CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
CH 1	1-27	Added	The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.
CH 2	2-2	Added	When a resident is readmitted to the hospital and an OBRA-required assessment is due during the resident's absence, the facility has up to 14 days after the resident's readmission to complete the assessment. If the assessment that was due during the resident's absence was the initial Admission assessment, see page 2-4. If a significant change is identified on readmission, the significant change assessment would replace the assessment that was due while the resident was in the hospital. (Error messages will result from the late assessment but can be ignored.)
CH 2	2-3	Moved from Page 2-2	Section 2.2 of this chapter examines each of the OBRA assessments and provides detailed information on the completion requirements. The following table summarizes the different types of federally mandated assessments.
CH 3	3-5	Added	The no-information code entered on the form manually or electronically may be any of the alternatives: circled dash, "NA", or plain dash.
CH 3	3-7	Added Deleted	And the first 9 characters must be digits (0-9). ~~If the first character is numeric (Medicare), then the first 9 characters must be digits (0-9)~~
CH 3	3-29	Added Deleted	See Chapter 2 for completion timing requirements for each assessment type. ~~The Admissions assessment must be completed by day 14 of the stay with the date of admission counted as day 1. All other assessments must be completed within 14 days of the ARD (Item A3a). For example, if item A3a was set for December 8th, the latest completion date for this assessment would be December 22nd (i.e., December 8 plus 14 days = December 22). Another way of looking at this is if ARD is counted as Day 1, then the completion date can be as late as Day 15.~~
CH 3	3-30	Deleted	~~Staff actually completes the MDS in the period of time between the ARD and the MDS Completion Date, Item R2b. It is allowable for the ARD to be the same as the MDS Completion Date in Item R2b. It may be more practical, although not a Federal requirement, to leave some time between the ARD date and the completion date. Assessment must be completed, signed (R2a) and dated (R2b) within: – 14 days of admission for an Admission assessment (AB1) or Readmission (A4a); – 14 days of the ARD for all assessments~~
CH 3	3-30	Added	When the resident dies or is discharged prior to the end of

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
			the observation period for a required assessment, the ARD must be adjusted to equal the discharge date. Generally, facilities are required to complete these assessments after the resident's discharge in order to bill for Medicare or Medicaid payment. Facilities have 2 options to choose from when adjusting the ARD to the date of discharge. In the first situation, changing the ARD would normally shorten the observation period. Since some facilities prefer to use data for a full observation period, even if it means collecting more information on the resident's condition prior to admission to the nursing facility, CMS has established a second option that would allow the nursing facility to establish a full observation period.
CH 3	3-31	Added	The observation period may not be extended simply because a resident was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. For example, if the ARD is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. ~~When collecting assessment information, you will not have data for two of the days in the observation period.~~ When collecting assessment information, you may use data from the time period of the LOA as long as the particular MDS item allows you. For example, section P7, if the family takes the resident to the physician, the visit may be counted. For information on coding minutes of therapy while the resident is out of the SNF, see page 3-185 and 3-186. This procedure applies to all assessments, regardless of whether or not they are being completed for clinical or payment purposes.
CH 3	3-42	Deleted and Added	If the resident is not comatose or is ~~semi-comatose~~ not in a persistent vegetative state, code "**0**" and proceed to the next Item (B2).
CH 3	3-83	Added and Deleted	*Coding rationale: Resident is independent in task in set-up help only.* After staff handed him his cane, Mr. X needed to be observed initially as he walked up and down the hall on his unit for the first time to insure that he appropriately used the cane. He does not require any additional staff assistance. *Self Performance = 0 Support Provided = ~~1~~ 0* *Coding rationale: Resident requires set up to complete task independently.*
CH 3	3-84	Deleted and Added	Staff must supervise the resident as she transfers from her bed to wheelchair. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly. *Self Performance = 1 Support Provided = ~~2~~ 1* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe transfer.*

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
CH 3	3-85	Deleted and Added	Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner, as he is tired and less interested in completing his meals. Staff must encourage him to continue to eat and frequently hand him his utensils and cups to complete the meal in order to insure adequate intake. *Self Performance = 2 Support Provided = ~~2~~ 1* *Coding rationale: Resident is highly involved in the activity but is unable to complete the meal without staff providing him utensils (i.e., set up help).*
CH 3	3-126	Deleted	To document changes in the resident's urinary continence status as compared to 90 days ago (or since the last ~~OBRA~~ assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. This item asks for a snapshot of "today" as compared to that of 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.
CH 3	3-127	Added	Check condition only if the resident's condition meets the description in I1.
CH 3	3-128	Added	**j. Peripheral Vascular Disease** – Vascular disease of the lower extremities that can be of venous and/or arterial origin including diabetic PVD. **r. Aphasia** - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA.
CH 3	3-131	Deleted	~~**For example:** If the record reveals that the resident has "osteoarthritis" you check Item I11 (Arthritis) and record "Osteoarthritis" with ICD 9 CM Code 715.00 in Section I3.~~
CH 3	3-132	Deleted	~~The following chart of ICD 9 CM codes for diseases listed in item I1 is intended to clarify the level of specificity represented when the disease item is checked. This is also the list to use in computer applications of the MDS.~~
CH 3	3-133	Deleted	Table
CH 3	3-134	Deleted	Table
CH 3	3-135	Deleted and Added	**f. Respiratory Infection** - Any upper or lower ~~(e.g., bronchitis)~~ acute respiratory infection other than pneumonia.
CH 3	3-136	Deleted and Added	**l. Wound infection** - Infection of any type of wound (e.g., ~~surgical~~ postoperative; traumatic; pressure) on any part of the body.
CH 3	3-137	Deleted	Table
CH 3	3-137	Added	To identify additional conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. If space permits, may also be used to record more specific designations for general disease categories listed under I1 and I2.

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
CH 3	3-139	Added	**i. Hallucinations** - False sensory perceptions that occur in the absence of any real stimuli.
CH 3	3-141	Deleted	~~If the resident does not experience any breakthrough pain. Or the resident's goal for pain management is being met in the 7 day assessment window, this item must also be coded "0". Remember that the assessment covers a 7 day period and should reflect the highest level of pain present.~~
CH 3	3-145	Added	**d. Headache** - The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.
CH 3	3-151	Deleted Deleted Added	Code "**0**" for No or "**1**" for Yes. ~~Round weight upward to the nearest whole pound.~~ If there is no weight to compare to, enter the unknown code (**-**). **Weight Gain in Percentages** (i.e., 5% or more in last 30 days, or 10% or more in up to the last 180 days). ~~Although height and weight are rounded up, percentage is not; e.g., 4.5% should not be rounded to 5%.~~ The first step in calculating percent weight gain or loss is to obtain the actual weights for the 30-day and 180-day time periods from the resident's clinical record. Calculate percentage for weight loss and weight gain based on the resident's actual weight. Do not round the weight. The calculation is as follows:
CH 3	3-153	Deleted and Added	**Parenteral/IV** - Intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (Keep Vein Open), or via heparin locks. ~~This category does not include administration of IV medications.~~ Do not code IV "push" medications here. Do include the IV fluids in IV piggybacks. IV medications dissolved in a diluent, as well as IV push medications are captured as IV medications in P1ac. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay. ~~Do not include insulin administered intravenously.~~
CH 3	3-154	Deleted and Added	If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in this item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and b, which refer to the caloric and fluid intake the resident received in the last 7 days. ~~Additives such as electrolytes and insulin which are added to the resident's parenteral nutrition, should be counted as medications and documented in Section O1, but NOT in~~

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
			~~P1ac.~~ Additives such as electrolytes and insulin which are added to the resident's TPN or IV fluids should be counted as medications and documented in Section O1, Number of Medications, AND P1ac, IV Medications.
CH 3	3-159	Added	A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of ~~injury,~~ circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.
		Added	**Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab, or shallow crater.
CH 3	3-160	Deleted	~~If, as the result of pressure, a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on her sacrum while being pulled up in bed), it should be coded as a Stage 2 ulcer (M1). However, the determination that an ulcer is the result of pressure cannot be made based merely on its location over a pressure point. Instead, a clinician's assessment may be required to determine the ulcer's cause. Using this example, if the resident cannot reposition herself while on her back in bed, it is logical to determine that pressure on the sacrum contributed to the formation of the ulcer, i.e., the resident cannot move independently to relieve the pressure. On the other hand, if the shear or tear occurred over a pressure point, but on a resident who is able to reposition herself, the determination is less likely that pressure on that point was the cause of the ulcer. In either case, Item M1 would be completed, but Item M2a would be completed only if pressure caused the lesion.~~
CH 3	3-164	Deleted	~~**Items M4, Other Skin Problems or Lesions Present**~~ ~~c. Open lesions other than pressure or stasis ulcers, rashes, cuts (e.g., cancer lesions)~~
CH 3	3-166	Added	**Surgical Wounds** - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
CH 3	3-167	Added	**Turning/Repositioning Program** - Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."
CH 3	3-168	Added	Good clinical practice dictates that staff should document treatments provided (e.g., the items listed in M5 and M6). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.
CH 3	3-169	Added Added	**Nails or Calluses Trimmed During the Last 90 Days** - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist. A CNA is not considered a "health professional" for the purpose of coding this item. Good clinical practice dictates that staff should document treatments provided. Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.
CH 3	3-176	Deleted and Added	Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Preparations used for preventative care are not included here. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. ~~For example, if the resident received a long-acting antipsychotic medication prior to the assessment period (e.g., if a fluphenazine deconoate or haloperidol deconoate is given once a month), count as one drug.~~
CH 3	3-178	Added	If the resident received an injection of Vitamin B12 prior to the observation period, code in Item O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics. Determine if a specific long-acting medication is still active based on physician, pharmacist, and/or PDR input. Do not code Vitamin B12 injections in Item O3 (Injections) if it was given outside of the observation period.
CH 3	3-179	Added	Subcutaneous pumps would be coded as follows: O1 - Count the ~~insulin~~ medication as a medication; O2 - Identify if this was a new medication or not; O3 - Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
		Deleted	~~A Subcutaneous Computer Assisted Dispatch (CAD) pump would be coded as an injection in this item.~~
Ch 3	3-182	Added and Deleted	**TREATMENTS** - The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc. ~~Check the appropriate MDS item regardless of where the resident received the treatment.~~
		Added	**Chemotherapy** - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
		Added	**Dialysis** - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions ~~in conjunction with~~ administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
CH 3	3-183	Added	**Transfusions** - Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered during dialysis or chemotherapy.
CH 3	3-185	Added	The licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.
CH 3	3-187	Added	**For Medicare A only:** A licensed therapist starts work directly with one resident beginning a specific task. Once

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
			the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a different task, while continuing to supervise the first resident. The treatment ends for each resident 30 minutes after it begins. For each resident, record 30 minutes therapy time for each resident at Item P1bB. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy. Medicare B only recognizes individual (one-on-one) therapy and group therapy.
CH 3	3-188	Added and Deleted	**Group Therapy (for Speech-Language Pathology and Occupational and Physical Therapies):** ~~For the most part, it is assumed that services coded on the MDS are individualized treatments, and the category does not include services received as part of a group of more than 4 residents per supervising helper.~~ For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time. **Note:** The 25% rule only applies to Medicare A residents.
CH 3	3-189	Deleted and Added	~~**Example:** A licensed therapist works directly with 2 - 4 residents where each resident is performing the same modality, e.g., upper body strengthening. The treatment ends 30 minutes after it starts. For each session, record 30 minutes of therapy time for each resident at Item P1bB. A maximum of 25% of the resident's therapy time can be delivered in groups.~~ **Supervision (Medicare A only):** Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
			Therapy students are recognized as skilled providers under Medicare A only. They must be "in line of sight" supervision (**Federal Register** November 4, 1999).
CH 3	3-192	Deleted	**Range of Motion (Passive)** - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. ~~Range of motion exercise is a~~ A program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a resident get dressed does not, in and of itself, constitute a range of motion exercise session.
CH 3	3-194	Added and Deleted	The use of Continuous Passive Motion (CPM) devices as Rehabilitation/ Restorative Nursing is coded when the following criteria are met: 1) ordered by a physician, 2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and 3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff is required to apply the device and monitor. ~~The CPM devices are recommended by the physical therapist and ordered by the resident's physician. Physical therapy staff may demonstrate application and use of the device to the nursing staff. The device is usually set up in the evening by the nursing staff. Monitoring of the device during the night, and documentation of the application of the device and effects on the resident are done by the nursing staff.~~
CH 3	3-204	Deleted and Added	**Physician** - Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, nurse practitioner, ~~(who is not employed by the nursing facility)~~ or clinical nurse specialist working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.
CH 3	3-205	Added Added and Deleted	Do not include physician visits that occurred during the resident's acute care stay. **Physician** - Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner or clinical nurse specialist working in collaboration with the physician. ~~Orders written by physician assistants or nurse practitioners employed by the~~

CHANGES TO THE DECEMBER 2002 RAI MANUAL, VERSION 2.0 AUGUST 2003			
Chapter	**Page**	**Changes**	**Description**
			~~facility are not included.~~
CH 3	3-212	Deleted	~~All persons completing part of the assessment must attest to the accuracy of the sections they completed. Completing a portion of the MDS is not the same as transcribing information. For example, if an RN enters the therapy time from the therapy log to the MDS, the therapist is still responsible for attesting to the accuracy of the data. The therapist must date and sign the therapy sections of the MDS.~~ The use of signature stamps is allowed. ~~The State Operation Manual Transmittal No. 274, survey protocol, F386, has the following guidance to surveyors on this topic: "When rubber stamp signatures are authorized by the facility's management, the individual whose signature the stamp represents shall place in the administrative offices of the facility a signed statement to the effect that he/she is the only one who has the rubber stamp and uses it. A list of computer codes and written signatures must be readily available and maintained under adequate supervision."~~ The facility must have policies in place to ensure proper use and secure storage of the stamps. The State ~~and facility~~ may have additional ~~policies or~~ regulations that apply.
CH 3	3-216	Added	Do not include evaluation minutes in the estimate of number of minutes. Do not count the evaluation day in the estimate number of days unless treatment is rendered.
CH 3	3-217	Deleted	~~*Because physical therapy was scheduled more frequently than speech therapy, the total number of days of physical therapy would be used.*~~
CH 5	5-9	Deleted	~~Instead, the facility completes and submits the hard copy of the Correction Request form~~
Appendix A	A-15	Added	COTA ~~Comprehensive~~ Certified Occupational Therapist Assistant
Appendix C	C-47 C-73	Added	**Side-Effects of Enteral Feeding Solutions:** Diarrhea **[H2c]**, Fecal Impaction **[H2d]**

1.18 Reproduction and Maintenance of the Assessments

A hard copy of all MDS forms within the last 15 months, including the signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record. This applies to all nursing facilities.

Until such time as CMS adopts an electronic signature standard that is compatible with pending Health Insurance Standards Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as CMS adopts an electronic signature standard, and the standard system is upgraded to enable compliance.

There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed, and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the MDS record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the state. Please see Chapter 5 for detailed instructions on correcting MDS data.

Facilities are required to maintain 15 months of assessment data in the resident's active clinical record according to CMS policy. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.

The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission.

needs. This decision-making process is documented on the Resident Assessment Protocol Summary, which is detailed in Chapter 4.

The timing requirements for a comprehensive assessment apply to both completion of the MDS (R2b) and the completion of the RAPs (VB2). For example, an Admission assessment must be completed within 14 days of admission. This means that both the MDS and the RAPs (R2b and VB2 dates) must be completed by day 14. The MDS Completion Date (R2b) may be earlier than or the same as the RAPs Completion Date (VB2), and neither can be later than day 14.

The comprehensive RAI is considered complete on the date the RN Coordinator indicates completion of the RAPs (VB2). The care plan must be completed by the end of the 7th day following completion of the RAI assessment. In other words, 7 days following the VB2 date.

Assuming the resident does not have any significant changes in status or is not discharged from the facility, the next assessment in the OBRA assessment schedule is the Quarterly assessment. The Quarterly assessment is to be completed within 92 days of the R2b date of the Admission assessment. The OBRA schedule would continue with another Quarterly assessment to be completed within 92 days of the R2b of the previous Quarterly. A third Quarterly is completed within 92 days of the completion (R2b) of the previous Quarterly.

Following the third Quarterly, and within a year of the Admission assessment, an Annual assessment is completed. This is a comprehensive assessment that requires a full MDS with RAPs and care plan review.

This cycle (comprehensive assessment – Quarterly – Quarterly - Quarterly assessment - comprehensive assessment) would repeat itself annually for a resident who never experienced a significant change or discharge.

However, residents do experience significant changes, are discharged and are readmitted to facilities. Therefore, OBRA regulations have defined a comprehensive assessment that a facility completes in the event of a significant change in status that includes RAP review and care plan revision. When a resident is discharged from a facility, a Discharge Tracking form may be required. When a resident who was discharged returns to a facility, a Reentry Tracking form may be required. When a resident is readmitted to the hospital and an OBRA-required assessment is due during the resident's absence, the facility has up to 14 days after the resident's readmission to complete the assessment. If the assessment that was due during the resident's absence was the initial Admission assessment, see page 2-4. If a significant change is identified on readmission, the significant change assessment would replace the assessment that was due while the resident was in the hospital. (Error messages will result from the late assessment but can be ignored.) The Significant Change in Status assessment, and the Discharge and Reentry Tracking forms, including their impact on the assessment schedule are discussed in more detail later in this chapter.

A comprehensive assessment is also required when the facility has identified a major error in a previously submitted comprehensive assessment. A Significant Correction of a Prior Full assessment (SCPA) must be completed within 14 days of the identification of the error. A major error is one where the resident's overall clinical status is not accurately represented on the MDS, has not been addressed in a subsequent assessment, nor addressed in the resident's care plan. Because this is a comprehensive assessment, completion of the full MDS, RAPs and the RAPs Summary is required.

Section 2.2 of this chapter examines each of the OBRA assessments and provides detailed information on the completion requirements. The following table summarizes the different types of federally mandated assessments.

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT	REGULATORY REQUIREMENT CMS "F" TAG
Admission (Initial) Assessment (Comprehensive)	Must be completed (VB2) by the 14th day of the resident's stay.	42 CFR 483.20 (b)(4)(i)/F 273
Annual Reassessment (Comprehensive)	Must be completed (VB2) within 366 days of the most recent comprehensive assessment.	42 CFR 483.20 (b)(4)(v)/F 275
Significant Change in Status Reassessment (Comprehensive)	Must be completed (VB2) by the end of the 14th calendar day following determination that a significant change has occurred.	42 CFR 483.20 (b)(4)(iv)/F 274
Quarterly Assessment (State mandated subset or MPAF)	Set of MDS items, mandated by State (contains at least CMS established subset of MDS items). Must be completed every 92 days.	42 CFR 483.20 (b)(5)/F 276
Significant Correction of a Prior Full Assessment	Completed (VB2) no later than 14 days following determination that a significant error in a prior full assessment has occurred.	42 CFR 483.20/F 287
Significant Correction of a Prior Quarterly Assessment	Completed (R2b) no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred.	42 CFR 483.20/F 287

The MDS is also completed for the Medicare Prospective Payment System. The Medicare schedule is discussed in detail in Section 2.5

2.2 Required OBRA Assessments for the MDS

ADMISSION ASSESSMENTS

The Admission assessment is a comprehensive assessment for a new resident that must be completed within 14 calendar days of admission to the facility if:

- this is the resident's first stay,
- the resident has just returned to the facility after being discharged prior to the completion of the initial assessment, or
- the resident has just returned to the facility after being discharged as return not anticipated.

The 14-day calculation includes weekends. When calculating when the RAI is due, the day of admission is counted as Day "1". For example, if a resident is admitted at 8:30 a.m. on Wednesday

- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences - boxes a. - m.).

- Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)

- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

The convention of entering "0": In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded "0" is a self-sufficient resident; the resident whose ADLs have no "0" codes indicates a resident that receives help from others.

- **When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.**

- **Dates** - Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2002 is recorded as:

0	1
Month	

0	3
Day	

2	0	0	2
Year			

- **The standard no-information code is a "dash" (-).** This code indicates that all available sources of information have been exhausted; that is the information is not available, and despite exhaustive probing, it remains unavailable. The no-information code entered on the form manually or electronically may be any of the alternatives: circled dash, "NA", or plain dash.

- **NONE OF ABOVE** is a response item to several items (e.g., MDS Item I2, Infections, box "m"). **Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If "None of Above" is not present and none of the items apply, e.g., H2 Bowel Elimination on MPAF), simply leave all boxes blank.**

- **"Skip" Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to "skip" over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to "skip" to Section G. if B1 is answered "1" - "yes". **The intervening items from B2 - F3 would not be coded.** If B1 were recorded as "0" - "no", then the assessor would continue with Item B2.).

  A useful technique for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" instructions before going to the next appropriate item.

Coding: Choose only one answer.

Clarification:

- Item AA4 uses the race/ethnicity categories mandated by the Executive Office of Management and Budget (OMB) in 1996 when MDS Version 2.0 was implemented nationally. OMB guidelines require self-identification of race/ethnicity. This means that the resident should be asked to select the category that most closely corresponds to her race/ethnicity from the list in AA4. If the resident is unable to respond, a family member should be asked to make the selection. If the resident is unable to respond and no family member is available, or if the resident does not appear to fit into any of the categories, the assessor should assign whichever category they feel is most appropriate. For example, an individual of Indian origin (i.e., Far East descent) is generally considered to be Asian (AA4 = 2).

AA5. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record. If these numbers are missing, consult with your admissions office.

Coding: Enter one number per box starting with the left most box. Recheck the number to be sure you have entered the digits correctly.

Social Security Number - If no Social Security number is available for the resident (e.g., if the resident is a recent immigrant or a child), leave it blank or enter the standard "no information" code (**-**).

Medicare Number (or comparable railroad insurance number) - Enter a Medicare number or railroad number exactly as it appears on the beneficiary documents. A Medicare number always starts with a number and the first 9 characters must be digits (0-9). It is important to remember that the Medicare Health Insurance number may be different from the resident's social security number (SSN). For example, many residents may be receiving Medicare benefits based on a spouse's Medicare eligibility.

In rare instances, the resident will have neither a Medicare number nor a social security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. Railroad retirement numbers contain 12 characters. Enter the number itself, one digit per box beginning with the left most box. CMS had required the letter "C" to be placed in the first box in front of the railroad retirement number. Effective October 1, 2002 CMS instructed facilities that the letter "C" is not to be placed

A3. Assessment Reference Date

a. Last Day of MDS Observation Period

Intent: To establish a common reference point for all staff participating in the resident's assessment. As staff members may work on a resident's MDS assessment on different days, establishing the Assessment Reference Date ensures a common assessment period. In other words, the ARD designates the end of the observation period so that all assessment items refer to the resident's objective performance and health status during the same period of time. See Chapter 2 for completion timing requirements for each assessment type.

Definition: This date refers to a specific end-point for a common observation period in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, the observation period is a 7-day period ending on this date. Some observation periods cover the 14 days ending on this date, and some cover 30 days ending on this date.

Clarifications:

- The ARD is the common date on which all MDS observation periods end. The observation period is also referred to as the look-back period. It is the time period during which data is captured for inclusion on the MDS assessment. The ARD is the last day of the observation period and controls what care and services are captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for an MDS item with a 7-day period of observation, assessment information is collected for 7 days prior to and including the date in Item A3a; for a 14-Day assessment item, the observation period is the 14 days prior to and including the date at Item A3a.

  NOTE: Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment. For Part A billing, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; e.g., Significant Change in Status or OMRA. In these situations, the ARD of the non-scheduled assessment has sometimes been referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.

- When the resident dies or is discharged prior to the end of the observation period for a required assessment, the ARD must be adjusted to equal the discharge date. Generally, facilities are required to complete these assessments after the resident's discharge in order to bill for Medicare or Medicaid payment. Facilities have 2 options to choose from when adjusting the ARD to the date of discharge. In the first situation, changing the ARD shortens the observation period. Since some facilities prefer to use data for a full observation period, even if it means collecting more information on the resident's condition prior to admission to the nursing facility, CMS has established a second option that would allow the nursing facility to establish a full observation period.

  Option 1 - Change the ARD to the date of discharge, but complete the MDS using less than a full observation period. In this case, the Assessment Reference Date had been set at Day 5, and the resident was discharged after 4 days of the observation period. For items with a 7-day observation period, the MDS would be completed using the data collected for the 4-day period in the nursing facility and the 2-day period prior to admission.

  Option 2 - Change the ARD to the date of discharge, but extend the observation period prior to the date of admission, and collect additional data to complete the assessment. Generally, this expanded observation period would require additional data from the prior hospital stay. In this example, if the resident was discharged after 4 days, the MDS would be completed using the data collected for the 4-day period in the nursing facility. For a 7-day assessment item, hospital data could be used for the 3-day period prior to the nursing facility admission.

  Nursing facility providers must select one of these options and apply it consistently in all cases where the resident is discharged prior to the end of the observation period. It is not appropriate to change options on a case-by-case basis in order to increase reimbursement.

- The observation period may not be extended simply because a resident was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. For example, if the ARD is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. When collecting assessment information, you may use data from the time period of the LOA as long as the particular MDS item allows you. For example, section P7, if the family takes the resident to the physician, the visit may be counted. For information on coding minutes of therapy while the resident is out of the SNF, see pages 3-185 and 3-186. This procedure applies to all assessments, regardless of whether or not they are being completed for clinical or payment purposes.

- If the resident is admitted to the hospital prior to completing the Admission assessment, and returns to the facility, the facility staff may choose to complete the original Admission assessment or start a new assessment. If the staff chooses to complete the original assessment, then the original Assessment Reference Date must be retained and staff must properly identify those MDS items that can be coded only when furnished during the nursing facility stay. For example, services such as therapy or doctor visits occurring during the resident's hospital stay would not be coded on the MDS. The facility can also choose to start a new assessment upon the resident's return. The facility would then have 14 days from the return date (A4a) to perform the Admission assessment.

  If the resident was in a Medicare Part A stay prior to the hospitalization, the facility will generally complete all or part of a 5-Day Medicare assessment in order to establish a RUG-III group for payment purposes. Then, when the beneficiary returns, the facility will complete a Medicare 5-Day Readmission/Return assessment (Item A8b=5). The Medicare Readmission/ Return assessment may be combined with the Admission assessment.

Coding: Complete the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, August 2, 2002 should be entered as:

0	8

Month

0	2

Day

2	0	0	2

Year

b. Original (00) or Corrected Copy of Form: Always enter a (00) in this item. It is not used in the correction process. See Chapter 5 for information on the correction process.

A4a. Date of Reentry

This item appears on the MDS Reentry Tracking form. See Chapter 1 for copies of this form.

that now. We can do it later". Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

It is often difficult to accurately assess cognitive function, or how someone is able to think, remember, and make decisions about their daily lives, when they are unable to verbally communicate with you. It is particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can converse with a resident and hear responses from them that give you clues to how the resident is able to think (judgment), if he understands his strengths and weaknesses (insight), whether he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia).

To assess an aphasic resident it is very important that you hone your listening and observation skills to look for non-verbal cues to the person's abilities. For example, for someone who is unable to speak with you but seems to understand what you are saying (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident.

In all cases code the cognitive items with answers that reflect your best clinical judgment, realizing the difficulty in assessing residents who are unable to communicate. MDS Items B1, B4, B5 and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment.

B1. Comatose (7-day look back)

Intent: To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Coding: Enter the appropriate number in the box.

If the resident has been diagnosed as comatose or in a persistent vegetative state, code "**1**". ***Skip to Section G***. If the resident is not comatose or not in a persistent vegetative state, code "**0**" and proceed to the next Item (B2).

Self-Performance - INDEPENDENT

ADLs - SELF-PERFORMANCE	INDEPENDENT
Bed Mobility	Mrs. D can easily turn and position her in bed and is able to sit up and lie down without any staff assistance. She requires use of a single side rail that staff place in the up position when she is in bed. *Self Performance = 0 Support Provided = 1* *Coding rationale: Resident is independent in task in set-up help only.*
Transfer	When transferring to her chair, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk over to her reclining chair. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident is independent.*
Eating	After staff delivered a lunch tray to Mr. K, he is able to consume all food and fluids without any cueing or physical help from staff. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident is independent.*
Toilet Use	Mrs. L was able to transfer herself to the toilet, adjust her clothing, and perform the necessary personal hygiene after using the toilet without any staff assistance. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident is independent.*
Walk in Room	Mr. R is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident is independent.*
Walk in Corridor	After staff handed him his cane, Mr. X needed to be observed initially as he walked up and down the hall on his unit for the first time to insure that he appropriately used the cane. He does not require any additional staff assistance. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident requires set up to complete task independently.*

Self-Performance – SUPERVISION

ADLs - SELF-PERFORMANCE	SUPERVISION
Bed Mobility	Resident favors laying on right side. Since she has had a history of skin breakdown, staff must verbally remind her to reposition. *Self Performance = 1 Support Provided = 0* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe ambulation.*
Transfer	Staff must supervise the resident as she transfers from her bed to wheelchair. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly. *Self Performance = 1 Support Provided = 1* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe transfer.*
Eating	One staff member had to verbally cue resident to eat slowly, and drink throughout the meal. *Self Performance = 1 Support Provided = 0* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe meal completion.*
Toilet Use	Staff member must remind resident to unzip pants and to wash his hands after using the toilet. *Self Performance = 1 Support Provided = 0* *Coding rationale: Resident requires staff supervision, cuing and reminders.*
Walk in Room	Resident is able to walk in room, but staff member is available to cue and stand by during ambulation since the resident has had a history of unsteady gait. *Self Performance = 1 Support Provided = 0* *Coding rationale: Resident requires staff supervision, cuing and reminders.*
Walk in Corridor	Staff member must provide continual verbal cueing while resident is walking down hallway to insure that the resident walks slowly and safely. *Self Performance = 1 Support Provided = 0* *Coding rationale: Resident requires staff supervision, cuing and reminders.*

Self Performance - Limited Assistance

ADLs - SELF-PERFORMANCE	LIMITED ASSISTANCE
Bed Mobility	Resident favors laying on right side. Since she has had a history of skin breakdown, staff must sometimes help the resident place her hands on the side rail and encourage her to change her position when in bed. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident requires cuing and encouragement with set up or minor physical help.*
Transfer	Mrs. H is able to transfer from the bed to chair when she uses her walker. Staff places the walker near her bed and then help to steady the resident as she transfers. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident requires staff to set up her walker and provide help when she is ready to transfer.*
Eating	Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner, as he is tired and less interested in completing his meals. Staff must encourage him to continue to eat and frequently hand him his utensils and cups to complete the meal in order to insure adequate intake. *Self Performance = 2 Support Provided = 1* *Coding rationale: Resident is highly involved in the activity but is unable to complete the meal without staff providing him utensils (i.e., set up help).*
Toilet Use	Staff must assist Mr. P to zip pants, hand him a washcloth and remind him to wash his hands after using the toilet. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident requires staff to perform non-weight bearing activities to complete the task.*
Walk in Room	Mr. K is able to walk in his room, but requires that a staff member place her arm around his waist when taking him to the bathroom due to his unsteady gait. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe ambulation.*
Walk in Corridor	Mrs. Q requires continual verbal cueing and help with hand placement when walking down the unit hallway. Mrs. Q needs frequent reminders how to use her walker, where to place her hands and to pick up feet. She frequently needs physically guide to the day room. *Self Performance = 2 Support Provided = 2* *Coding rationale: Resident requires staff supervision, cuing and reminders for safe ambulation.*

Self-Performance – EXTENSIVE ASSISTANCE

ADLs - SELF-PERFORMANCE	EXTENSIVE ASSISTANCE
Bed Mobility	Mr. Q has slid to the foot of the bed. Two staff members must physically lift and reposition him toward the head of the bed. Mr. Q was able to assist by bending his knees and push with legs when reminded by staff. *Self Performance = 3 Support Provided = 3* *Coding rationale: Resident partially participates in the task. 2 staff members are required.*
Transfer	Resident always had a difficult time standing from her chair. One staff member had to partially physically lift and support the resident as she stands up. *Self Performance = 3 Support Provided = 2* *Coding rationale: Resident partially participates in the task. 1 staff member is required.*
Eating	Mr. F begins eating a meal by himself. After he has only eaten the bread, he states he is tired and is unable to complete the meal. One staff member physically supports his hand and provides verbal cues to swallow the food in his mouth. The resident is able to complete the meal. *Self Performance = 3 Support Provided = 2* *Coding rationale: Resident partially participates in the task. 1 staff member is required.*
Toilet Use	Mrs. M has had recent bouts of vertigo. One staff member must assist and support her as she transfers to the bedside commode. *Self Performance = 3 Support Provided = 2* *Coding rationale: Resident partially participates in the task. 1 staff member is required.*
Walk in Room	Mr. A has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to support him to help him select clothing from his closet. *Self Performance = 3 Support Provided = 2* *Coding rationale: Resident partially participates in the task. 1 staff member is required.*
Walk in Corridor	A resident had back surgery two months ago. Two staff members must physically support the resident as he is walking down the hallway due to his unsteady gait and balance problem. *Self Performance = 3 Support Provided = 3* *Coding rationale: Resident partially participates in the task. 2 staff members are required to help him walk.*

Example of Functional Limitation

Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her legs flat on the bed. She has no feet. She has no other limitations.

Coding	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement
a. Neck	2	0
b. Arm	1	1
c. Hand	1	1
d. Leg	1	1
e. Foot	2	2
f. Other	0	0

In this example, the resident is only able to turn her head slightly from side to side and tip her head towards each shoulder. Cervical ROM is an important component in every day activities. For example, cervical rotation is extremely important during walking. From a safety standpoint, a person can normally walk and move one's head to look for potential obstacles, not only on the ground, but also to the side. If cervical ROM is not functional, then the person may be a potential fall risk. In this example, the resident has limited rotation and lateral flexion bilaterally.

G5. Modes of Locomotion (7-day look back)

Intent: To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

Definition:

a. Cane/Walker/Crutch - Also check this item in those instances where the resident walks by pushing a wheelchair for support, or uses an enclosed four-wheeled walker with/without a posterior seat and lap cushion.

b. Wheeled Self - Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

c. Other Person Wheeled - Another person pushed the resident in a wheelchair.

d. Wheelchair Primary Mode of Locomotion - Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

e. ***NONE OF ABOVE (is not used on the MPAF)***

Coding: Check all that apply during the last 7 days. If no appliances or assistive devices were used, check *NONE OF ABOVE*.

H4. Change in Urinary Continence (90 days ago)

Intent: To document changes in the resident's urinary continence status as compared to 90 days ago (or since the last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. This item asks for a snapshot of "today" as compared to that of 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

Coding: Code "**0**" for No change, "**1**" for Improvement, or "**2**" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. A resident who was continent 90 days ago is on a bladder retraining program, but is leaking urine during the new observation period would be coded deteriorated (2).

Examples of Change in Urinary Continence

During an outbreak of gastroenteritis at the nursing facility six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.** ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

SECTION I.
DISEASE DIAGNOSES

Intent: To code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan.

- The disease conditions in this section **require a physician-documented diagnosis in the clinical record**. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

- **Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan**. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Check condition only if the resident's condition meets the description in I1.

Definition: **Nursing Monitoring** - Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

I1. Diseases (7-day look back)

Definition: **ENDOCRINE/METABOLIC/NUTRITIONAL**

a. Diabetes Mellitus - Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

b. Hyperthyroidism

c. Hypothyroidism

HEART/CIRCULATION

d. Arteriosclerotic Heart Disease (ASHD)

e. Cardiac Dysrhythmias - Disorder of heart rate or heart rhythm.

f. Congestive Heart Failure

g. Deep Vein Thrombosis

h. Hypertension

i. Hypotension

j. Peripheral Vascular Disease - Vascular disease of the lower extremities that can be of venous and/or arterial origin including diabetic PVD.

k. Other cardiovascular disease

MUSCULOSKELETAL

l. Arthritis - Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

m. Hip Fracture - Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

n. Missing Limb (e.g., Amputation) - Includes loss of any part of any upper or lower extremity. Missing digits should be coded in I3.

o. Osteoporosis

p. Pathological Bone Fracture - Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

NEUROLOGICAL

q. Alzheimer's Disease

r. Aphasia - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA.

s. Cerebral Palsy - Paralysis related to developmental brain defects or birth trauma. Includes spastic quadraplegia secondary to cerebral palsy.

t. Cerebrovascular Accident (CVA/Stroke) - A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, and emboli.

u. Dementia Other Than Alzheimer's - Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic

diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

v. Hemiplegia/Hemiparesis - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

w. Multiple Sclerosis – Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.

x. Paraplegia - Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

y. Parkinson's Disease

z. Quadriplegia - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.

aa. Seizure Disorder

bb. Transient Ischemia Attack (TIA) - A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

cc. Traumatic Brain Injury - Damage to the brain as a result of physical injury to the head.

PSYCHIATRIC/MOOD

dd. Anxiety Disorder

ee. Depression

ff. Manic Depressive (Bipolar Disease) - Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

gg. Schizophrenia

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I, close to the scheduled MDS. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Coding: Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-9-CM code) under I3. Coders in long-term care facilities should refer to official coding guidance in assigning and reporting code numbers.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the

resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing facility.

Clarifications:

- Residents with communication problems as a result of Alzheimer's, Parkinson's or multi-infarct dementia need to be carefully assessed. These diagnoses may result in impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening, reading, speaking, writing and gesturing.

- Depression secondary to Alzheimer's disease should be coded only if there is physician documentation in clinical record to support the diagnoses.

  If the resident with a diagnosis of Alzheimer's disease has expressions/features defined in Section E, Mood and Behavior Patterns, code accordingly. The resident's diagnosis of depression should have physician's documentation supporting the diagnosis. In addition, staff should address the resident's mood and behavior in the resident's record.

In situations such as this, always ask the resident's physician to provide clarification to assure proper coding of the disease or condition.

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I2. Infections (7-day look back)

Definition:

a. Antibiotic Resistant Infection (e.g., including but not limited to Methicillin Resistant Staphylococcus Aureus (MSRA), Methycillin Amnioglycocite Resistant Staphylococcus Aureus, and Vancomycin Resistant Enterococcus (VRE), and Extended Spectrum Beta-Lactalase Organisms) - An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

b. Clostridium Difficile (C.diff) - Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

c. Conjunctivitis - Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

d. HIV Infection - Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS. If a state has a policy to omit transmission of HIV information, the State policy supercedes the MDS requirement.

e. Pneumonia - Inflammation of the lungs; most commonly of bacterial or viral origin.

f. Respiratory Infection - Any upper or lower acute respiratory infection other than pneumonia.

g. Septicemia - Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the resident's clinical record.

h. Sexually Transmitted Disease - Check this item only if there is supporting documentation of a current diagnosis including but not limited to gonorrhea, or syphilis. DO NOT include HIV in this category. If a state has established statutory or regulatory privacy policies precluding transmission of sexually transmitted diseases information, the State policy supercedes the MDS requirement.

g. Tuberculosis - Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

j. Urinary Tract Infection - Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.

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

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

k. Viral Hepatitis - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.

l. Wound infection - Infection of any type of wound (e.g., postoperative; traumatic; pressure) on any part of the body.

m. ***NONE OF ABOVE***

Process: Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial.

Coding: Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago

unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis, check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

I3. Other Current Diagnoses and ICD-9-CM Codes (7-day look back)

Intent: To identify additional conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. If space permits, may also be used to record more specific designations for general disease categories listed under I1 and I2.

Coding: Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes. V codes may be used if they affect the resident's current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

d. Insufficient Fluid; Did NOT Consume All/Almost All Liquids Provided During Last 3 Days - Liquids can include water, juices, coffee, gelatins, and soups. This item should be coded only when the resident is receiving, but not consuming, the proper amount of fluids to meet their daily minimum or assessed requirements. The item should not be coded for residents who may request excessive amounts above and beyond what could reasonably be expected to be consumed.

OTHER

e. Delusions - Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

f. Dizziness/Vertigo - The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

g. Edema - Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

h. Fever – A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date.

i. Hallucinations - False sensory perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

j. Internal Bleeding - Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded as internal bleeding.

k. Recurrent Lung Aspirations in Last 90 Days - Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (i.e., esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked

CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-Day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-Day assessment window, the assessor would indeed code "0", no pain. Remember that the assessment covers a 7-day period and should reflect the highest level of pain reported by any staff member, not just the assessment of the professional completing the MDS.

Definition: **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows Evidence of Pain - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process: Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain in the last week.

Coding: Code for the highest level of pain present in the last seven days. Code for the presence or absence of pain, regardless of pain management efforts; i.e., breakthrough pain. If the resident has no pain, code "0" (No Pain) then Skip to Item J4.

a. FREQUENCY - How often the resident complains or shows evidence of pain.

Codes: 0. No pain (Skip to Item J4)
1. Pain less than daily
2. Pain daily

b. INTENSITY - The severity of pain as described or manifested by the resident.

Codes:
1. Mild Pain - Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate Pain - Resident experiences "a medium" amount of pain.

3. Times When Pain is Horrible or Excruciating - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. ***Rationale*:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement. The 5 coding examples shown below were designed to assist you in making appropriate coding decisions. Please note that the last 3 examples are new, and did not appear in the original MDS manual.

b. Bone Pain - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c. Chest Pain While Doing Usual Activities - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d. Headache - The resident complains or shows evidence (clutching or rubbing the head) of headache.

e. Hip Pain - Pain localized to the hip area. May occur at rest or with physical movement.

f. Incisional Pain - The resident complains or shows evidence of pain at the site of a recent surgical incision.

g. Joint Pain (Other Than Hip) - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h. Soft Tissue Pain - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

i. Stomach Pain - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j. Other - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.

Coding: Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

J4. Accidents (30 and 180 day look backs)

Intent: To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly nursing facility residents. Residents who have sustained at least one fall are at risk of future falls.

Definition: **a. Fell in past 30 Days**

Definition: **Weight Loss in Percentages** (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

Process: **New Admission** - Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current Resident - Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: Code "**0**" for No or "**1**" for Yes. If there is no weight to compare to, enter the unknown code (**-**).

b. Weight Gain

Definition: **Weight Gain in Percentages** (i.e., 5% or more in last 30 days, or 10% or more in up to the last 180 days).

Process: **New Admission** - Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current Resident - Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

Coding: Code "**0**" for No or "**1**" for Yes. If there is no weight to compare to, enter a dash (-).

Clarifications:

- The first step in calculating percent weight gain or loss is to obtain the actual weights for the 30-day and 180-day time periods from the resident's clinical record. Calculate percentage for weight loss and weight gain based on the resident's actual weight. Do not round the weights. The calculation is as follows:

  1. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than this 5%, code a "1" for Yes.

  3. Start with the resident's weight from 180 days ago and multiply it by the proportion (0.10). If the resident has gained or lost more than this 10%, code a "1" for Yes.

- Residents experiencing a 7½% weight change (gain or loss) 90 days ago must be evaluated to determine how much of the 7½% weight change occurred over the last 30 days.

c. Leaves 25% or More of Food Uneaten at Most Meals - Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day. This assumes the resident is receiving the proper amount of food to meet their daily requirements and not excessive amounts above and beyond what they could be expected to consume.

d. ***NONE OF ABOVE***

Process: Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, and dietary progress notes/assessments. Consult with direct-care staff, dietary staff and the consulting dietitian. Ask the resident if he or she experienced any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating? Would you eat if something else was offered?" Observe if resident winces or makes faces while eating. **NOTE:** Facilities are required to offer substitutions when residents do not eat or like the food being served. Observe whether or not residents have refused offers for substitute meals.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

K5. Nutritional Approaches (7-day look back)

Definition: **a. Parenteral/IV** - Intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (Keep Vein Open), or via heparin locks. Do not code IV "push" medications here. Do include the IV fluids in IV piggybacks. IV medications dissolved in a diluent, as well as IV push medications are captured as IV medications in P1ac. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay.

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

b. Mechanically Altered Diet - A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below.

d. Syringe (Oral Feeding) - Use of syringe to deliver liquid or pureed nourishment directly into the mouth. All efforts should be made to utilize other feeding methods (e.g., rubber tipped spoon) as this can result in lowered resident dignity.

e. Therapeutic Diet - A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

f. Dietary Supplement Between Meals - Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

g. Plate Guard, Stabilized Built-Up Utensils, Etc. - Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

h. On Planned Weight Change Program - Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).

i. ***NONE OF ABOVE (Not Used on the MPAF)***

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

Clarification:

- If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in this item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and b, which refer to the caloric and fluid intake the resident received in the last 7 days. Additives such as electrolytes and insulin which are added to the resident's TPN or IV fluids should be counted as medications and documented in Section O1, Number of Medications AND P1ac, IV Medications

K6. Parenteral or Enteral Intake (7-day look back)

Skip to Section L on the MDS if neither Item K5a nor K5b is checked.

SECTION M.
SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. Ulcers (due to any cause) (7-day look back)

Intent: To record the number of ulcers/open lesions, of any type at each ulcer stage, on any part of the body.

Definition: A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer/open lesion. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer/open lesion can be missed.

Assessing a Stage 1 ulcer/open lesion requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers/open lesions in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a

subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: All skin ulcers/open lesions should be coded in this item. Record the number of ulcers/open lesions at each stage on the resident's body, in the last 7 days, regardless of the ulcer/open lesion cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer/open lesion as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers/open lesions at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers/open lesions at any one stage, enter a "9" in the appropriate box.

Clarifications:

- All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.

- Staff should code healing ulcers in the MDS using a reverse-staging protocol. For the MDS assessment, Item M2a, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2". Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.

    - Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments).

mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1, Ulcers (due to any cause)	**Code (# at stage)**
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0

Items M2, Type of Ulcer	**Code (highest stage)**
a. Pressure Ulcer	2
b. Stasis Ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1, Ulcer (due to any cause)	**Code (# at Stage)**
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0

Items M2, Type of Ulcer	**Code (highest stage)**
a. Pressure ulcer	0
b. Stasis ulcer	0

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."
- Compare the sensations in symmetrical areas on both sides of the body.
- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.
- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

f. Skin Tears or Cuts (Other Than Surgery) - Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.

g. Surgical Wounds - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.

h. ***NONE OF ABOVE***

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.

Coding: Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should **NOT** be coded here. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE.*

Clarification:

- It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

M5. Skin Treatments (7-day look back)

Intent: To document any specific or generic skin treatments the resident has received in the past seven days.

Definition:

a. Pressure Relieving Device(s) for Chair - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

b. Pressure Relieving Device(s) for Bed - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

c. Turning/Repositioning Program - Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."

d. Nutrition or Hydration Intervention to Manage Skin Problems - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to mange a potential or active skin problem, should be coded here.

e. Ulcer Care - Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. Surgical Wound Care - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

g. Application of Dressings (With or Without Topical Medications) Other Than to Feet - Includes dry gauze dressings, dressings moistened with saline

or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

h. Application of Ointments/Medications (Other Than to Feet) - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. Other Preventative or Protective Skin Care (Other Than to Feet) - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).

j. ***NONE OF ABOVE***

Process: Review the resident's records. Ask the resident and nurse assistant.

Coding: Check all that apply. If none apply in the past 7 days, check *NONE OF ABOVE*.

Clarifications:

- Good clinical practice dictates that staff should document treatments provided (e.g., the items listed in M5 and M6). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

- Dressings do not have to be applied daily in order to be coded on the MDS. If any dressing meeting the MDS definitions provided for MDS Items M5e-h was applied even once during the 7-day period, the assessor would check the appropriate MDS item.

M6. Foot Problems and Care (7-day look back)

Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition:

a. Resident Has One or More Foot Problems (e.g., Corns, Callouses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems – includes ulcerated areas over plantar's warts on the foot.

b. **Infection of the Foot** – e.g., Cellulitis, Purulent Drainage

c. **Open Lesions On the Foot** - Includes cuts, ulcers, fissures.

d. **Nails or Calluses Trimmed During the Last 90 Days** - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist. A CNA is not considered a "health professional" for the purpose of coding this item.

e. **Received Preventative or Protective Foot Care** - Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

f. **Application of Dressings (With or Without Topical Medications)** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. ***NONE OF ABOVE***

Process: Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*.

Clarification:

- For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in Item M5.
- Good clinical practice dictates that staff should document treatments provided. Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

SECTION N.
ACTIVITY PURSUIT PATTERNS

Intent: To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility.

Definition: **Activity Pursuits** - Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

Example

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offers to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

		Code
a.	**Type of activities in which resident is currently involved**	1 (Slight change)
b.	**Extent of resident involvement in activities**	1 (Slight change)

SECTION O. MEDICATIONS

O1. Number of Medications (7-day look back)

Intent: To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past seven days.

Process: Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Preparations used for preventative care are not included here. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication.

Coding: Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. Do not count medications ordered but not given.

Medication). If the Epogen was given subcutaneously, also record it in Item O3 (Injections). If it is given intravenously, it should be indicated at MDS Item P1ac (IV medication).

- Heparin included in a saline solution used to irrigate a "heparin lock" is not counted in this item.
- Each type of insulin that a resident receives should be counted separately. For example, Lente, Neutral Protamine Hagedorn (NPH), and Regular are different types of insulin and are considered different medications.
- Ensure or any nutritional supplement is not counted as a medication for coding in Section O. The dietary supplement could be recorded in Section K5f, provided it fits the definitions.
- If the resident received an injection of Vitamin B12 prior to the observation period, code in Item O1. Vitamin B12 maintains a blood level, as do long acting antipsychotics. Determine if a specific long-acting medication is still active based on physician, pharmacist, and/or PDR input. Do not code Vitamin B12 injections in Item O3 (Injections) if it was given outside of the observation period.
- Record suppositories in Item O1, Number of Medications. For facilities in states using Section U, also record in Section U.

Example

Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. **Code "1" (one medication received).**

O2. New Medications (90-day look back)

Intent: To record whether or not the resident is currently receiving medications that were initiated in the last 90 days.

Coding: Code "**1**" if the resident received (and continues to receive) new medications in the last 90 days. Code "**0**" if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code "0" (no new medication).

O3. Injections (7-day look back)

Intent: To determine the number of days during the past seven days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are

considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1ac, IV medications.

Coding: Record the number of DAYS in the answer box.

Clarifications:

- Subcutaneous pumps would be coded as follows:

  O1 - Count the medication as a medication;
  O2 - Identify if this was a new medication or not;
  O3 - Code **only** the number of days that the resident actually required a subcutaneous injection to restart the pump.

- If a test or vaccination is provided on one day and another vaccine provided on the next day, code "2" for the number of days when the resident received injections. If both injections were administered on the same day, code "1". Also include these medications when coding Item O1.

Example

During the last 7 days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B_{12} injection on Wednesday. **Code "3" for Resident received injections on three days during the last seven days**.

During the last 7 days, Miss C received a flu shot and her vitamin B_{12} injection on Thursday. **Code "1" for resident received 2 injections on the same day in the last 7 days.**

O4. Days Received the Following Medication (7-day look back)

Intent: To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. See Appendix E for list of drugs by category. Includes any of these medications given to the resident by any route (po, IM, or IV) in any setting (e.g., at the nursing facility, in a hospital emergency room).

Process: Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

SECTION P.
SPECIAL TREATMENTS AND PROCEDURES

P1. Special Treatments, Procedures, and Programs

Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical procedure, and the immediate post-operative recovery period.**

a. SPECIAL CARE (14-day look back)

TREATMENTS - The following treatments may be received by a nursing facility resident either at the facility, at a hospital as an outpatient, or as an inpatient, etc.

Definition:

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

b. Dialysis - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

c. IV Medication - Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy.

d. Intake/Output - The measurement and evaluation of all fluids the resident received and/or excreted for at least three consecutive shifts (i.e., 24 hours).

e. Monitoring Acute Medical Condition - Includes observation by a licensed nurse for ANY acute physical or psychiatric illness. Note that this is a determination regarding the resident's clinical status. Payer source is not a factor.

f. Ostomy Care - This item refers only to care that requires nursing assistance. Includes both ostomies used for intake and excretion. Do not include tracheostomy care. Code tracheostomy care by checking Item P1aj.

g. Oxygen Therapy - Includes continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy).

h. Radiation - Includes radiation therapy or having a radiation implant.

i. Suctioning - Includes nasopharyngeal or tracheal aspiration **only**. Oral suctioning should **not** be coded here.

j. Tracheostomy Care - Includes cleansing of tracheostomy and cannula.

k. Transfusions - Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered during dialysis or chemotherapy.

l. Ventilator or Respirator - Assures adequate ventilation in residents who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

PROGRAMS - The following programs refer to those received within a nursing facility ONLY.

m. Alcohol/Drug Treatment Program - A comprehensive interdisciplinary program within an entire or contiguous unit, wing, or floor where interventions are designed specifically for the treatment of alcohol or drug addictions.

n. Alzheimer's/Dementia Special Care Unit - Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

THERAPIES (7-day look back)

Therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision).

The licensed therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents. Includes **only** medically necessary therapies furnished after admission to the nursing facility. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility.

Intent: To record the **(A) number of days**, and **(B) total number of minutes** each of the following therapies was administered to residents (for at least 15 minutes a day) in the last 7 days.

Definition:

a. Speech-Language Pathology, Audiology Services - Services that are provided by a licensed speech-language pathologist.

b. Occupational Therapy - Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed occupational therapist.

c. Physical Therapy - Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.

d. Respiratory Therapy – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (respiratory therapists, trained nurse). Does not include hand held medication dispenser. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.")

training on the administration of respiratory treatments and procedures. This training may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.

- The MDS instructions clearly require reporting the actual minutes of therapy received by the resident.
  - The resident's treatment time starts when he/she begins the first treatment activity or task and ends when he/she finishes with the last apparatus and the treatment is ended.
  - The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident, is the set-up time and may be included in the count of minutes of therapy delivered to the resident.
  - The therapist's time spent on documentation or on initial evaluation may not be included.
  - Time spent on periodic reevaluations conducted during the course of a therapy treatment may be included.
  - Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as a family-funded services) may not be counted in Item P1b, even when performed by a licensed therapist.
- Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. For MDS reporting purposes, conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion of Item P1b. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in Item P1b, since the specific interventions would be considered restorative nursing services when performed by nurses or aides.
- **For Medicare A only:** A licensed therapist starts work directly with one resident beginning a specific task. Once the resident can proceed with supervision, the licensed therapist works directly with a second resident to get him/her started on a different task, while continuing to supervise the first

resident. The treatment ends for each resident 30 minutes after it begins. For each resident, record 30 minutes therapy time for each resident at Item P1bB. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy. Medicare B only recognizes individual (one-on-one) therapy and group therapy.

- In some cases, the resident will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the resident is a part of total treatment time. For example, as the last treatment task of the day, a resident uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the resident up on the apparatus. The therapist or assistant, under the supervision of a PT, may then leave the resident to help another resident in the same exercise room. However, the therapist still has eye contact with the resident and is providing supervision, verbal encouragement and direction to the resident on the bicycle. Therefore, if it took 2 minutes to set the resident up with the cycling apparatus, the resident was supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the resident did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the MDS assessment is 60 minutes. The key is that the resident was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process.

- Two licensed therapists, each from a different discipline, begin treating one resident at the same time. The treatment ends 30 minutes after it starts. Split the time between the two disciplines as appropriate. For example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT at Item P1bA, and 20 minutes of PT at Item P1bB. Also code the 10 minutes of OT in Item P1bB. In this example, no days may be coded for OT at Item P1bA, because the sessions only lasted 10 minutes.

Group Therapy (for Speech-Language Pathology and Occupational and Physical Therapies):

- For groups of four or fewer residents per supervising therapist (or assistant), each resident is coded as having received the full time in the therapy session. For example, if a therapist worked with three residents for 45 minutes on training to return to the community, each resident received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the resident's time, not for the therapist's time. **Note:** The 25% rule only applies to Medicare A residents.

Supervision (Medicare A only):

- Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist when allowed by state law. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

- Therapy students are recognized as skilled providers under Medicare A only. They must be "in line of sight" supervision (**Federal Register** November 4, 1999).

Maintenance Therapy/Nursing Rehabilitation:

- Once the licensed therapist has designed a maintenance program and discharged the resident from the rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the aide should no longer be reported at Item P1b as skilled therapy. The services of the aide may be reported on the MDS assessment as restorative nursing at Item P3, provided they meet the requirements for restorative therapy.

- There may be situations where nursing staff request assistance from a licensed therapist to evaluate the restorative nursing aides or to recommend changes to a restorative nursing program. Consultation with nursing staff and staff training are certainly good clinical practice. The therapist's time cannot be reported as skilled therapy in Item P3.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: **Rehabilitation/Restorative Care** - Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in Item P1b. In addition, **to be included in this section, a rehabilitation or restorative care must meet all of the following additional criteria:**

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

a. Range of Motion (Passive) - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. A program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a resident get dressed does not, in and of itself, constitute a range of motion exercise session.

b. Range of Motion (Active) - Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record. When residents do most of the modality, but need some assistance with the final stretch, it is still considered active range of motion.

c. Splint or Brace Assistance - Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff

Coding: For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The time provided for Items P1a-k must be coded separately, in time blocks of 15 minutes or more. For example, to check Item P3a, 15 or more minutes of PROM must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift) however; 15-minute time increments cannot be obtained by combining P3a, P3b, and P3c. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Clarifications:

- If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- When not contraindicated by State practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services **may not** be coded as therapy in Item P1b, since the specific interventions are considered restorative nursing services when performed by nurses or aides. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

- Active or passive movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures.

- The use of Continuous Passive Motion (CPM) devices as Rehabilitation/ Restorative Nursing is coded when the following criteria are met: 1) ordered by a physician, 2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and 3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff is required to apply the device and monitor.

- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to have goals, objectives and documentation of progress included in the clinical record.

Examples

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the nursing facility the next afternoon. **Code "0" for No ER visits.** The **rationale** for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the nursing facility within several hours. **Code "1" for 1 ER visit.**

Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and nursing facility staff was unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. **Code "1" for ER visit.**

P7. Physician Visits (14-day look back)

Intent: To record the **number of days** during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

Definition: **Physician** - Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.

Physician Exam - May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)"

Coding: Enter the number of days the physician examined the resident. If none, enter "**0**".

Clarification:

- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician visit. Documentation of the physician's evaluation should be included in the clinical record. The physician's evaluation can include partial or complete

examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.

Do not include physician visits that occurred during the resident's acute care stay.

P8. Physician Orders (14-day look back)

Intent: To record the **number of days** during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition: **Physician** - Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician.

Physician Orders - Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

Coding: Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "**0**".

Clarifications:

- 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.
- Do not count visits or orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. And do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.
- A monthly Medicare Certification is a renewal of an existing order and should not be included when coding this item.
- If a resident has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.

P8. Physician Orders (14-day look back)

Intent: To record the **number of days** during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition: **Physician** - Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner working in collaboration with the physician.

Physician Orders - Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

Coding: Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "**0**".

Clarifications:

- 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.

- Do not count visits or orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. And do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.

- A monthly Medicare Certification is a renewal of an existing order and should not be included when coding this item.

- If a resident has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

Process: Each staff member who completes any portion of the MDS must sign and date (at AA9) the MDS and indicate beside the signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding: All persons completing part of this assessment, including the RN Assessment Coordinator, must sign their names in the appropriate locations at Item AA9. To the right of the name, enter title and the letters that correspond to sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If, for some technical reason, such as computer or printer breakdown, the MDS cannot be signed on the date it is completed, it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.

Clarifications:

- The use of signature stamps is allowed. The facility must have policies in place to ensure proper use and secure storage of the stamps. The State may have additional regulations that apply.

- The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment." Further, CFR 42 483.20(i)(2) states, "Each individual who completes a portion of the assessment must sign, date and certify the accuracy of that portion of the assessment in Item AA9."

  For facilities that use a sign-in form for care planning and MDS completion, the facility would need to have a written policy that explains how the sign-in process and format are used. It would have to provide attestation by the registered nurse regarding the completion of the assessment, and for each individual, who must certify the accuracy of the portion of the assessment that they completed. The State may have additional regulations that apply.

Section R. - Assessment/Discharge Information:

R3. Discharge Status (Item appears on the Discharge Tracking Form)

Coding: **a.** Code for resident disposition on discharge.

Definition:

1. **Private Home or Apartment with No Health Services** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.

5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.

6. **Psychiatric Hospital, MR/DD Facility** – A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

completed and therapy treatment(s) has been scheduled. If therapy treatment(s) will **not** be scheduled, skip to Item T3.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission to Medicare Part A.

c. ESTIMATE OF NUMBER OF DAYS (first 14 days through day 15)

Coding: **Estimate of Number of Days** - Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission. Count the days of therapy already delivered from Item P1a, b, and c. Calculate the expected number or days through day 15, even if the resident is discharged prior to day 15. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the MDS should be coded as 3 days, not 6 days.

d. ESTIMATE OF NUMBER OF MINUTES (first 14 days through day 15)

Coding: **Estimate of Number of Minutes** - Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission. Include the number of minutes already provided from MDS Items P1ba(B), P1bb(B), and P1bc(B). Calculate the expected number of minutes through day 15, even if the resident is discharged prior to day 15.

Clarifications:

- Do not include evaluation minutes in the estimate of number of minutes.
- Do not count the evaluation day in the estimate number of days unless treatment is rendered.

Example of Ordered Therapies on Medicare 5-Day Assessments

Mr. Z was admitted to the nursing facility late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5-Day assessment. Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

Enter "8" in Item T1c for the number of days that at least one therapy service is expected to be delivered.

Enter "720" in Item T1d for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.

Mrs. C was admitted to the facility Tuesday with an evaluation order for all three therapies. The physical therapist completed the evaluation for physical therapy on Wednesday and scheduled treatment to begin on Thursday, five days a week for 30 minutes each day. The occupational therapist completed the evaluation on Friday and scheduled therapy to begin on Monday, 3 days a week for one hour each day. The speech language pathologist's evaluation did not recommend speech therapy for the resident so speech therapy was not scheduled. The RN Assessment Coordinator identified Monday as the end of the observation assessment period. Within the observation assessment period, the resident received 3 days of physical therapy for a total of 90 minutes. The resident received one occupational therapy treatment for a total of 60 minutes. It was expected that Mrs. C would receive 6 more days of physical therapy within the 15 days after the resident's admission for a total of 180 minutes and 3 more days of occupational therapy within the 15 days after the resident's admission for a total of 180 minutes.

Enter "9" in Item T1c for the number of days that at least one therapy service is expected to be delivered.

Enter "510" in Item T1d for the estimated total number of minutes that both physical therapy and occupational therapy is expected to be delivered.

INACTIVATION REQUESTS

Records must be inactivated when an incorrect reason for assessment has been submitted in either the Primary Reason for Assessment (AA8a) or Medicare Reason for Assessment (AA8b). The record must then be resubmitted with the correct reason(s) for assessment.

An Inactivation should also be used when an **invalid** record has been accepted into the State MDS database, since it moves the inactive record into the history file in the database. Examples of invalid records include the following situations:

1. It was a test record inadvertently submitted as production.
2. The event did not occur; e.g., the record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident but there was no actual discharge. There was no event.
3. The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.
4. The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking form was submitted when the resident was discharged.
5. Inadvertent submission of an inappropriate, non-required record, such as a non-standard assessment performed for "in-house" quality improvement or quality assurance programs.

When inactivating a record, the facility is required to submit an electronic record.

5.7 Inactivation of Submitted Records Lacking State or Federal Authority

Submission of MDS assessment records to the MDS standard database constitutes a release of private information and must conform to privacy laws. The facility indicates the submission authority for a record in a field labeled SUB_REQ. (See Section 5.1)

SUB_REQ may not be modified with a normal MDS modification request. The formal Inactivation process is also insufficient, since the inappropriately submitted record would still remain in the database in the history file. If the SUB_REQ value is incorrect on a record already accepted into the standard MDS database, the facility must make a request to the State help desk to evaluate the problem and, if appropriate, the MDS database will be manually corrected.

Common Acronyms

ADLs	Activities of Daily Living
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPT	(Physicians) Current Procedural Terminology
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
ESRD	End Stage Renal Disease
FI	Fiscal Intermediary
FMR	Focused Medical Review
FR	Final Rule
FY	Fiscal Year
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCFA Pub. 10	Hospital Manual
HCFA Pub. 12	Skilled Nursing Facility Manual
HCFA Pub. 7	State Operations Manual
HCFA Pub.13-3	Medicare Intermediary Manual, Claims Process, Part 3
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance PPS (Rate Codes)

13. FEEDING TUBES STATUS RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

Consider efficacy and need for feeding tubes if:

- Feeding Tube Present*
  [K5b = checked]

* **Note:** This item also triggers on the Dehydration RAP.

GUIDELINES

Factors that may impede removal of tube:

- Comatose **[B1]**
- Failure to Eat **[K4c] AND** Resists Assistance in Eating **[E4e]**
- **Diagnoses:** CVA **[I1t]**, Gastric Ulcers **[I3]**
- Gastric Bleeding **[from record]**
- Chewing Problem **[K1a]**
- Swallowing Problem **[K1b]**
- Mouth Pain **[K1c]**
- Length of Time Feeding Tube Has Been in Use **[from record]**

Potential complications of tube feeding:

- **Diagnostic Conditions:** Delirium **[B5]**, Repetitive Physical Movements **[E1n]**, Anxiety **[I1dd]**, Depression **[I1ee]**, Recurrent Lung Aspirations **[J1k]**
- Self-Extubation (removal of tube by resident) **[from record]**
- Limb Restraints in Use to Prevent Self-Extubation **[P4d]**
- **Infections in Lung/Trachea:** Pneumonia **[I2e]**, Fever **[J1h]**, Shortness of Breath **[J1l]**, Placement or Dislodgement of Tube in to Lung **[from exam, record]**
- **Side-Effects of Enteral Feeding Solutions:** Constipation **[H2b]**, Diarrhea **[H2c]**, Fecal Impaction **[H2d]**, Abdominal Distention or Pain **[exam]**, Dehydrated **[J1c]**
- **Respiratory Problems:** Pneumothorax, Hydrothorax, Airway Obstruction, Acute Respiratory Distress, Respiratory Distress **[I3; from observation, record]**
- **Cardiac Distress/Arrest:** Chest Pain **[J3c]**, Loss of Heart Beat, Loss of Consciousness, Loss of Breathing **[from observation, record]**
- Abnormal Lab Values **[P9]**