REVISIONS TO THE Resident Assessment Instrument MANUAL APRIL 2004	
Section	**Manual Revision**
Page 1-17 1.11 Change in Ownership	**CHANGE IN OWNERSHIP** There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment schedule for existing residents continues, ~~but~~ and the facility continues to use the ~~new~~ existing provider number. For example, if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the ~~new~~ existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the ~~new~~ existing provider number.
Page 3-27, ADa	Change coding paragraph: When the RN Assessment Coordinator worked on the *Background (Face Sheet) Information at Admission*, he or she must enter his or her signature on the date it is complete. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the *Background (Face Sheet) Information at Admission* cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.
Page 3-29, A3 Clarify ARD coding.	Revise example in first clarification (5th sentence): For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7th day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (Item A3a).
Page 3-83 Clarify scenario.	After ~~staff handed him his~~ receiving a new cane, Mr. X needed to be observed ~~initially~~ the first time he used it 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 no set up to complete task independently.*
Page 3-85 Clarify scenario.	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.~~ In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist in guiding his hand in order to get the utensil to his mouth. *Self Performance = 2 Support Provided = 2* *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)~~ non-weight-bearing assistance (3 or more times in the observation period).*
Page 3-129, I1z	Add sentence: "Do not code Quadriparesis here."

REVISIONS TO THE Resident Assessment Instrument MANUAL APRIL 2004	
Section	**Manual Revision**
Pages 3-130 / 3-136, I1, I2 Clarify "initiate necessary physician documentation".	1. Under Process section on page 3-130 the last sentence should read, "Consult with physician for confirmation. A physician diagnosis is required to code the MDS." 2. On page 3-136, under Process section, delete the last sentence and replace it with the above sentence.
Page 3-141, J2 Clarify "level of pain".	Coding—Replace the first sentence with: Code the frequency of pain during the observation period in J2a. Code the highest intensity of pain that occurred during the observation period in J2b.
Page 3-153, K5a	Revise paragraph to include the following addition: Do not include fluids administered solely as flushes.
Page 3-159, M1	Remove in M1, the line in bold, "due to any cause".
Page3-159, M1	Delete "of any type" in the Intent section.
Page 3-159, M Second bullet from page 3-160 moved.	~~Staff should code healing ulcers in the MDS using a reverse-staging protocol.~~ For the MDS assessment, ~~Item M2a, pressure~~ staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. 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" for purposes of the MDS assessment. 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.
Page 3-160 Made consistent with deleting "due to any cause".	~~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.
Page 3-165, M4c	Rewrite M4c to state: Code in M4c any open lesions/sores that are not coded elsewhere in Section M. Do NOT code skin tears or cuts here.
Page 3-176, O1	Revise Process section -- Delete: ~~Preparations used for preventative care are not included here.~~ Add: Topical preparations that are used for preventative skin care (i.e. moisturizers and moisture barriers) should not be coded here.
Page 3-176 / 3-179, O1	1. Revise Process section to add last line that reads: Antigens and vaccines also are counted here. 2. Delete last line of bullet #2 on page 3-179 that says, "Also include these medications when coding Item O1."
Page 3-185, P1b	A trained nurse may perform the assessment.
Page 3-193, P3i	Add: "Dentures are not considered to be prostheses for coding this item."
TYPOS	
Page 3-77	Showering should be shaving
Page 3-131	Paragraph 2, R2 should be AA9
Page 3-151	#3 should be #2.
Page 3-153	Second K5b should be c
Page 3-206	Planed should be planned

schedule for existing residents continues, and the facility continues to use the existing provider number. For example, if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.

There are situations where the new owner will not assume the assets and liabilities of the previous owner. In these cases, each resident is considered a new admission effective on the date of sale. New assessment schedules will be required for all residents in certified beds.

TRANSFERS OF RESIDENTS

Any time a resident is admitted to a new facility (regardless of whether or not it is a transfer within the same chain), a new comprehensive assessment must be done within 14 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an Admission assessment, and if applicable, a 5-Day Medicare assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new assessment for the purpose of planning care within the facility to which the resident has been transferred. The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper--that is, the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff. States may have other requirements from a payment perspective. Therefore, facilities should contact their survey agency as well for clarification.

In instances where there has been a massive transfer of new residents to a nursing facility secondary to natural disasters (flood, earthquake, fire), a new MDS must be completed by the admitting facility. The admitting facility should try to complete the MDS within 14 days of transfer if at all possible. If the admitting facility is having problems meeting the requirement they should contact their State agency to discuss the situation and receive guidance about any extensions in the 14-day time factor.

1.12 Completion of the RAI

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations[1] require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical

[1] 42 CFR 483.20 (h)--(F 278)

x. ***NONE OF ABOVE***

y. ***UNKNOWN*** - If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check the last box in the category ("UNKNOWN"). Leave all other boxes in Section AC blank.

Coding: Coding is limited to selected routines in the year prior to the resident's first admission to a nursing facility. *Code the resident's actual routine rather than his or her goals or preferences* (e.g., if the resident would have liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/close friends").

Under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a *NONE OF ABOVE* choice is available. For example, if the resident did not engage in any of the items listed under Cycle of Daily Events, indicate this by checking *NONE OF ABOVE* for Cycle of Daily Events.

If an individual item in a particular category is not known (e.g. "Finds strength in faith," under Involvement Patterns), enter "-".

If information is unavailable for all the items in the entire Customary Routine section, check the final box "UNKNOWN" - Resident/family unable to provide information. If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

SECTION AD. FACE SHEET SIGNATURES

ADa. Signature of RN Assessment Coordinator

Coding: When the RN Assessment Coordinator worked on the *Background (Face Sheet) Information at Admission*, he or she must enter his or her signature on the date it is complete. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the *Background (Face Sheet) Information at Admission* cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.

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 a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7th day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD (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.

e. **Locomotion On Unit -** How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a wheelchair, locomotion is defined as self-sufficiency once in the chair.

f. **Locomotion Off Unit** - How the resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in a wheelchair, locomotion is defined as self-sufficiency once in chair.

g. **Dressing -** How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas, and housedresses.

h. **Eating -** How the resident eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and is not to be coded as an "8". The resident must be evaluated under the Eating ADL category for his/her level of assistance in the process. A resident who is highly involved in giving himself/herself a tube feeding is not totally dependent and should not be coded as a "4".

i. **Toilet Use** - How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.

j. **Personal Hygiene** - How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

Process: In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the

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 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 T.V.) without any cueing or physical assistance from staff. *Self Performance = 0 Support Provided = 0* *Coding rationale: Resident is independent.*
Walk in Corridor	After receiving a new cane, Mr. X needed to be observed the first time he used it as he walked up and down the hall on his unit 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 no set up to complete task independently.*

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. In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist in guiding his hand in order to get the utensil to his mouth. *Self Performance = 2 Support Provided = 2* *Coding rationale: is unable to complete the meal without staff providing him non-weight-bearing assistance (3 or more times in the observation period).*
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.*

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. Do not code quadriparesis here.

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**

PULMONARY

hh. Asthma

ii. Emphysema/COPD - Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), and chronic restrictive lung diseases such as asbestosis and chronic bronchitis.

SENSORY

jj. Cataracts

kk. Diabetic Retinopathy

ll. Glaucoma

mm. Macular Degeneration

OTHER

nn. Allergies - Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

oo. Anemia - Includes anemia of any etiology.

pp. Cancer

qq. Renal Failure

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

Process: Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS.

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 AA9 (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

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. A physician diagnosis is required to code the MDS.

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

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 frequency of pain during the observation period in J2a. Code the highest intensity of pain that occurred during the observation period in J2b. 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.

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 actual weight. 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 5%, code a "1" for Yes.
  2. 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 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. Do not include fluids administered solely as flushes.

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.

c. 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.

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.

For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. 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" for purposes of the MDS assessment. 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.

M1. Ulcers (7-day look back)

Intent: To record the number of ulcers/open lesions, 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: Record the number of ulcers/open lesions at each stage on the resident's body, in the last 7 days. 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.

- 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).

M3. History of Resolved/Cured Ulcers (90 days ago)

Intent: To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers.

Process: Review clinical records, including the last Quarterly or Medicare PPS assessment.

Coding: Code "**0**" for No or "**1**" for Yes.

M4. Other Skin Problems or Lesions Present (7-day look back)

Intent: To document the presence of skin problems, ulcers, (other than pressure or stasis ulcers) and conditions that are risk factors for more serious problems.

Definition:

a. Abrasions, Bruises - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

b. Burns (Second or Third Degree) - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

c. Open Lesions/Sores Other Than Pressure or Stasis Ulcers, Rashes, Cuts (e.g. cancer lesions) – Code in M4c any open lesions/sores that are not coded elsewhere in Section M. Do NOT code skin tears or cuts here.

d. Rashes (e.g., intertrigo, exzema, drug rash, heat rash, herpes zoster) - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

e. Skin Desensitized to Pain or Pressure - The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and

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. Topical preparations that are used for preventative skin care (i.e. moisturizers and moisture barriers) should not be coded 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. Antigens and vaccines also are counted here.

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.

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".

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.

b. 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 (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining "trained nurse.") A trained nurse may perform the assessment.

have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

TRAINING AND SKILL PRACTICE IN: - Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed Mobility - Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Transfer - Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Walking - Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

g. Dressing or Grooming - Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

h. Eating or Swallowing - Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

i. Amputation/Prosthesis Care - Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.

j. Communication - Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

k. Other - Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation/restorative care schedule, and implementation record sheet on the nursing unit.

- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable; e.g., for a new or altered treatment. An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed. Orders written to increase the resident's RUG-III classification and facility payment are not acceptable.

- When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item.

- Orders for transfer of care to another physician may not be counted.

P9. Abnormal Lab Values (90-day look back)

Intent: To document whether the resident had any abnormal laboratory values during the last 90 days or since admission to the nursing facility. This item refers only to laboratory tests performed after admission to the nursing facility. "Abnormal" refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident.

Example

An elevated prothrombin time in a resident receiving coumadin therapy is coded "1" for Yes (Abnormal) even though this may be the desired effect.

Process: Check medical records, especially laboratory reports.

Coding: Enter "**0**" if no abnormal value was noted in the record, and "**1**" if the resident has had at least one abnormal laboratory value. Abnormal blood glucose levels, including levels obtained via finger-sticks are included in this item.