the resident's record.
  - This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

K0300: Weight loss

- Physician Prescribed Weight-loss Regimen
- A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight-loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.
- To code K0300 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.

Section K (continued)

- K0520 Nutritional Approaches:
  - Trial diets not captured RAI page K-13

- K0520 A Parenteral/IV feeding: Needs documentation that reflects the need for additional fluids to address nutrition, hydration or prevention.
- K0510B Feeding tube: Only mark this if used for nutrition or hydration.

K0520 Modified Definition of Feeding Tube

DEFINITIONS

FEEDING TUBE

Presence of any type of tube that can deliver food/ nutritional substances/ fluids directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes. RAI page K-10

- Coding tip matches the black box definition

- **Coding Tip for K0520B**
- Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B. RAI page K-12

Section K0520

K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. **On Admission**
   Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B
2. **While Not a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 2 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 2 blank.
3. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
4. **At Discharge**
   Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

Check all that apply

	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
A. **Parenteral/IV feeding**	☐	☐	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐		☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐		☐	☐
Z. **None of the above**	☐	☐	☐	☐

- Nutritional Approaches include new time frames

1. On Admission: Assessment period is days 1-3 of the SNF PPS starting with A2400B

2. While Not a Resident: Performed while not a resident of the facility and within the last 7 days. If the resident entered 7 or more days ago, leave column 2 blank.

3. While a Resident: Performed while a resident and within the last 7 days.

4. At Discharge: Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C.

K0520 Parenteral/IV Feeding

- **Coding Tips for K0520A**
- IV fluids can be coded in K0520A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and*/or* hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record. RAI page K-12

K0520A: Parenteral/IV Feeding

- Include only if given for nutrition or hydration and when there is documentation addressing the need.
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy

K0710

K0710: Percent Intake by Artificial Route

Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B.

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 7 days***
3. **During Entire 7 Days**
   Performed during the entire ***last 7 days***

	2. While a Resident	3. During Entire 7 Days
	↓ Enter Codes ↓	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	☐	☐

Section L

- L0200 Dental

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

Section L: Oral/Dental Status

- L0200B: No natural teeth or tooth fragments (edentulous). This means complete tooth loss.
- Dentures are not natural teeth.
- Implants are permanently affixed hardware and are considered natural teeth as they are not removable.
- F676, F677 ADLs and F790, F791 Dental Services

Section L (continued)

- Residents who have some, but not all of their natural teeth, that do not appear damaged, broken, loose, or with obvious or likely cavity and do not have any other conditions in L0200 A-G should be coded at L0200Z, a none of the above.
- Many residents have dentures or partials that fit well and work properly. For individualized care planning purposes, consideration should be taken to make sure residents are in possession of their dentures or partials and that they are being utilized properly for meals, snack, med pass and social activities. Also, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

MDS 1.18.11 Section M

No new items for Section M

Section M: Skin Conditions

- If a Pressure Ulcer heals on or before the ARD, it is not captured.
- Wounds do not heal in reverse. Page M-7 discusses backstaging.
- M0300E: Unstageable-Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Only code with supporting documentation in the record.
- A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable. M-8

Present on Admission

- If a wound was present upon admission, then becomes unstageable, or at a higher stage, then new category was NOT present upon admission. RAI page M-8

- If a resident has a pressure ulcer/injury that was documented on admission then closed that reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as “present on admission.” RAI page M-9

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

Section M (continued)

- M1040 D Open lesion(s) other than ulcers, rashes, cuts: that are not coded elsewhere and develop as a result of a disease process should be coded here.
- Cuts, lacerations, and abrasions are not coded on the MDS.
- M1040 H Moisture Associated Skin Damage (MASD): Superficial skin damage. If MASD if present with a PU, only code the pressure ulcer. If the tissue damage extends into the subcutaneous tissues, then code as a pressure ulcer.
- Kennedy Terminal Ulcers (KTU) and Skin Failure are not coded in section M. RAI page M-6

Section M	Skin Conditions

M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. **Nutrition or hydration intervention** to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. **Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	H. **Applications of ointments/medications** other than to feet
☐	I. **Application of dressings to feet** (with or without topical medications)
☐	Z. **None of the above** were provided

Section M (continued)
M1200 Skin and Ulcer/Injury Treatments

- M1200 H Applications of ointments/medications other than to feet: Includes barrier creams and skin prep.
- Skin prep to the heel for prevention is not captured on the MDS.
- If skin prep is being used on the heel to treat a DTI, code at M1200 E, Pressure ulcer/injury care.
- Band aids are not coded as dressings.

Section N

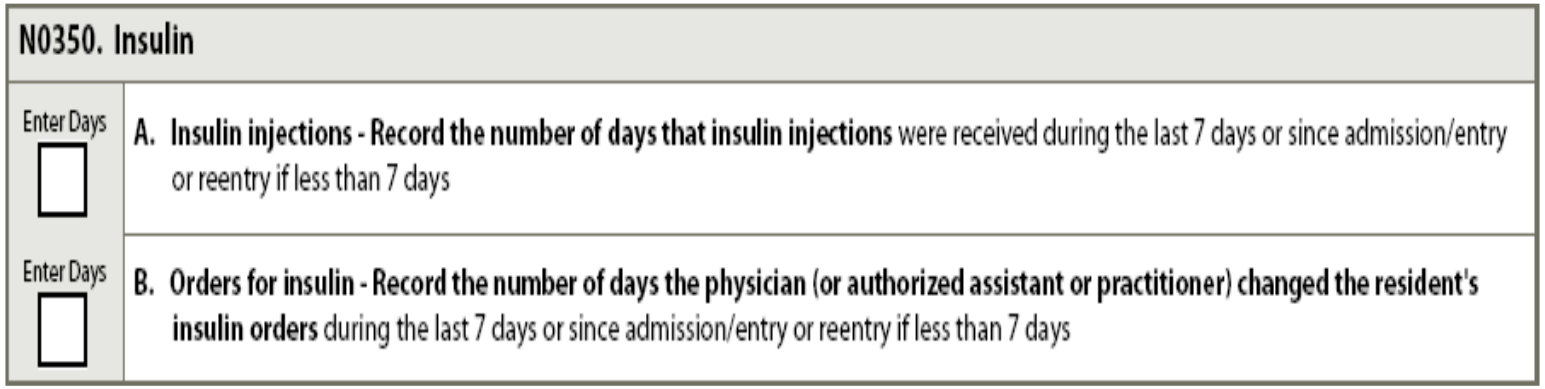
- N0300 Injections
- N0350 Insulin

- N0450 Antipsychotic Medication Review
- N2001 Drug Regimen Review
- N2003 Medication Follow-Up
- N2005 Medication Intervention

Section N: Medications

- Look back period is 7 days or since admission if less than 7 days. The look back does not extend into the preadmission period.
- N0415 High-Risk Drug Classes: Use and Indication: Code according to how the medication is classified and not how it is used.
- Examples: Compazine- is an antipsychotic and often used to treat nausea and vomiting.
- Symbyax is a combination medication- fluoxetine (antidepressant) and olanzapine (antipsychotic). Code both medication categories.
- Benzodiazepines: some are classified as anxiolytic and some as hypnotic. Be sure to know which one should be counted where.
- Watch for combination medications like Zestoretic which has HCTZ.

N0350 Insulin



N0350. Insulin	
Enter Days ☐	A. **Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days
Enter Days ☐	B. **Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days

For sliding scale orders:

— A sliding scale dosage schedule that is written to cover different dosages depending on lab values **does not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

— If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days **can** be counted and coded.

• For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.

Section N
N0415 High Risk Drug Classes: Use and Indication

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

	1. Is taking	2. Indication noted
	↓ Check all that apply ↓	
A. Antipsychotic	☐	☐
B. Antianxiety	☐	☐
C. Antidepressant	☐	☐
D. Hypnotic	☐	☐
E. Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F. Antibiotic	☐	☐
G. Diuretic	☐	☐
H. Opioid	☐	☐
I. Antiplatelet	☐	☐
J. Hypoglycemic (including insulin)	☐	☐
K. Anticonvulsant	☐	☐
Z. None of the above	☐	

- Is taking- check column 1 if the resident is taking any medication by classification listed.
- Indication noted for all medications in the drug class. RAI page N-6
- The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.
- Indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s) since a diagnosis alone may not warrant treatment with medication. RAI Panel 8/23/23

N0450: Antipsychotic Medication Review Gradual Dose Reduction (GDR)

- Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.
  See F758.

Antipsychotic Medication Review

- N0450A- Did the resident receive antipsychotic medications since admission/entry or the prior OBRA assessment, whichever is more recent?
  - 0. No, not received
  - 1. Yes, received on a routine basis only
  - 2. Yes, received on a PRN basis only
  - 3. Yes, antipsychotics were received on a routine and PRN basis

Gradual Dose Reduction (GDR)
N0450 Antipsychotic Medication Review

- N0450B: Do not include Gradual Dose Reductions completed prior to admission.
- No not count as a GDR an antipsychotic medication reduction performed for the purpose of switching from one antipsychotic to another.
- Discontinuation of an antipsychotic, even without a GDR process, should be coded in N0450B
- The date of the GDR in N0450C is the first day the of the dose reduction attempt.

N0450 Antipsychotic Medication Review Continued

- N0450B- Has a gradual dose reduction (GDR) been attempted?
- 0. No- skip to physician documented GDR as clinically contraindicated (this needs to be documented at least annually)
- 1. Yes- continue to date of last attempted GDR
- N0450C- Date of last attempted GDR

N0450 Antipsychotic Medication Review Continued

- N0450D Physician documented GDR as clinically contraindicated
  - 0. No- GDR has not been documented by a physician as clinically contraindicated.
  - 1. Yes- GDR has been documented by a physician as clinically contraindicated, continue to date physician documented GDR as clinically contraindicated
- N0450E- Date physician documented GDR as clinically contraindicated

Section N: N2001-2005

- N2001 Drug Regimen Review: Only on the 5-day PPS. Were there any medication issues identified?
- N2003 Medication Follow-up: Only on the 5-day PPS. If any medication issues were identified, was the physician contacted and were actions to correct this issue completed by the next day?
- N2005 Medication Intervention: Only on the PPS discharge. Had any medication issues been identified, the physician contacted, and an action taken since the admission?
- Clinically Significant: wrong medication, dose, time, omission, interactions, duplicate therapy, known allergy, ineffective therapy.

Section N Resources

The following resources and tools provide information on medication classifications. Providers are responsible for coding each medication's pharmacological/therapeutic classification accurately.

Page N-11:

- GlobalRPh Drug Reference, http://globalrph.com/drug-A.htm

- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcareprofessionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50v40#Guidelines6.
Directions: Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"

- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html

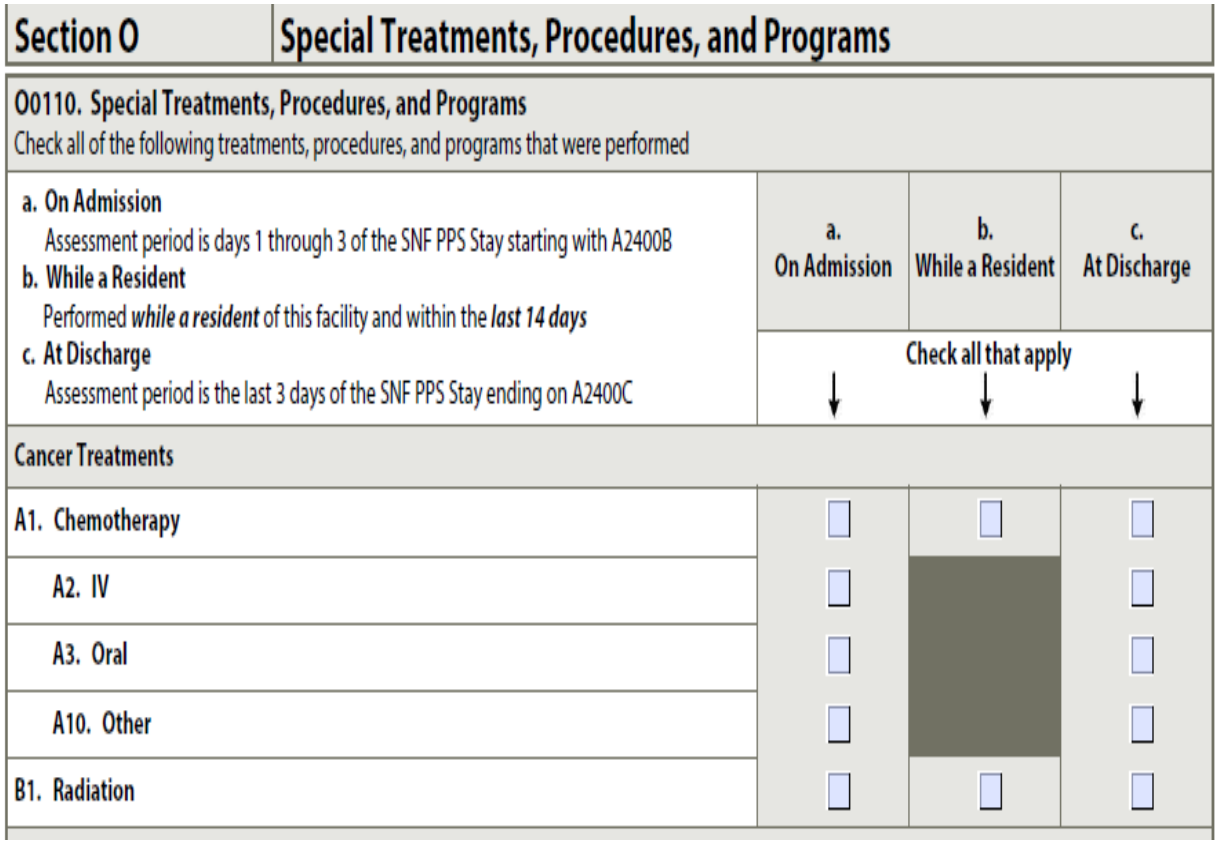
Section O:
Special Treatments, Procedures, and Programs

- The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

O0110: Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff.
- Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0110 Special Treatments, Procedures, and Programs



Section O	Special Treatments, Procedures, and Programs		
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed			
a. On Admission Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B b. While a Resident Performed *while a resident* of this facility and within the *last 14 days* c. At Discharge Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C	a. On Admission	b. While a Resident	c. At Discharge
	Check all that apply ↓	↓	↓
Cancer Treatments			
A1. Chemotherapy	☐	☐	☐
A2. IV	☐		☐
A3. Oral	☐		☐
A10. Other	☐		☐
B1. Radiation	☐	☐	☐

a. On Admission- Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B

b. While a Resident- Performed while a resident of this facility and within the last 14 days

c. At Discharge- Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C

O0110A1-O0100A10 Chemotherapy

- Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item.
- Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment.
  - For example, megestrol acetate is classified as an antineoplastic drug. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item.
  - Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.
- IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K05210A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

O0110 Coding Tips

- O0110B1. Radiation: Includes intermittent radiation therapy, as well as radiation administered via radiation implant.
- O0110C. Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item.
- O0110D. Suctioning: Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.
- O0110E1. Tracheostomy care: Code cleansing of the stoma, tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

O0110 Special Treatments, Procedures, and Programs

Respiratory Treatments			
C1. Oxygen therapy	☐	☐	☐
C2. Continuous	☐		☐
C3. Intermittent	☐		☐
C4. High-concentration	☐		☐
D1. Suctioning	☐	☐	☐
D2. Scheduled	☐		☐
D3. As needed	☐		☐
E1. Tracheostomy care	☐	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐	☐
G2. BiPAP	☐		☐
G3. CPAP	☐		☐

Oxygen

-O0110C2, Continuous

Check if oxygen therapy was continuously delivered for 14 hours or greater per day.

– ***O0110C3, Intermittent***

Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).

– ***O0110C4, High-concentration***

Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).

- *A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks) These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%. Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO2 of greater than 40%.*

RAI page O-4

Suctioning

O0110D2 Scheduled- Check if suctioning was scheduled. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, guidelines.

O0110D3 As Needed- Check in suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals.

O0110E1 Tracheostomy care- Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care and includes laryngectomy tube care.

O0110F1 Invasive Mechanical Ventilator

- Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become unable to support their own respiration in this item. During invasive mechanical ventilation, the resident's breathing is controlled by the ventilator.
- A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here.
- Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

O0100G1 Non-Invasive Mechanical Ventilator (O0110G2 BiPAP/O0110G3CPAP)

- Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual.
- If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐		☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐		☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care		☐	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐		☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

O0110H1- O0110H10 IV Medications

- Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code flushes to keep an IV access port patent, or IV fluids without medication here.
- Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently, and they involve continuous administration of a substance. Subcutaneous pumps are not coded in this item.
- Do not include IV medications of any kind that were administered during dialysis or chemotherapy.
- Lactated Ringers given IV is not considered medications and should not be coded here.

O0110H1 IV Medications

– Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.

Lactated Ringers given IV *is* not considered *a* medication and should not be coded here.

– ***O0110H2, Vasoactive medications***

Check when at least one of the IV medications was an IV vasoactive medication.

– ***O0110H3, Antibiotics***

Check when at least one of the IV medications was an IV antibiotic.

– ***O0110H4, Anticoagulation***

Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

– ***O0110H10, Other***

Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

O0110 Coding Tips (continued)

- O0110I1. Transfusions: Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.
- O0100J1. Dialysis: Code O0110J2 Hemodialysis or O0110J3 Peritoneal which occurs at the nursing home or at another facility.
- O0110K1. Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

O0110M Isolation or Quarantine for Active Infectious Disease

- Code only when the resident requires transmission-based precautions
  - Is alone in a separate room
  - Has an active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage)
  - Highly transmissible or significant pathogens that have been acquired by physical contact, airborne, or droplet transmission.
- Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA - no active symptoms).
- Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone.

Code for “single room isolation” only when all of the following conditions are met:

- 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
- 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
- 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

O0110O1 IV Access

- O0110O2. Peripheral- usually a short plastic catheter inserted into the hand, arm, antecubital region, foot or scalp
- O0110O3. Midline- usually inserted into the antecubital region or upper arm, 8-12 cm long terminating just below the axilla.
- O0110O4. Central- usually placed in the jugular, subclavian or femoral veins. PICC and subcutaneous ports are types of central lines.

Section O

- O0250 Influenza Vaccine
- O0300 Pneumococcal Vaccine
- O0350 COVID
- O0400 Therapies
- O0420 Distinct Calendar Days of Therapy
- O0425 Part A Therapies
- O0430 Distinct Calendar Days of Part A Therapy
- O0500 Restorative Nursing Programs

O0250 Influenza Vaccine
O0300 Pneumonia Vaccine

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?

0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:

1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?

0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:

1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

O0250: Influenza Vaccine

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm, https://www.cdc.gov/flu/
- Facilities can also contact their local health department website for local influenza surveillance information.

O0300: Pneumococcal Vaccine

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf.
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations. For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at https://www.cdc.gov/vaccines/schedules/hcp/index.html http://www.cdc.gov/vaccines/hcp/acip-recs/index.html https://www.cdc.gov/pneumococcal/vaccination.html

Pneumococcal Vaccine continued

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.
- Advisory Committee on Immunization Practices (ACIP) Vaccine Recommendations and Guidelines https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

O0350: Resident's COVID-19 vaccination is up to date

O0350. Resident's COVID-19 vaccination is up to date

Enter Code ☐

0. **No**, resident is not up to date
1. **Yes**, resident is up to date

- **Steps for Assessment**
- *Vaccination status may be determined based on information from any available source. Review the resident's medical record or documentation of COVID-19 vaccination and/or interview the resident, family or other caregivers or healthcare providers to determine whether the resident is up to date with their COVID-19 vaccine.*

- *If the resident is **not up to date**, and the facility has the vaccine available, ask the resident if they would like to receive the COVID-19 vaccine.*

Definition

- **UP TO DATE for COVID-19 Vaccine**

- *For the definition of "up to date," providers should refer to the CDC webpage "Stay Up to Date with COVID-19 Vaccines" at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html*

O0400: Therapies Coding Tips

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
  - Ordered by a physician (or an approved extender) based on a qualified therapist's assessment and treatment plan
  - Documented in the resident's medical record, and
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
- Therapy can occur inside or outside the facility

Interrupted Stay

- If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted, except in the case of an interrupted stay.

- In the case of an interrupted stay, the therapy start date entered in O0400A5, O0400B5 and/or O0400C5 must reflect a date on or after the date in A2400 B. Although the therapy start date occurred prior to the interrupted stay, the data specifications only accept a therapy start date that is on or after the date entered in A2400B. RAI page O-24

O0400D: Respiratory Therapy

- Respiratory Therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.

- **See Appendix A- Glossary page A-22 and Page O-24 for definitions**

Respiratory Therapy continued

- Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

O0400: Special Treatments, Procedures, and Programs

- O0400D Respiratory Therapy
- Do not include exams prior to admission, ER visits, medicine men, or psychologists (O0400E)
- Examinations (full or partial) can occur in the facility or in the physician’s office
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E

O0400E: Psychological Therapy

- Psychological Therapy: The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth. Psychological therapy may be provided by a psychiatrist, psychologist, clinical social worker, or clinical nurse specialist in mental health as allowable under applicable state laws.

O0400F
Recreational Therapy

- Services that are provided or directly supervised by a qualified recreational therapist who holds a national certification in recreational therapy, also referred to as a Certified Therapeutic Recreation Specialist."
- Recreational therapy includes, but is not limited to, providing treatment services and activities using a variety of techniques, including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings.
- Recreation therapists treat and help maintain the physical, mental, and emotional well-being to reduce depression, stress, and anxiety; recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively.
- Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment. Glossary page A-20

O0425 Part A Therapies

- Only completed for PPS Discharge
- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
  - Ordered by a physician (or an approved extender) based on a qualified therapist's assessment and treatment plan
  - Documented in the resident's medical record, and
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
- Therapy can occur inside or outside the facility

O0500: Restorative Nursing Programs

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.
- A resident may be started on a restorative nursing program when they are admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy.
- Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

O0500: Restorative Nursing Programs

- Must meet specific criteria prior to coding
  - Measurable objectives and interventions documented in the care plan and medical record
  - Periodic evaluation by a licensed nurse in the medical record
  - Nursing assistants/aides/other staff/volunteers must be trained in the techniques that promote resident involvement
  - A nurse must supervise the activities in a nursing restorative program
  - Groups no larger than 4 residents per staff
  - Cannot claim techniques that therapists claim under O0400 A,B or C

Section P

Section P	Restraints and Alarms

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. Not used
1. Used less than daily
2. Used daily

↓ Enter Codes in Boxes

	Used in Bed
☐	A. Bed rail
☐	B. Trunk restraint
☐	C. Limb restraint
☐	D. Other
	Used in Chair or Out of Bed
☐	E. Trunk restraint
☐	F. Limb restraint
☐	G. Chair prevents rising
☐	H. Other

P0200. Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected

Coding:
0. Not used
1. Used less than daily
2. Used daily

↓ Enter Codes in Boxes

☐	A. Bed alarm
☐	B. Chair alarm
☐	C. Floor mat alarm
☐	D. Motion sensor alarm
☐	E. Wander/elopement alarm
☐	F. Other alarm

- No new items for Section P
- P0100 Physical Restraints
- P0200 Alarms

Section P:
Restraints and Alarms

- Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7 day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.
- ***DEFINITION PHYSICAL RESTRAINTS:*** **Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body** (State Operations Manual, Appendix PP).

Restraints and Alarms

- Any manual method or physical or mechanical device should be classified as a restraint *only* when it meets the criteria of the physical restraint definition.
  - This can *only* be determined on a case-by-case basis by individually assessing each and every method or device, attached or adjacent to the resident's body, *and* the effect it has on the resident.
- Any manual method or physical or mechanical device, material, or equipment that *meets the definition* of a physical restraint *must* have:
  - physician documentation of a medical symptom that supports the use of the restraint
  - a physician's order for the type of restraint and parameters of use
  - a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

Restraints and Alarms (continued)

- A clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom.
- If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint must be documented in the resident's medical record, ongoing assessments, and care plans.
- There also must be a physician's order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint.

Bed Rails

- Bed rails include any combination of partial or full rails.
- Bed rails used as positioning devices: If the use of bed rails meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint.
- Bed rails used with residents who are immobile: If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation, the bed rails do not meet the definition of a physical restraint.
- For residents who have no voluntary movement: Staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others.

Bed Rails (continued)

- Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed.
  - When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered.
- While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.

Even These Have Caused Injury or Death

Restraints (continued)

- Chairs that prevent rising include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.
- For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual.
- For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint.

Alarms

- An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

Alarms (continued)

- Steps for Assessment
  - Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
  - Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
  - Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.

Alarms (continued)

- Bracelets or devices worn by or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether or not the device activates a sound or alerts the staff.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when anyone (including visitors or staff members) exits the door.
- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section “Determination of the Use of Position Change Alarms as Restraints” of F604 in Appendix PP of the State Operations Manual.

Restraints
Federal Tags

- F604: Right to be free from Physical Restraints. Without medical justification/staff convenience.
- F605: Right to be free from Chemical Restraints (revised to include psychotropic drug and unnecessary medication use, please read!)
- F700: Bedrails: Accidents hazards, bedrail entrapment issues.

Section Q: Participation in Assessment and Goal Setting

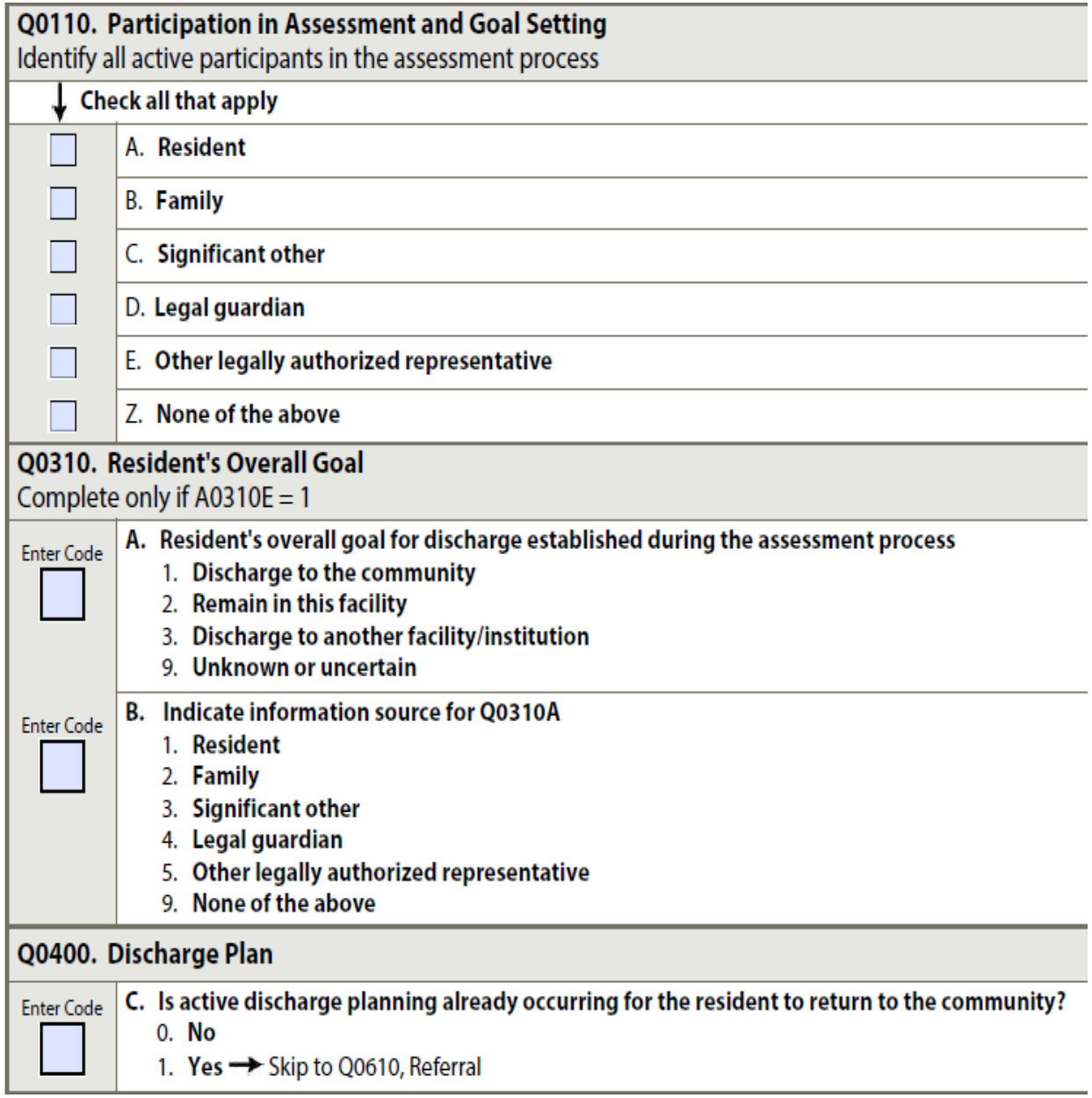
- Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.
- Section Q ensures all individuals have the opportunity to learn about home and community-based 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. 6/21/24



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 ☐

C. 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.medicare.gov/publications/11376-your-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:

Local Contact Agency

- **NC Medicaid Clinical Section**
  Phone: 919-855-4340
  Fax: 919-733-2796

Care Link 1-866-271-4894

Money Follows the Person

- MFPinfo@dhhs.nc.gov
- or call 1-855-761-9030

Section V:
Care Area Assessments (CAA)

- Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as “triggered care areas,” which form a critical link between the MDS and decisions about care planning.
- Documentation supports your decision.

Section V | Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date — Month / Day / Year

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature

2. Date — Month / Day / Year

CAAs

- A risk factor increases the chances of having a negative outcome or complication. Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.
- Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with complex or mixed causes of impaired behavior, cognition and mood.
- Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and possible approaches to improve function or minimize decline.

The CAA Process Should…

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function
- Identify areas that may warrant interventions
- Help develop interventions to improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, choices, and preferences for interventions

CAAs

For each triggered CAA describe:

1. Identified nature of the condition and why it's a problem
2. Complications caused by the care area for this person
3. Risk factors related to the condition that affect the decision to care plan/or not to care plan
4. Factors to consider in developing *individualized* care plan interventions, including decision to care plan or not to care plan
5. The need for additional evaluation by the physician and other health professionals, as appropriate;
6. The resource(s), or assessment tool(s) used for decision-making

See Appendix C for CAA triggers, Chapter 4 CAA Process and Care Planning

Care Area Triggered

Step 1: For any care area triggered (CAT), assess the resident using the care area-specific resources.

Step 2: Check the box in the left column if the item is present for this resident. ***Some of this information will be on the MDS - some will not.***

Step 3: In the right column, Care Planning Decision, you can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor for item checked, etc.

CAAs

- Step 4: Get input from resident and/or family regarding the care area.
- Step 5: Analyze the findings for this care area in the context of this resident as an individual. Draw conclusions about the causal/contributing factors and effect(s) on the resident and document these conclusions in the Analysis of Findings section.

CAAs

Step 6: Decide whether referral to other disciplines is warranted and document this decision.

Step 7: Document the Care Planning Decision

Step 8: Use the “Location and Date of CAA Documentation” (at V0200 A) to note where the CAA summary can be found

Summary: Decision Making / Documentation

- Formulate clear picture of the resident
- Create a resident-centered care plan
  - Based on conclusions from clinical problem solving and decision-making process AND
  - Resident preferences, personal goals
- Document basis for conclusions
  - Not just conclusions

A Smooth Transition to the Care Plan

A good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.

The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.

RAI Chapter 4

Care Planning

- No required format or structure
- Must have measurable goals and timetables
  - Goals should have a subject, verb, modifier, time frame and goal
- Approaches should identify what staff are to do and when to do it and when it will be evaluated by the nurse for possible changes

Subject	*Verb*	*Modifiers*	*Time frame*	*Goal*
Mr. Jones **OR** I	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area

The Overall CP Should Be Oriented Toward:

1. Preventing avoidable declines in functioning or clarifying why another goal takes precedence (e.g. palliative care for end of life).
2. Managing risk factors or indicating the limits of such interventions.
3. Ways to try to preserve and build upon resident strengths.
4. Applying current standards of practice in care planning.
5. Evaluating measurable objectives, timetables and outcomes.
6. Respecting the resident's right to decline treatment.
7. Offering alternative treatments, as applicable.

(cont.) CP Should Be Oriented Toward:

8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.

9. Involving resident, resident's family and other resident representatives as appropriate.

10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs.

11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.

12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.

Section X:
Correction Request

- Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the Internet Quality Improvement and Evaluation System (iQIES) system.
- Corrections/modifications should be made within 14 days of discovery and submitted within 14 days of the attestation date.

Section X (continued)
Major vs Minor Errors

- **Check your validation reports.**
- Significant Error is an error in an assessment where:
  - 1. the resident's overall clinical status is not accurately represented and
  - 2. the error has not been corrected via submission of a more recent assessment.
- Minor errors are all other errors related to coding the MDS.

Section X: Correcting Significant Errors(continued)

- When any significant error is discovered in an OBRA comprehensive or quarterly assessment in the iQIES system, the nursing home must take the following actions to correct the OBRA assessment:
- Create a corrected record with all items included, not just the items in error.
- Complete the required correction request section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
- Submit this modification request record.
- Perform a new Significant Correction to Prior Assessment (SCPA) or Significant Change in Status Assessment (SCSA) and update the care plan as necessary.

Section X: A0050 Modifications (continued)

- Create a corrected MDS record with all item included, not just the items in error.
- Complete Section X (correction request) to identify the record that needs to be modified and include with the corrected record.
- Submit both the Section X and the corrected record to QIES ASAP.
- A hard copy of the Section X must be kept with corrected paper copies of the MDS record in the clinical file to track changes. A hard copy of Section X should also be kept with any inactivated record.

Inactivation vs Modification

- Modification can be used for most items
- Entry and discharge dates, ARD when it was a typographical error and when type of assessment does not change the item set.
- Inactivation needs to be followed by a new record with a new ARD.
- Correction/Deletion request is required to correct: Unit Certification or Licensure Designation (A0410).
- Accidental transmission of a resident who never entered the facility.
- The facility must submit a written request to the state MDS Coordinator to have these problems fixed.
  See chapter 5 pages 14-15 for more information.

Section Z:
Assessment Administration

- The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.
- Rational: Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

HIPPS Codes

- DEFINITION HIPPS CODE:
- Health Insurance Prospective Payment System code is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.

HIPPS Codes

- 1st Character: PT/OT Payment Group
- 2nd Character: SLP Payment Group
- 3rd Character: Nursing Payment Group
- 4th Character: NTA Payment Group
- 5th Character: PPS Assessment Indictor Code
- See RAI Chapter 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

Section Z: Assessment Administration

- Z0400: Signatures of all persons who completed any part of the MDS.
  - Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.
  - Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Assessment Administration continued

- Z0500: Signature of the RN Assessment Coordinator
  - Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete. F642
  - The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Signature Date

- Signature Date:
  - Gathering information from staff, family or significant others about the resident's status should be done after the observation period ends so as to capture information from the entire look back period.
  - All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
  - If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

Transmitting MDS Data

- From RAI page 5-1:
- Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans.

Validation Reports

- *Please* review your transmission validation reports regularly.
  - Reviewing will help you identify and correct errors
  - Reviewing will help prevent “missing assessments” and duplicate folders in the CMS data base
  - Reviewing will help ensure the facility will be paid

From RAI page 5-2

-When the transmission file is received by iQIES, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards.

-MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by iQIES for the same resident.

-The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report.

-All error and warning messages are detailed and explained in the Error Messages guide.

Validation Report References

- **iQIES Resources are available at:** https://qtso.cms.gov/software/iqies/reference-manuals
- **MDS 3.0 Provider User's Guide** is available at: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual
- **CASPER Reporting User's Guide For MDS Providers** is available at: https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-mds-providers

CHECK YOUR VALIDATION REPORTS!

The resident had 2 files in the database

One Male and one Female

The 1/16/23 transmissions contained warnings

Recent call from nurse consultant. Resident had DCRNA March, June readmitted and Q done, then SCSA and asking about admission assessment. Certainly, there had been warnings on both Q and SCSA validation reports

Section A: Identification Information

Remember:

The CMS Database

matching process includes:

- First Name
- Last Name
- Social Security Number
- Gender
- Date of Birth
- Please communicate with your business office regarding any changes to the resident's demographic information

Contact Information

- Janet Brooks, RAI Education Coordinator
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- Sandra McLamb, IT Automation Coordinator
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Thank you!

- Thank you for all the work you do to ensure the care, comfort and safety of our most vulnerable in society. This is not an easy job you do, and it must come from the heart. Weariness and frustration can easily become your best friends, but don’t let them take over! Know that you are not alone in your work. Reach out, make friends and contacts who will encourage your soul.
  Please know that you are welcome
  to call or email me anytime.
  Sincerely, Janet