Training Manual for the Minimum Data Set Assessment Tools for Assisted Housing (MDS-AH)

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Chapter 1. The Residential Care and Adult Family Care Home Environment

1.1 Background and Overview

- Given the growing demand for long-term care and the significance of the assisted housing sector, there is a need for a greater understanding of the types of clients being served, the quality of care they receive, and the ability to adequately reimburse providers for the care and services required to meet these needs. In Maine, the Minimum Data Set (MDS) is a screening and assessment tool that helps providers in the provision of care and service planning process. It provides a core set of elements, including standard definitions and coding categories, that form a basis for a comprehensive assessment.
- The MDS does not provide all the information a facility will need for a comprehensive assessment. Facilities will want to augment and add items to this core set as appropriate to complete their comprehensive assessment process. The MDS assessment information is used to reimburse providers for care and services provided to MaineCare members in Assisted Housing settings. The Assisted Housing setting that is referenced above includes Residential Care Facilities, Level IV, Appendix C (PNMI-C), and Adult Family Care Homes. As of July 2004, Adult Family Care Home (AFCH) services, also referred to as Level III or Level IV Residential Care Facilities, are required to submit MDS information for all clients for quality monitoring and reimbursement.
- Maine has been using assessment tools since the 1990s, starting with the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) in nursing facilities. Maine developed a tool based on the MDS called the Medical Eligibility Determination (MED) assessment form to determine eligibility for long-term care services. In 1995, Maine implemented the MDS for Residential Care Facilities, which is currently used in Level IV, Appendix C, Private Non-Medical Institution (PNMI-C) facilities. This MDS tool has been used by PNMI-C and AFCH until the development and launch of this new tool, the MDS-AH, for assisted housing facilities, including PNMI-C and AFCH.
- This manual provides guidance, instruction, and examples for the effective use and completion of the MDS assessment tool. It should be readily available for staff use for consultation during the assessment process. Assessing staff should be trained on how to complete the MDS. The Maine Department of Health and Human Services offers training

sessions on how to complete the MDS assessment, and you can contact the MDS Helpdesk for more information via email at mds.ah.dhhs@maine.gov.

1.2. Assessor Responsibilities

- It is the responsibility of the facility staff assessor to complete the MDS thoroughly and accurately. As assessors are selected by the owner/operator of the home, it is their responsibility to complete the MDS for each resident in your facility. One MDS must be completed and submitted for each resident, regardless of payer source. To achieve this, you will need to familiarize yourself with residents by reviewing documentation and talking with direct-care staff to identify the resident's strengths, needs, and preferences. This information will be used to develop a service plan for each resident.
- Your duties as an assessor include:
    - Read the training materials and ensure a current version is always available for reference.
    - Attending case mix sponsored training sessions (recommended for PNMI-C and AFCH in accordance with the MaineCare Benefits Manual).
    - Completing all resident assessments in a thorough, efficient, and timely manner.
    - Maintaining resident confidentiality.
    - Editing all completed MDS assessments for typographical errors and incorrect responses to ensure accurate data entry of information into provider software.
    - Submitting all MDS materials (including assessments, tracking forms, discharges, and modifications, as instructed and in a timely manner).
- PNMI-C and AFCH facilities are required by policy to submit all assessments electronically.

1.3 Facility Responsibilities

New Facilities:

- Facilities MUST be licensed before they can admit residents.
- Facilities MUST operate in compliance with state licensure.
- Performing MDS assessments is a mandatory requirement for MaineCare payment and should be carried out in accordance with the guidelines outlined in the MaineCare Benefits Manual and this training manual. The MDS assessment schedule is established based on the date when a resident is admitted to the facility. It's important to note that in

situations where there is a delay in the facility's licensing process due to a resurvey, the facility is still obligated to perform MDS assessments according to the original schedule based on the resident's admission.

Transfer of Residents:

- Any time that a resident is transferred to a new facility, even if it is within the same chain or corporation, facility staff MUST complete a new assessment within 30 days. The facility transferring the resident must provide the new facility with all necessary medical records, discharge assessment reports, and other necessary documents to ensure continuity of care. When the new facility admits the resident, the MDS schedule begins with an Admission assessment based on the date of admission. The admitting facility should carefully review the previous facility's documents to understand the resident's history and promote continuity of care. The admitting facility must also perform a new admission assessment for the purpose of planning care.
- In case of emergencies such as floods, earthquakes, or fires, resulting in resident transfers with an expected return to the facility, the evacuating facility must contact the Division of Licensing (DLC) and the Office of MaineCare Services (OMS) for guidance. If the originating facility determines that the resident will not return to the evacuating facility, the provider will discharge the resident. The receiving facility will then admit the resident and the MDS cycle will begin as of the admission date. Providers with questions related to this type of situation should contact OMS.

Facility Closing:

- If a facility closes or is no longer licensed, ALL residents must be discharged from that facility. Residents transferred to another facility must be treated as transferring residents, and the procedures outlined above are to be followed.

1.4. Facility Change in Level of Care

- When a facility applies for and receives a license for a new level of care, it must adhere to new regulatory and payment requirements.
- If a facility is required to complete an MDS assessment and then changes the level of care to another level that also requires an MDS assessment, all residents must be discharged and admitted to the new level of care.

- This requirement applies even if the same buildings are used. Facility staff must complete new MDS admission assessments for each resident, and a new assessment schedule must be observed.
- Residents who do not move into the new level of care should be discharged and transferred to another facility appropriately.
- The facility's administrative systems, including MDS software, must be updated to reflect the new level of care requirements.

Note: "Assume assignment" means that the new owner is accepting the facility's assets and liabilities, which include the history of sanctions, deficiencies, resident assessments, quality indicators, debts, etc. Contact the MDS Helpdesk for more information via email at mds.ah.dhhs@maine.gov.

1.5. Conversations with Direct Care Staff

- When selecting a staff member to interview or gather information about a resident, it is important to choose someone who provides direct personal care or assistance to the resident. It is not appropriate to utilize staff members who do not provide any direct care or assistance to the residents.
- During the interview or information-gathering session, some staff members may likely provide more information than necessary about the home, residents, or other topics. If a staff member goes off-topic, it is best to redirect them back to the questions at hand. You can say something like, “That’s interesting, and now I need to know,” or “Let’s get back to…” and then continue immediately to the next item.
- It is important to keep in mind that some staff members may feel hesitant to answer certain questions. In such cases, you should reassure them that any information collected will be kept strictly confidential.

1.6. Conversations with Residents

- When conducting interviews or gathering information from residents, it is important to be mindful of their schedules and needs.
- Some residents may have pre-scheduled activities they want to attend, while others may require more time to answer your questions. In such cases, it would be helpful to offer to come back at a later time.

- During the interview, some residents may veer off-topic or provide excessive information. To avoid this, gently guide them back to the subject using the redirection techniques mentioned in the section above.
- If a resident appears hesitant to answer your questions, you can reassure them that any information collected will be kept confidential. This reassurance can build trust and encourage them to share their thoughts and experiences with you.

1.7. Confidentiality Requirements and Residents' Rights

The Importance of Maintaining Confidentiality:

- Confidentiality is of utmost importance when working with residents, administrative, or other staff. It is crucial to ensure that no information that may reveal an individual's identity or place of residence is disclosed. As an assessor, you must adhere to strict confidentiality guidelines.
- To maintain privacy, it is advisable to conduct individual interviews in a secluded area. You may ask the resident to accompany you to a quiet and private room.
- As an interviewer, it is vital to be fully aware of the laws, regulations, and project (?) rules governing confidentiality. This will assist in reassuring respondents that their information is secure.
- It is your responsibility to maintain confidentiality, and you must not disclose any resident or staff person's name to anyone other than staff at the Catherine Cutler Institute or the Department of Health and Human Services.
- If someone asks for information pertaining to residents or homes, respond by saying, "I'm sorry, but that information is confidential, and I am not authorized to discuss it." This will demonstrate your commitment to maintaining confidentiality.
- All completed forms should be kept in a secure location, and access should be limited to ensure their confidentiality.
- Your conduct should reflect your dedication to confidentiality, which will encourage accurate responses.

Note: The Catherine Cutler Institute has policies in place to make sure all information is kept confidential. Data confidentiality and security are governed by a Business Associates Agreement (BAA) between the Maine Department of Health and Human Services, the Office of MaineCare Services, and the Catherine Cutler Institute

Chapter 2. General Procedures for Completing the Assessment

This section includes detailed instructions for preparing and using the Item Sets. A detailed set of item-by-item instructions for each assessment is included in the next chapter.

2.1. Resident Records

- The record of each resident contains different reports, such as physician notes, admission documents, case manager's service plan, flow sheets, focused charting, and a medical eligibility determination (MED) assessment referral form. It serves as a source of information that can be used to identify relevant data and speed up the process.
- To complete the MDS form, it is necessary to assess the resident's functioning, review documentation, and conduct interviews with residents and staff. Relevant information can also be gathered from the MDS record in Section A - Identification and Background Information.

Note: While MED assessments are not mandatory for determining eligibility in an Adult Family Care Home, eligibility requirements are outlined in the MaineCare Benefits Manual, Chapter II, Section 2.

The assessor may need to engage in conversation with residents, family members, and staff to complete an assessment. The assessor must ensure that the information obtained is accurate, relevant to the subject matter, and documented in the resident record.

2.2. Assessment Questions

- Understanding the purpose of a question can aid in defining the goals of each inquiry and facilitate decision-making.
- If the assessor needs to engage with staff and residents, avoid influencing or directing the individual toward a particular answer. The following are general guidelines to assist with the assessment process:
- When gathering information from a staff or resident, use neutral, open-ended questions or statements to encourage respondents to expand on an incomplete answer.
- Examples of open-ended questions are "What do you mean?" "How do you mean?" "Tell me what you have in mind" and "Tell me more about….".
- Briefly pause to indicate that you require additional or better information and to encourage the individual to provide further information.

- Use clarifying questions if the response is unclear, ambiguous, or contradictory. Always employ a neutral approach to avoid appearing confrontational when seeking clarification. An example of a clarifying question is: "Could you please be more specific?"
- Ask the resident, family member, or staff member if they would like you to repeat any question if it appears to have been misunderstood or misinterpreted.
- Complete the item with the correct number or response or place a checkmark in the box corresponding to the right response.
- Record a "dash" (-) if an item cannot be answered because no information is available in the individual's record.

Note: "None of the Above" is a response option in several items. This option should indicate that none of the other responses apply rather than signify a lack of information about the item (e.g., no information available). Do not code "None of the Above" if other options are selected or applied.

Mandatory Response Selection:

- The MDS items require a range of responses, including check marks, numerical entries, or pre-assigned codes. If information is unavailable and cannot be obtained, enter a dash (-).
- All items that are not part of a skip pattern cannot be left blank. If a dash (-) is used, it indicates that you attempted to obtain information from various sources but could not determine the correct response.
- It's vital to be thorough when editing your work and to make every effort to provide all the information required.
- Any missing information can cause delays or errors in processing. Therefore, it is essential to check that all items are filled out correctly and completely, that any blanks are intentional, and that the instructions for the given item are followed.

2.3. Sources of Information for the Assessment

There are four primary sources of information, all of which should be used in completing most MDS items.

The Resident:

- The resident is a critical source of information. Most residents, including many with mild to moderate cognitive impairment, will be valuable sources of information about their

routines, preferences, mood, and psychosocial well-being, as well as their cognitive status and physical functioning in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

- Discussions with the resident are an essential part of the assessment.
- When residents cannot communicate or are so impaired cognitively that they cannot verbally impart useful information, observation of the resident may provide a method to gain information.

The Resident's Family:

- As this is used as an operational assessment system for residents, you may also be asked to contact the resident's family and secure information from them about the resident's history, etc.

Direct Care Staff:

- Staff that provides direct care to residents is a vital source of information about the resident's cognitive performance, health, and physical and social functioning.
- Other staff may provide valuable insights, but the staff member who provides care on most days to the resident is the single best source of staff information.
- As you will see in the item-by-item specifications, most of the items ask you to consult staff across all shifts and a period of several days (usually 7).
- The goal of this method is to ensure that the assessment captures the variations in the resident's functioning, mood, and behaviors over time since this method creates a better, more accurate picture of the resident's status.
- In some facilities, there may be multiple shifts of staff or staff that specialize in only one area of function. In some extensive facilities, several staff may be on each shift, sometimes specializing in social work, activities, dietary, housekeeping, and resident care.
- In some smaller facilities, there may be only one main staff person, and they may provide coverage for periods comparable to two shifts—e.g., from 7 a.m. to 6:00 p.m. Thus, keep the goal in mind - capturing natural variations in the resident's status across time - when you see instructions about consulting staff across shifts or staff in different areas or departments.

The Resident's Record:

- Some facilities will have extensive records for each resident, including an admission assessment, physician's notes and orders, medication records, other assessment information, and a care or service plan.
- Written records will vary in the relevant information they provide for completing the MDS. Since the assessment generally calls for information on the client's status, the record should contain specific and up-to-date information.
- It is helpful to use this information with interviews with staff and the residents to complete each section.

2.4. Order to Follow in Completing the MDS

- There is no required order of completion. Let the availability of residents and staff and the timing of access to the resident's records help determine the order in which you seek information for specific items to complete the items and sections. However, you should look over the MDS carefully and consider the following:
    - Which items require information from the resident's record (or another source such as the billing office) so that you can complete all these items during one review of the record?
    - Which items for which a discussion with the resident is essential (e.g., customary routine, mood, psychosocial well-being, activity preferences and patterns, cognitive status) to group them in your discussion with the resident, and which items require specific discussions with staff?
- When you find conflicting reports about a resident's functioning in a particular area, seek additional information to clarify the issue and, when possible, resolve the apparent conflict.
- When a conflict remains, use your best judgment when reaching a decision.
- There must be documentation in the clinical record of the decision-making process when there is a conflict between various sources of documentation.

2.5. The MDS Is Not a Questionnaire

- The items on the MDS are not questions, and you should not proceed through the functional assessment as if they were (e.g., "Are you feeling suicidal today?"). Instead,

the items are part of a structured inquiry using multiple sources of information to discover the resident's strengths, preferences, and needs.

- You will also find that discussion with the resident, which may start with the topic of their life and routines before entering the facility, spontaneously provides the information you need to assess other items (e.g., mood, relationships with others, long-term memory).
- Complete the review of the resident's record as specified under the assessment procedures.
- As you review the record, note MDS items, which can be scored solely by using information from the resident's record.

Chapter 3. Item-by-Item Guide to MDS-AH

3.1. Overview of the Item-by-Item Guide to MDS-AH

This chapter provides information to facilitate an accurate resident assessment. Item-by-item instructions focus on the intent of items included in the MDS-AH, supplemental definitions, and instructions for completing MDS-AH items, reminders of which MDS-AH items refer to a time frame for observing the resident other than the standard 7-day observation period, and sources of information to be consulted for specific MDS-AH items.

3.2. Types of Information

To facilitate the completion of the assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many (but not all) items:

- **Item Rationale:** Reason(s) for including the item (or set of items) in the MDS, discussions of how the information will be used by staff to identify resident problems and develop the service plan.
- **Definitions:** Explanation of key terms.
- **Steps for Assessment:** Sources of information and methods for determining the correct response for an item. Sources include:
    - Discussion with the facility, staff, and both licensed and non-licensed members.
    - Resident interview and observation.
    - Records - physician orders, laboratory results, medication records, treatment sheets, service plans, and any similar documents in the facility record system.
    - Discussion with the resident's family.
- **Coding Instructions:** The facility is responsible for ensuring that all documentation to support the MDS coding is present and accessible in the clinical record, accurate, and available for review.

3.3 Section A: Identification and Background Information

A0100. Type of Record

A0100. Type of Record

Enter code ☐

1. **Add a new record**
2. **Modify an existing record**
3. **Inactivate an existing record** → Skip to X0100, Type of Provider

Coding Instructions:

- **Code 1**: If this is a new record that has not been previously submitted.
- **Code 2**: If this is a request to modify the MDS items for a record that already has been submitted and accepted.
- **Code 3**: If this is a request to inactivate a record that already has been submitted and accepted.

A0200. Facility Information

A0200. Facility Information

A. **Facility Name:** _____

B. **National Provider Identifier** *(NPI)*:

☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number** *(NPI+3)*:

☐☐☐☐☐☐☐☐☐☐ - ☐☐☐

Item Rationale:

- To record the facility's name and provider number.

Steps for Assessment:

1. You can obtain the facility's name from the facility's business office or owner.
2. Once you have these items, they apply to all residents of that facility.

Coding Instructions:

A. **Enter the facility name.**

B. **National Provider Identifier** (NPI)

C. **State Provider Number** (NPI + three-digit location code).

A0300. Type of Provider

A0300. Type of Provider

Enter code ☐

Type of provider:

1. **Residential Care Level IV PNMI** *(RCF)*
2. **Adult Family Care Home** *(AFCH)*

Item Rationale:

- Allows designation of the type of provider.

Coding Instructions:

- **Code 1:** If Residential Care Level IV PNMI (RCF)
- **Code 2:** If Adult Family Care Home (AFCH)

A0400. Type of Assessment

A0400. Type of Assessment	
Enter code	A. **Reason for assessment:** 01. **Admission assessment** (*REQUIRED BY DAY 14*) 02. **Semi-annual assessment** 03. **Significant change in status assessment** 04. **Significant correction to prior assessment** 99. **None of the above**
Enter code	B. **Entry/discharge reporting:** 01. **Entry tracking record** 02. **Discharge assessment -** Return not anticipated 03. **Discharge assessment -** Return anticipated 04. **Death in facility -** Tracking record 05. **Discharge prior to completion of assessment** 99. **None of the above**

Item Rationale:

- Document the reason for completing the assessment.

Coding Instructions for A0400A:

Enter the number corresponding to the reason for the assessment. This item contains two digits. For codes 01-06, enter "0" in the first box and place the correct number in the second box.

- **Code 01:** A comprehensive assessment is required by day 14. The day of admission is counted as day one.
- **Code 02:** A new assessment is required within 180 days of the A0900 date (ARD) of the previous assessment, on an ongoing basis for as long as the resident resides in the facility, according to guidelines and time frames provided by the Department of Health and Human Services.
- **Code 03:** A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts two or more areas of the resident's clinical status, and requires revision of the service plan. The assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. "Self-limiting" means the condition will normally resolve itself without further intervention or by staff implementing standard interventions within 14 days.
    - A Significant Change assessment is warranted if there is a consistent pattern of change with two or more areas of decline or improvement of the resident's

clinical status.

- Documentation of the identification of an event or situation that may lead to completion of a significant change assessment must be in the resident's clinical record. This note will serve as the beginning of the observation period to determine if there are changes in the resident's condition that meet the definition of "significant change" (i.e. a major change that is not self-limiting, impacts two or more areas of the resident's clinical status, and requires revision of the service plan) to ensure the change in the resident's needs is being addressed. A single note in the clinical record on or around the assessment date (item A0900) indicating the resident had a significant change without documentation of the qualifying characteristics does not meet the requirements for a significant change.
- The MDS assessment must be completed at item Z0200 with revision of the service plan no later than 14 days after the identification of the event or situation that led to completion of the significant change assessment. The next assessment would be due 180 days from A0900 (ARD) date of the significant change assessment.

- **Code 04:** This assessment type is selected when information has not been coded on an assessment that had already been completed and submitted. It will require a new assessment reference date (ARD) and creates a new look-back period based on the new ARD. Significant corrections or changes cannot be made to an assessment that has already been submitted and accepted if it will change the payment group. This also means that if you are requested by a case mix nurse to complete a modification/correction to an assessment as a result of a case mix review, a facility cannot "add" items to an assessment to maintain a payment group or prevent a decrease in the payment group as a result of the errors discovered by the case mix nurse during the review.
- **Code 05:** if none of the above choices applies to this assessment

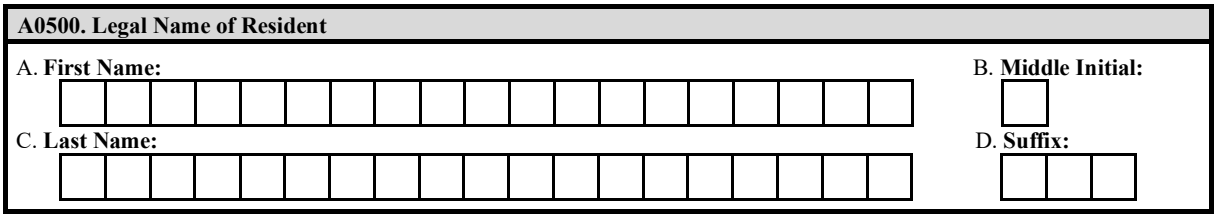
Coding Instructions for A0400B:

Enter the number corresponding to the reason for entry/discharge reporting. This item contains two digits. For codes 01-05, enter "0" in the first box and place the correct number in the second box.

- **Code 01:** If an entry tracking record

- **Code 02:** If this assessment is being completed because the resident is discharged and resident's return is NOT anticipated.
- **Code 03:** If this assessment is being completed because the resident was discharged and admitted to another facility, such as a hospital or skilled nursing facility and the resident's return is anticipated.
- **Code 04:** If the resident has passed away, died, or expired while a resident of the facility – complete this death in facility tracking record
- **Code 05:** If the resident is discharged prior to completion of an admission assessment. You can submit a claim for services provided using the facility's case mix average, according to your rate letter or payment roster. Rates are effective 1/1-6/30 and 7/1-12/31 of every year.
- **Code 99:** If none of the above apply.

A0500. Legal Name of Resident



Item Rationale:

- Allows identification of resident and for matching each of the resident's records.

Steps for Assessment:

1. Check the resident's name on their Medicare card, Medicaid card, or other government-issued document.

Coding Instructions:

A. Enter the resident's legal first name.

B. Enter the resident's middle initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name)

C. Enter the resident's legal last name.

D. Enter the resident's suffix (e.g., Jr./Sr.), if applicable.

A0600. Social Security Number

A0600. Social Security Number
☐☐☐ - ☐☐ - ☐☐☐☐

Item Rationale:

- Allows identification of the resident and records for the resident to be matched in the system.

Steps for Assessment:

1. Review the resident's record; if these numbers are missing, consult with your facility's business office.
2. If the resident does not have a Social Security number, contact the MDS help desk for assistance.

Coding Instructions:

- Enter one number per box, starting with the left-most box.
- Recheck the number to be sure you have written the digits correctly.

A0700. Gender

A0700. Gender	
Enter code ☐	1. **Male** 2. **Female** 3. **Non-binary**

Item Rationale:

- Assists in correct identification
- Provides demographic gender-specific health trend information.

Coding Instructions:

- **Code 1:** If the resident identifies as male.
- **Code 2:** If the resident identifies as female.
- **Code 3:** If the resident does not identify as either male or female.

A0800. Birth Date

A0800. Birth Date
☐☐ - ☐☐ - ☐☐☐☐ M M D D Y Y Y Y

Item Rationale:

- Assists in correct identification

- Allows determination of age.

Coding Instructions:

- Fill in the boxes with the appropriate number.
- Do not leave any boxes blank.
- If the month or day contains only a single digit, fill the first box in with a "0". For example, January 2, 1918, should be entered as 01-02-1918.

A0900. Assessment Reference Date (ARD)

A0900. Assessment Reference Date *(ARD)*
Observation end date: [ ][ ] - [ ][ ] - [ ][ ][ ][ ] (M M - D D - Y Y Y Y)

Item Rationale:

- To establish a common reference point for all staff participating in the resident's assessment.
- Although staff members may begin their evaluation tasks on different dates, they should refer the assessment to a fixed end date, thereby ensuring the commonality of the assessment period.

Definitions:

- **Last Day of MDS Observation Period:** The date refers to a specific endpoint in the process. Almost all MDS items refer to the resident's status over a designated period, most frequently the seven days ending on this date. The date sets the designated endpoint of the common observation period, and all MDS items refer back in time from this point. The look back (observation) period is seven (7) days unless otherwise specified.

Coding Instructions:

- The first coding task is to enter the observation reference date (e.g., the end date of the observation period).
- For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for setting the ARD for an admission assessment).
- For a follow-up assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all MDS items must refer.
- For an admission assessment, staff will begin to gather some information on the day

of admission. An observation end date must be set, on or before day 14 of residency.

- Use all boxes.
- For a one-digit month or day, place a zero in the first box. For example, February 3, 2024, should be entered as 02-03-2024.

A1000. MaineCare Number

A1000. MaineCare Number
Record a "+" if pending and an "N" if not a MaineCare recipient: ☐☐☐☐☐☐☐☐☐

Coding Instructions:

- Record this number if the resident is a MaineCare recipient. Begin writing one number per box in the left-hand box.
- Recheck the number to be sure you have entered the digits correctly. Enter a "+" in the left-most box if the number is pending. If not applicable, enter a dash "-".

A1100. Current Payment Source for Stays

A1100. Current Payment Source for Stay	
Check the payer source at the time of the ARD: *(Billing Office to indicate)*	
☐	A. **MaineCare**
☐	B. **Other** (*specify*) _____

Item Rationale:

- To determine payment source(s) that will cover the daily per diem services for the resident's days of stay in the facility as of the ARD

Steps for Assessment:

1. Check with the billing office or person who handles the facility finances to review current payment sources.
2. Do not rely exclusively on information recorded in the resident's record. Usually, the business office tracks such information.

Coding Instructions:

- **Code A:** If the payment source is MaineCare.
- **Code B:** If the payment source is NOT MaineCare (i.e., private pay).

A1200. Date of most recent Admission or Reentry

A1200. Most Recent Admission/Entry or Reentry into this Facility
M M - D D - Y Y Y Y

Item Rationale:

- To document the date of admission or readmission to the facility**.**

Definition:

- **Date:** The initial date of admission to the facility or the date the resident most recently returned to your facility after being discharged with a return anticipated, such as a discharge to a hospital or for a skilled nursing facility stay.

Steps for Assessment:

1. Review the clinical record. If dates are unclear or unavailable, ask the business office at your facility.

Coding Instructions:

- Use all boxes.
- For a one-digit month or day, place a zero in the first box. For example, January 2, 2023, should be entered as 01-02-2023.

A1300. Type of Entry

A1300. Type of Entry
Enter code ☐ 1. **Admission** 2. **Reentry**

Item Rationale:

- Captures whether the date in A1400 is an admission/entry or reentry date

Coding Instructions:

- **Code 1:** When one of the following occurs:
  - Resident has never been admitted to this facility before, OR
  - The resident has been in this facility previously, was discharged, return *not* anticipated, and was then readmitted to the facility as a new resident at a later time, OR
  - The resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- **Code 2**: When all the following occurred prior to this entry, the resident:

- Previously admitted to this facility, AND
- Discharged return anticipated, AND
- Returned to the facility within 30 days of discharge.

A1400. Original Date of Admission

A1400. Date of Admission
On what date did the resident's stay begin? (***Note**: This does not include readmission if the record was closed at the time of temporary discharge to the hospital, etc. In such cases, use the prior admission date*) ☐☐ - ☐☐ - ☐☐☐☐ M M D D Y Y Y Y

Item Rationale:

- To track the entry information that was recorded at the time of admission to the facility.

Definition:

- **Date The Stay Began**: The date the resident was most recently admitted to your facility

Steps for Assessment:

1. Review the clinical record. If dates are unclear or unavailable, ask the admissions office at your facility.

Coding Instructions:

- Use all boxes.
- For a one-digit month or day, place a zero in the first box. For example, January 2, 2023, should be entered as 01-02-2023.

A1500. Admitted From (at entry)

A1500. Admitted From *(at entry)*	
Enter code ☐☐	**Where was the resident admitted from?** 01. **Home/Community** (*e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care*) 02. **Nursing home** (*long-term care facility*) 03. **Skilled Nursing Facility** (*SNF, swing beds*) 04. **Short-Term General Hospital** (*acute hospital, IPPS*) 05. **Long-Term Care Hospital** *(LTCH)* 06. **Inpatient Rehabilitation Facility** (*IRF, free-standing facility or unit*) 07. **Inpatient Psychiatric Facility** (*psychiatric hospital or unit*) 08. **ID/DD facility** 09. **Hospice** (*home/non-institutional*) 10. **Hospice** (*institutional facility*) 11. **Critical Access Hospital** *(CAH)* 12. **Home under the care of an organized home health service organization** 99. **Not listed**

Item Rationale:

- Knowing the setting the individual was in immediately prior to facility admission or reentry assists with care planning services the resident receives during their stay and may

also assist with discharge planning.

Steps for Assessment:

1. Review admission records.
2. Consult the resident and the resident's family.

Coding Instructions:

Check only one answer.

- **Code 01:** If the resident was admitted from a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person, in retirement communities, or independent housing for the elderly.
- **Code 02:** If the resident was admitted from an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.
- **Code 03:** If the resident was admitted from a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other related health services. This category also includes residents admitted from an SNF swing bed in a swing-bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.
- **Code 04:** If the resident was admitted from an acute care hospital.
- **Code 05:** If the resident was admitted from a Medicare-certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit. (**Note:** there are none of these facilities in Maine).
- **Code 06:** If the resident was admitted from a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents admitted from a rehabilitation unit of a critical access hospital.
- **Code 07:** If the resident was admitted from an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of

mentally ill patients. This category also includes residents admitted from a psychiatric unit of a critical access hospital.

- **Code 08:** If the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).
- **Code 09:** If the resident was admitted from a community-based program for terminally ill persons.
- **Code 10:** If the resident was admitted from an inpatient program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider.
- **Code 11:** If the resident was admitted from a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all the criteria to be designated by CMS as a CAH and is receiving acute care services from the CAH at the time of discharge.
  - https://gateway.maine.gov/dhhs-apps/aspen/type_pop_services.asp?types=1
  - At the time this manual was written, there were 16 Critical Access Hospitals in Maine, according to the link above. If you are unsure of the type of hospital where a resident was admitted or sent, please check the link above.
- **Code 12:** If the resident was admitted from home under the care of an organized home health service organization. This includes only skilled services provided by a home health agency.
- **Code 99:** If the resident was admitted from none of the above.

A1600. Lived Alone (prior to admission)

A1600. Lived Alone *(prior to admission)*	
Enter code ☐	**Did the resident live alone prior to admission?** 0. **No** 1. **Yes** 2. **In another facility**

Item Rationale:

- To document the resident's living arrangements prior to admission.

Steps for Assessment:

1. Review admission records.

2. Consult the resident and the resident's family.

Coding Instructions:

- **Code 0:** If the resident was not living alone prior to admission to the facility.
- **Code 1:** If the resident lived alone prior to admission to the facility.
- **Code 2:** If the resident lived in another facility (i.e., nursing facility, group home, assisted living) prior to admission to the current facility.

A1700. Primary Zip Code (prior to admission)

A1700. Primary Zip Code *(prior to admission)*
Provide the zip code for the Resident's primary residence prior to admission:

Definition:

- **Prior Primary Residence:** The community address where the resident last resided prior to admission. A primary residence includes a primary home apartment, board, care home, and group home. Suppose the resident was admitted to your facility from a nursing home or institutional setting. In that case, the primary residence is the address of the resident's home prior to entering the nursing home, State mental institution, etc.

Steps for Assessment:

1. Review resident's admission records and transmittal records as necessary.
2. Ask residents and family members as appropriate.
3. Check with your facility's admissions office.

Coding Instructions:

- Enter town, state, and zip code.
- For zip code, enter one digit per box beginning with the left box. For example, Beverly Hills, CA 90210 should be entered as Beverly Hills, CA:

9	0	2	1	0

A1800. Date of Death or Discharge

A1800. Date of Death or Discharge
M M - D D - Y Y Y Y

Steps for Assessment:

1. Review the clinical record.

2. If dates are unclear or unavailable, ask the business office at your facility.

Coding Instructions:

- Use all boxes.
- For a one-digit month or day, place a zero in the first box. For example, January 2, 2023, should be entered as 01-02-2023.

A1900. Discharge Status

A1900. Discharge Status

Where was the resident discharged to?

Enter code ☐☐

01. **Home/Community** (*e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care*)
02. **Nursing home** (*long-term care facility*)
03. **Skilled Nursing Facility** (*SNF, swing beds*)
04. **Short-Term General Hospital** (*acute hospital, IPPS*)
05. **Long-Term Care Hospital** *(LTCH)*
06. **Inpatient Rehabilitation Facility** (*IRF, free-standing facility or unit*)
07. **Inpatient Psychiatric Facility** (*psychiatric hospital or unit*)
08. **ID/DD facility**
09. **Hospice** (*home/non-institutional*)
10. **Hospice** (*institutional facility*)
11. **Critical Access Hospital** *(CAH)*
12. **Home under the care of an organized home health service organization**
13. **Home with no home health service care**
14. **Deceased**
99. **Not listed**

Steps for Assessment:

1. Review the clinical record.
2. If the status is unclear or unavailable, ask the business office at your facility.

Coding Instructions:

Enter the corresponding number for the resident disposition upon discharge (i.e., the reason for discharge).

- **Code 01:** If the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person, in retirement communities, or independent housing for the elderly.
- **Code 02:** If the resident was discharged to an institution that is primarily engaged in providing medical and non-medical care to people who have a chronic illness or disability.
- **Code 03:** If the resident was discharged to a nursing facility with staff and equipment for the provision of skilled nursing services, skilled rehabilitative services, and/or other

related health services. This category also includes residents discharged to an SNF swing bed in a swing-bed hospital. A swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide posthospital SNF care and meets certain requirements.

- **Code 04:** If the resident was discharged to an acute care hospital.
- **Code 05:** If the resident was discharged to a Medicare-certified acute care hospital that focuses on patients who stay, on average, more than 25 days. Most patients in LTCHs are chronically and critically ill and have been transferred there from an intensive or critical-care unit.
- **Code 06:** If the resident was discharged to a rehabilitation hospital or a distinct rehabilitation unit of a hospital that provides an intensive rehabilitation program to inpatients. This category also includes residents discharged to a rehabilitation unit of a critical access hospital.
- **Code 07:** If the resident was discharged to an institution that provides, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. This category also includes residents discharged to a psychiatric unit of a critical access hospital.
- **Code 08:** If the resident was discharged to an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals with intellectual disabilities (ID) or developmental disabilities (DD).
- **Code 09:** If the resident was discharged to a community-based program for terminally ill persons.
- **Code 10:** If the resident was discharged to an inpatient program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider.
- **Code 11:** If the resident was discharged to a Medicare-participating hospital located in a rural area or an area that is treated as rural and that meets all the criteria to be designated by CMS as a CAH and is receiving acute care services from the CAH at the time of discharge.
- **Code 12:** If the resident was discharged to home under the care of an organized home

health service organization. This includes only skilled services provided by a home health agency.

- **Code 13:** If the resident was discharged to their home without any home health services.
- **Code 14:** If the resident was deceased at the time of discharge.
- **Code 99:** If the resident was discharged to a location other than listed above.

A2000. Provision of Current Reconciled Medication List to Another Provider at Discharge

A2000. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge	
Enter code ☐	**At the time of discharge, did your facility provide the resident's current reconciled medication list to the subsequent provider?** 0. **No** 1. **Yes** 2. **Not applicable**

Item Rationale:

- The transfer of a current reconciled medication list at the time of discharge can improve care coordination and quality of care and help the next providers reconcile medications, and it may decrease adverse outcomes related to medications.
- Communication of medication information at discharge is critical to ensure safe and effective transitions from one healthcare setting to another.

Definition:

- For the purposes of coding this item, the next provider is based on the discharge locations in A1900 and defined as any of the following:
  01. Home/Community
  02. Nursing Home
  03. Skilled Nursing Facility
  04. Short-Term General Hospital (acute care)
  05. Long-Term General Hospital
  06. Inpatient Rehabilitation Facility
  07. Inpatient Psychiatric Facility
  08. ID/DD Facility
  09. Hospice (home/non-institutional)
  10. Hospice (institutional facility)
  11. Critical Access Hospital
  12. Home under the care of an organized home health service organization

While the resident may receive care from other providers after discharge from your facility, such as primary care providers, other outpatient providers, and residential treatment centers, these locations are not considered to be subsequent providers for the purpose of coding this item.

- **Current Reconciled Medication List**: This refers to a list of the resident's current medications at the time of discharge that was checked for accuracy by the facility prior to the resident's discharge. Your facility should be guided by current standards of care and any applicable regulations and guidelines when determining what information should be included in a current reconciled medication list.

Steps for Assessment:

1. Determine if the resident was discharged to one of the next servicing providers defined in Item 1900.
2. If yes, determine whether, at the time of discharge, your facility provided a current reconciled medication list to the resident's next provider.

Coding Instructions:

- **Code 0:** If at discharge to another provider, your facility did not provide the resident's current reconciled medication list to the next provider, or the resident was not discharged to another provider.
- **Code 1:** If at discharge to another provider, your facility did provide the resident's current reconciled medication list to the next provider.
- **Code 2:** If this does not apply to the resident.

A2100. Provision of Current Reconciled Medication List to Resident at Discharge

A2100. Provision of Current Reconciled Medication List to Resident at Discharge	
Enter code ☐	**At the time of discharge, did your facility provide the resident's current reconciled medication list to the resident?** 0. **No** 1. **Yes** 2. **Not applicable**

Item Rationale:

- The transfer of a current and accurate medication list at the time of discharge can improve care coordination and quality of care and help the next providers ensure medications are accurate, and it may decrease adverse outcomes related to medications.
- Communication of medication information at discharge is critical to ensure safe and effective transitions from one healthcare setting to another.

Definitions:

- **Current Medication List**: This refers to a list of the resident's current medications at the time of discharge that was reviewed for accuracy by the facility prior to the resident's discharge. Your facility should be guided by current standards of care and any applicable regulations and guidelines in determining what information should be included in a current reconciled medication list.

Steps for Assessment:

1. Determine whether the resident was discharged to one of the next servicing providers defined in item A1900.
2. If yes, determine whether, at the time of discharge, your facility provided a currently reviewed and accurate medication list to the resident's next servicing provider.

Coding Instructions:

- **Code 0:** If at discharge, your facility did not provide the resident's currently reviewed and accurate medication list to the resident.
- **Code 1:** If at discharge, your facility did provide the resident's current reconciled medication list to the resident.
- **Code 2:** If this does not apply to the resident.

A2200. Level I Preadmission Screening and Resident Review (PASRR)

A2200. Level I Preadmission Screening and Resident Review *(PASRR)*	
Enter code ☐	**Has the resident received a level I PASRR assessment?** 0. **No** → Skip to A2400, Conditions related to ID/DD 1. **Yes**

Item Rationale:

- All individuals who are admitted to a Medicaid-certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions.
    - **Note:** This is a requirement in nursing facilities, not in residential care facilities or adult family care homes in Maine. The goal for these items is to be able to collect data to explore the need for resources in these facilities.
- Those residents covered by the Level II PASRR process may require certain care and services.

- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition.
- Any services to be provided by the facility as a result of PASRR screening should be addressed in the service plan.

A2300. Level II Preadmission Screening and Resident Review (PASRR)

A2300. Level II Preadmission Screening and Resident Review *(PASRR)*	
Enter code ☐	A. **Has the resident received a level II PASRR assessment?** 0. **No** → Skip to A2400A, Conditions related to ID/DD 1. **Yes**
Enter code ☐	B. **Is the resident currently considered by the state level II PASSR to have serious mental illness and/or intellectual disability or a related condition?** 0. **No** 1. **Yes**
Enter code ☐	C. **Based on Level II PASRR, does the resident have a serious mental illness?** 0. **No** 1. **Yes**
Enter code ☐	D. **Based on Level II PASRR, does the resident have an intellectual disability?** 0. **No** 1. **Yes**
Enter code ☐	E. **Based on Level II PASRR, does the resident have other related conditions?** 0. **No** 1. **Yes**

Coding Instructions:

Check all that apply.

- Code A, Serious mental illness: if the resident has been diagnosed with a serious mental illness.
- Code B, Intellectual Disability: if the resident has been diagnosed with intellectual disability/developmental disability (ID/DD).
- Code C, Other related conditions: if the resident has been diagnosed with other related conditions.

A2400. Conditions related to ID/DD Status

A2400. Conditions related to ID/DD Status	
Check all that apply:	
☐	A. **Down syndrome**
☐	B. **Autism**
☐	C. **Epilepsy**
☐	D. **Other organic conditions related to ID/DD**
☐	E. **ID/DD with no organic condition**
☐	Z. **None of the above**

Item Rationale:

- To document conditions associated with intellectual disability or developmental disabilities.

Definitions:

- **Other Organic Conditions Related To ID/DD**: Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrocephaly, meningomyelocele, congenital hydrocephalus, etc.

Steps for Assessment:

1. Review the resident's clinical record.
2. For any item to be checked, the condition must be documented in the clinical record.

Coding Instructions:

- Check all conditions related to ID/DD status that were present before age 22.
- When the age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- If an ID/DD condition is present, check "Yes" for each condition that applies.
- If an ID/DD condition is present, but the resident does not have any of the specific conditions listed, check item E ("ID/DD with No Organic Condition").

A2500. Marital Status

A2500. Marital Status	
Enter code ☐	1. **Never married** 2. **Married** 3. **Widowed** 4. **Separated** 5. **Divorced**

Item Rationale:

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.

Steps for Assessment:

1. Ask the resident about their marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither the family member nor significant other can report, review the medical

record for information.

Coding Instructions:

- Choose the answer that best describes the current marital status of the resident.
- Enter the corresponding number in the code box.

A2600. Legal Guardian

A2600. Legal Guardian	
Check all that apply:	
☐	A. **Does the resident have a legal guardian?**
☐	B. **Does the resident have other legal oversight?**
☐	C. **Does the resident have a durable power of attorney for health care?**
☐	D. **Does the resident have a durable power of attorney for finances?**
☐	E. **Is a family member responsible for the resident?**
☐	F. **Is the resident responsible for personal decisions?**
☐	G. **Does the resident have a legal conservator?**
☐	H. **Does the resident have a representative payee?**
☐	Z. **None of the above**

Item Rationale:

- To record who is responsible for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs.
- Depending on the resident's condition, multiple options may apply.
    - For example, a resident with moderate dementia may be competent to make decisions in certain areas, although, in other areas, a family member will assume decision-making responsibility.
    - Or a resident may have executed a limited power of attorney to someone responsible only for legal affairs (e.g., a son) while another (e.g., a daughter) makes health care decisions.

Steps for Assessment:

1. Legal oversight, such as guardianship, durable power of attorney, and living wills, are generally governed by state law.
2. The descriptions provided here are for general information only. Be sure to refer to the law in your state and the facility's legal counsel, as appropriate, for any additional details or clarification.
3. Consult the resident and the resident's family.
4. Review records.

5. Legal oversight or guardianship is court-ordered and a copy of the legal document must be included in the resident's record for the item to be checked on the MDS form.

Coding Instructions:

- **Code A:** If someone has been appointed after a court hearing and is legally authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.
- **Code B:** Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.
- **Code C:** If there is documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agency or proxy decision-maker and may include instructions concerning the resident's wishes for care. Unlike guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.
- **Code D:** If there is documentation that someone other than the resident is legally responsible for financial decisions if the resident is or becomes unable to make decisions.
- **Code E:** If the resident has designated immediate family or significant other(s) to make decisions.
- **Code F:** If the resident retains responsibility for decisions in the absence of guardianship or legal documents indicating that decision-making has been delegated to others; always assume that the resident is the responsible party.
- **Code G:** If there is documentation that someone other than the resident is responsible for the welfare and the property of a person ruled incompetent.
- **Code H:** If someone other than the resident has financial responsibility for the payment of bills.
- **Code Z:** If none of the above apply to the resident.

A2700. Advanced Directives

A2700. Advanced Directives	
Check all that apply:	
☐	A. **Does the resident have a living will?**
☐	B. **Does the resident have a DNR directive?**
☐	C. **Does the resident have a directive to not hospitalize?**
☐	D. **Does the resident have a directive not to intubate?**
☐	E. **Does the resident have feeding restrictions?**
☐	F. **Does the resident have a directive to donate organs?**
☐	G. **Does the resident have another type of directive?**
☐	Z. **None of the above**

Item Rationale:

- To record the legal existence of directives regarding treatment for the resident, whether made by the resident or a legal proxy.
- The absence of pre-existing directives for the resident should prompt discussion by staff with the resident and family regarding the resident's wishes.
- Any discrepancies between the resident's wishes and what is stated in legal documents in the resident's file should be resolved immediately.

Steps for Assessment:

1. You will need to familiarize yourself with the legal status of each type of directive in your state. In some states, only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and appointment of individuals with durable power of attorney for health care decisions.
2. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.
3. Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the clinical record for the directive to be considered current and binding.
4. Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new resident has ever created an advance directive (e.g., ask family members or check with the primary physician).
5. Lacking any directive, treatment decisions will likely be made with the resident's

closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding Instructions:

- **Code A:** If there is a document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.
- **Code B:** If, in the event of respiratory or cardiac failure, the resident or family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods be used to restore the resident's respiratory or circulatory function.
- **Code C:** If there is a document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.
- **Code D:** If there is a document indicating that the resident has a "Do not intubate" on file.
- **Code E:** If the resident has feeding restrictions.
- **Code F:** If there are instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.
- **Code G:** If the resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include but are not limited to, blood transfusion, tracheotomy, respiratory incubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.
- **Code Z:** If none of the above choices is applicable to the resident.

Note: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.
- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded

or after the physician provides the necessary order. Where a physician's current order is recorded, but the resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after obtaining documentation confirming that the resident's or proxy's wishes have been entered into the record.

- If your facility has a standard protocol for withholding treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; the facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.
- Check "1" for Yes if any of the above-stated treatment options are documented in medical records. If none of the directives are verified by documentation in the medical records, check "0" for No. Please specify if you check the "Other" advanced directive.

A2800. Ethnicity

A2800. Ethnicity	
Is the resident of Hispanic, Latino/a, or Spanish origin? Check all that apply:	
☐	A. **No, not of Hispanic, Latino/a, or Spanish origin**
☐	B. **Yes, Mexican, Mexican American, Chicano/a**
☐	C. **Yes, Puerto Rican**
☐	D. **Yes, Cuban**
☐	E. **Yes, another Hispanic, Latino/a, or Spanish origin**
☐	X. **Resident unable to respond**
☐	Y. **Resident declines to respond**

Item Rationale:

- The ability to improve understanding of and address ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.
- The ethnicity data element uses a one-question multi-response format based on whether the resident is of Hispanic, Latino/a, or Spanish origin. The collection of ethnic data provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.
- This item uses the common uniform language approved by the Office of Management

and Budget (OMB) to report ethnic categories.

- Collection of ethnicity data is an important step in improving quality of care and health outcomes.
- Standardizing self-reported data collection for ethnicity allows for the comparison of data within and across multiple post-acute-care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.
- For the source of these categories and definitions, see "Racial and Ethnic Categories and Definitions for NIH Diversity Programs and for Other Reporting Purposes, Notice Number: NOT-OD-15-089" available at https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-089.html. Additional information on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status is available at https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53.

Steps for Assessment:

1. Ask the resident to select the category or categories that most closely correspond to their ethnicity from the list in A2800.
2. If the resident is unable to respond, the assessor may ask a family member, significant other, and/or guardian/legally authorized representative.
3. Ethnic category definitions are provided only if requested to answer the item.
4. Respondents should be offered the option of selecting one or more ethnic designations.
5. Only use medical record documentation to Ethnicity, if the resident is unable to respond and no family member, significant other, and/or guardian/legally authorized representative provides a response for this item.
6. If the resident declines (refuses) to respond, do not code based on other resources (family, significant other, guardian/legally authorized representative, or medical records).

Coding Instructions:

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

- **Code X:** If the resident is unable to respond.

- In the cases where the resident is unable to respond and the response is determined via family, significant other, or legally authorized representative input or medical record documentation, check all boxes that apply, including X. Resident unable to respond.
- If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provided the necessary information, code as X, Resident unable to respond.

- **Code Y:** If the resident declines or refuses to respond.
  - When the resident declines or refuses to respond, code only Y. Resident declines or refuses to respond.
  - When the resident declines or refuses to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).
- **Code Z:** If none of the above choices is applicable to the resident.

A2900. Race

A2900. Race	
Check all that apply:	
☐	A. **White**
☐	B. **Black or African American**
☐	C. **American Indian or Alaska Native**
☐	D. **Asian Indian**
☐	E. **Chinese**
☐	F. **Filipino**
☐	G. **Japanese**
☐	H. **Korean**
☐	I. **Vietnamese**
☐	J. **Other Asian**
☐	K. **Native Hawaiian**
☐	L. **Guamanian or Chamorro**
☐	M. **Samoan**
☐	N. **Other Pacific Islander**
☐	X. **Resident unable to respond**
☐	Y. **Resident declines to respond**
☐	Z. **None of the above**

Item Rationale:

- The ability to improve understanding of and address racial disparities in health care outcomes requires the availability of better data related to social determinants of health,

including race.

- Collection of A2900. Race provides data granularity important for documenting and tracking health disparities and conforms to the 2011 Health and Human Services Data Standards.
- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial categories (see Definitions: Race).
- The collection of race data is an important step in improving the quality of care and health outcomes.
- Standardizing self-reported data collection for race allows for the equal comparison of data across multiple post-acute-care settings.
- These categories are NOT used to determine eligibility for participation in any Federal program.

Coding Instructions:

If the resident responds, check the box(es) indicating the race category or categories identified by the resident.

- **Code X:** If the resident is unable to respond.
    - In the cases where the resident is unable to respond, and the response is determined via family, significant other, or legally authorized representative input or medical records, check all boxes that apply, including X. Resident unable to respond.
    - If the resident is unable to respond and no other resources (family, significant other, or legally authorized representative or medical records) provide the necessary information, code as X. Resident unable to respond.
- **Code Y:** If the resident declines or refuses to respond.
    - When the resident declines or refuses to respond, code only Y. Resident declines or refuses to respond.
    - When the resident declines or refuses to respond, do not code based on other resources (family, significant other, or legally authorized representative or medical records).
- **Code Z:** If the resident reports or it is determined from other resources (family, significant other, or legally authorized representative or medical records) that none of the

listed races apply.

A3000. Language

A3000. Language	
	A. **What is the resident's preferred language?** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Enter code ☐	B. **Does the resident need or want an interpreter to communicate with a doctor or healthcare staff?** 0. **No** 1. **Yes**

Item Rationale:

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can lead to social isolation, depression, resident safety issues, and unmet needs.
- Language barriers can interfere with accurate assessment.
- When a resident needs or wants interpreter services, facilities must ensure that an interpreter is available.
- An alternate method of communication should also be made available to help ensure that basic needs can always be expressed (e.g., a communication board with pictures on it for the resident to point to, if possible).
- Identifies residents who need interpreter services to answer interview items or participate in the consent process.

Coding Instructions for A3000A:

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, significant other, and/or guardian/legally authorized representative and/or reviewing the medical record.
- If the resident, family member, significant other, guardian/legally authorized representative, and/or medical record documentation cannot or does not identify the preferred language, enter a dash (—) in the first box. A dash indicates "no information."

Coding Instructions for A3000B:

- **Code 0:** If the resident (family, significant other, guardian/legally authorized representative, or medical record) indicates there is no need or want of an interpreter to communicate with a doctor or health care staff.
- **Code 1:** If the resident (family, significant other, guardian/legally authorized representative, or medical record) indicates the need or want of an interpreter to

communicate with a doctor or health care staff. Ensure that the preferred language is indicated.

3.4. Section B: Hearing, Speech, and Vision

B0100. Hearing

B0100. Hearing	
Enter code ☐	**Ability to hear with hearing aid or hearing appliances if normally used:** 0. **Adequate -** No difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty in some environments** *(e.g., when a person speaks softly or the setting is noisy)* 2. **Moderate difficulty -** The speaker has to increase the volume and speak distinctly 3. **Highly impaired -** The absence of useful hearing

Item Rationale:

- To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the past seven-day look-back period.

Steps for Assessment:

1. If the resident uses an appliance (e.g., hearing aid), evaluate hearing ability after the resident has a hearing appliance in place.
2. Review the record.
3. Interview and observe the resident and ask about the hearing function.
4. Consult the resident's family, direct care staff, and speech or hearing specialists.
5. Test the accuracy of your findings by observing the resident during your verbal interactions.

Coding Instructions:

Check the numbered box that corresponds with the most correct response.

- **Code 0:** If the resident hears all normal conversational speech, including when using the telephone, watching television, and engaging in group activities.
- **Code 1:** If the resident can hear speech at conversational levels but faces challenges when the environment is not quiet or when the conversation is not one-on-one.
- **Code 2:** If, although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly, or the resident can hear only when the speaker's face is clearly visible.
- **Code 3:** If the resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

B0200. Communication Devices & Techniques

B0200. Communication Devices & Techniques	
Check all that apply during the LAST 7 DAYS:	
☐	A. **Hearing aid -** Present and used
☐	B. **Hearing aid -** Present and not used regularly
☐	C. **American Sign Language**
☐	D. **Non-traditional sign or gesture language**
☐	E. **Other receptive communication techniques used** *(e.g., lip reading or communication board)*
☐	Z. **None of the above**

Steps for Assessment:

1. Consult with the resident and direct care staff.
2. Observe the resident closely during your interaction.

Coding Instructions:

Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check none of the above**.**

- **Code A:** If a hearing aid or another assistive listening device is available to the resident and is used regularly.
- **Code B:** If a hearing aid or another assistive device is available to the resident and is not regularly used (e.g., the resident has a hearing aid that is broken or is used only occasionally).
- **Code C:** If the resident uses American Sign Language (ASL) to communicate.
- **Code D:** If a resident uses specific gestures, hand signals, or other ways of letting staff or family know of a need or request.
- **Code E:** If the resident uses a mechanism or process to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, writing by a staff member, use of communication board).
- **Code Z:** If none of the above apply to the resident.

B0300. Speech Clarity

B0300. Speech Clarity	
Enter code ☐	**Select the best description of the resident's speech pattern:** 0. **Clear speech -** Distinct intelligible words 1. **Unclear speech -** Slurred or mumbled words 2. **No speech -** Absence of spoken words

Item Rationale:

- Unclear speech or absent speech can result in physical and psychosocial needs not being met and can contribute to depression and social isolation. Unclear speech or absent speech can hinder communication and be very frustrating to an individual.
- If speech is absent or is not clear enough for the resident to make needs known, other methods of communication should be explored. Lack of speech clarity or ability to speak should not be mistaken for cognitive impairment.

Definitions:

- Speech or language refers to the means of communication used by people. Speech is the expression of ideas and thoughts by means of articulate vocal sounds or the faculty of thus expressing ideas and thoughts.

Steps for Assessment:

1. Listen to the resident and ask direct caregivers about the resident's speech patterns.
2. Determine the quality of the resident's speech, not the content or appropriateness – just the words spoken.

Coding Instructions:

- **Code 0:** If the resident usually utters distinct, intelligible words.
- **Code 1:** If the resident usually utters slurred or mumbled words.
- **Code 2:** If there is an absence of spoken words.

B0400. Makes Self Understood

B0400. Makes Self Understood	
Enter code ☐	**Ability to express ideas and wants, consider both verbal and non-verbal expression:** 0. **Understood** 1. **Usually understood -** Difficulty communicating some words or finishing thoughts but is able if prompted or given time 2. **Sometimes understood -** Ability is limited to making concrete requests 3. **Rarely/never understood**

Item Rationale:

- To document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.

Steps for Assessment:

1. Interact with the resident.
2. Observe and listen to the resident's efforts to communicate with you.

3. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated).
4. Consult with the primary caregivers (across all shifts) and the resident's family.

Coding Instructions:

Check the numbered box that corresponds with the most correct response.

- **Code 0:** If the resident is able to make themselves understood.
- **Code 1:** If the resident has difficulty finding the right words or finishing thoughts. They may have delayed responses or may require some prompting to make themselves understood.
- **Code 2:** If the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet, and pain).
- **Code 3:** If, at best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language/gestures (e.g., indicated presence of pain or need to toilet).

B0500. Ability to Understand Others

B0500. Ability to Understand Others	
Enter code ☐	**Understanding information content:** 0. **Understands** 1. **Usually understands -** May miss some part and/or intent of the message 2. **Sometimes understands -** Responds adequately to simple direct communication 3. **Rarely/never understands**

Item Rationale:

- The ability to express or communicate requests, needs, and opinions and to conduct social conversation in their primary language, whether in speech, writing, sign language, gestures, or a combination of these.
- Deficits in the ability to make oneself understood (expressive communication deficits) can include reduced voice volume, difficulty producing sounds, difficulty in finding the right word, making sentences, writing, and/or gesturing.
- This item measures the resident's ability to process and understand language and the resident's ability to comprehend information, whether communicated to the resident orally, by writing, in sign language, or Braille.

Steps for Assessment:

1. Interact with the resident.
2. Consult with primary caregiver staff across all shifts and, if possible, the resident’s family.

Coding Instructions:

Check the numbered box that corresponds with the most appropriate response.

- **Code 0:** If the resident comprehends the speaker's message(s) clearly and demonstrates comprehension by words or actions/behaviors.
- **Code 1:** If the resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2:** If the resident has limited communication abilities but can express basic needs such as requests for food, drink, sleep, or the toilet. When staff rephrase or simplify messages and use gestures, the resident's comprehension improves.
- **Code 3:** If the resident demonstrates very limited ability to understand communication. At best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

B0600. Vision

B0600. Vision	
Enter code ☐	**Ability to see in adequate light with glasses or other visual appliances:** 0. **Adequate -** Sees fine detail, such as regular print in newspapers and/or books 1. **Impaired -** See large print, but not regular print in newspapers and/or books 2. **Moderately impaired -** Limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired -** Object identification in question, but eyes appear to follow objects 4. **Severely impaired -** No vision or sees only light, colors, or shapes; eyes do not appear to follow objects

Item Rationale:

- To record the resident's visual abilities and limitations and to evaluate the resident's ability to see close objects in adequate lighting, using the resident's usual visual appliances for close vision (e.g., glasses, magnifying glass).

Definitions:

- **Adequate lighting:** The amount of lighting that is sufficient or comfortable for an individual with normal vision to see fine print.

Steps for Assessment:

1. Ask direct care staff across all shifts and family if the resident has experienced any change in usual vision patterns over the past seven days (e.g., if the resident could previously, is the resident still able to read newsprint, menus, greeting cards, etc.).
2. Then, ask the resident about his or her visual abilities.

3. Test the accuracy of your findings by asking the resident to look at a regular-size print in a book or newspaper. Ensure there is adequate lighting and whatever visual appliances they usually use for close vision (e.g., glasses, magnifying glass). Ask the resident to read aloud, starting with larger headlines and ending with smaller print.
4. Be sensitive to the fact that some residents may not be literate, may be unable to read aloud due to aphasia, or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

Coding Instructions:

Check the numbered box that corresponds with the most correct response.

- **Code 0:** Adequate: If the resident sees fine detail, including regular print in newspapers/books.
- **Code 1:** Impaired: If the resident sees large print but not regular print in newspapers/books.
- **Code 2:** Moderately impaired: If the resident has limited vision and is not able to see newspaper headlines but can identify objects in their environment.
- **Code 3:** Highly Impaired: If the resident's ability to identify objects nearby in their environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).
- **Code 4:** Severely Impaired: If the resident has no vision, sees only light colors or shapes, or does not appear to be following objects.

Note: Many residents with severe cognitive impairments are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes.

Examples:

1. When asked about whether they can see fine detail, including regular print in newspapers/books, the resident responds, "When I wear my glasses, I can read the paper fine. If I forget to wear glasses, it is harder to see unless I hold the paper a little closer."
    a. **Coding:** B0600 would be coded 0, Adequate.
    b. **Rationale:** The resident can read regular print when wearing glasses.

2. The assessor asks the resident to read aloud from a newspaper, starting with larger headlines and then the smaller print. The resident is able to read the headlines but not the regular newspaper print.
    a. **Coding:** B0600 would be coded 1. Impaired.
    b. **Rationale:** The resident is able to read large, but not regular, print.
3. "I cannot read the newspaper headlines, even with glasses." When the assessor presents the resident with newspaper text while wearing glasses, the resident is not able to correctly read the headlines. The resident is able to identify the objects on the table a few feet away.
    a. **Coding:** B0600 would be coded 2, Moderately Impaired**.**
    b. **Rationale:** The resident is not able to read large print (i.e., newspaper headlines) but is able to identify objects in their environment.
4. During the assessment, the resident states, "I cannot see much of anything at this point. I can see blurry shapes, and I can tell what large objects are, but I cannot read books anymore—even the ones with giant prints. I do okay recognizing my caregivers by their voices, but I could not tell you what they look like. Everyone is just a blob of color, even with my glasses on." The resident's eyes appear to follow the assessor when they move about the room. When the assessor presents the resident with newspaper text while wearing glasses, the resident is able to reach for and successfully hold the paper appropriately but is not able to correctly read the headlines.
    a. **Coding:** B0600 would be coded 3, Highly Impaired.
    b. **Rationale:** The resident can follow objects and track movement in the environment (e.g., people moving throughout the room) but is unable to see people or objects in detail.

B0700. Corrective Lenses

B0700. Corrective Lenses	
Enter code ☐	**Were corrective lenses used in completing B0600, Vision?** 0. **No** 1. **Yes**

Item Rationale:

- To determine if the resident uses visual appliances regularly.

Definitions:

- **Visual appliances:** This may include glasses, contact lenses, magnifying glasses, or any corrective device used by the resident.

Coding Instructions:

- **Code 0:** If the resident did not use eyeglasses or another visual aide.
- **Code 1:** If corrective lenses or other visual aides were used when visual ability was assessed.

3.5. Section C: Cognitive Patterns

C0100. Short-term Memory

C0100. Short-term Memory	
Enter code ☐	**Seems or appears to recall after 5 minutes:** 0. **Memory OK** 1. **Memory problem**

Item Rationale:

- To determine the resident's functional capacity to remember recent events.

Steps for Assessment:

1. Ask the resident to describe a recent event that both of you had the opportunity to remember. Can the resident describe the breakfast meal, or an activity just completed?
2. Alternatively, you could use a more structured short-term memory test, such as asking the resident to remember three items (e.g., book, watch, and table). After you have stated all three items, wait a few minutes and ask the resident to repeat the name of each item. If the resident is unable to recall all three items, check "1."

Coding Instructions:

- **Code 0:** If memory appears OK.
- **Code 1:** If there appears to be a memory problem.

C0200. Long-term Memory

C0200. Long-term Memory	
Enter code ☐	**Seems or appears to recall long past:** 0. **Memory OK** 1. **Memory problem**

Item Rationale:

- To determine the resident's functional capacity to remember long-past events.

Steps for Assessment:

1. Engage in conversation that is meaningful to the resident.
2. Ask questions for which you already know the answers (from your review of the resident's record, general knowledge, or the resident's family):
3. Ask the resident, "Where did you live just before you came here? If "at home" is the reply, ask, "What was your address?" If "a residential facility or assisted living facility" is the reply, ask, "What was the name of the place?" then ask: "Are you married?"

"What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?" "In what year were you born?"

Coding Instructions:

- **Code 0:** If memory appears OK.
- **Code 1:** If there appears to be a memory problem.

C0300. Memory & Recall Ability

C0300. Memory & Recall Ability	
Check all that the resident was normally able to recall:	
☐	A. **Current season**
☐	B. **Location of own room**
☐	C. **Staff names and faces**
☐	D. **That they are in a residential care facility**
☐	Z. **None of the above**

Item Rationale:

- To determine the resident's memory/recall performance within the environmental setting.
- Residents may have intact social graces and respond to staff and others with a look of recognition, yet they may not know who they are.
- This item will enable staff to probe beyond first, perhaps mistaken, impressions.

Steps for Assessment:

1. Test memory/recall.
2. Use information obtained from clinical records or staff.
3. Ask the resident about each item. For example, "What is the current season?" "What is the name of this place?" "What kind of place is this?"
4. If the resident is not in his or her room, ask, "Will you show me to your room?" Observe the resident's ability to find the way.

Coding Instructions:

Check the corresponding answer box for each item the resident can recall. If the resident can recall none, check none of the above.

- **Code A:** If the resident is able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
- **Code B:** If the resident is able to locate and recognize their own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

- **Code C:** If the resident is able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.
- **Code D:** To check this item, it is not necessary that the resident be able to state the name of the facility, but they should be able to refer to the facility by a term such as a "home for older people," "rest home," "a place where older people live," etc.
- **Code Z:** If none of the above applies to the resident.

C0400. Cognitive Skills for Daily Decision-Making

C0400. Cognitive Skills for Daily Decision-Making	
Enter code ☐	**Made decisions regarding tasks of daily living:** 0. **Independent** *(decisions consistent/reasonable)* 1. **Modified independence** *(some difficulty in new situations only)* 2. **Moderately impaired** *(decisions poor; cues/supervision required)* 3. **Severely impaired** *(never/rarely made decisions)*

Item Rationale:

- To record the resident's actual performance in making everyday decisions about the tasks or activities of daily living.
- This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance or that staff may be inadvertently fostering the resident's dependence.
- Remember, this item intends to record what the resident is doing (performance). When a staff member has taken decision-making responsibility away from the resident regarding tasks of everyday living, or the resident is unable to participate in decision-making, the resident should be considered to have impaired performance in decision-making.

Steps for Assessment:

1. Review the clinical record. Consult family and caregiver staff. Observe the resident.
2. The inquiry should focus on whether the resident is actively making these decisions and not whether staff believes the resident might be capable of doing so. Examples include:
    a. Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events).

b. In the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others to plan the day, using awareness of one's own strengths and limitations in regulating the day's events (e.g., asking for help when necessary).
c. Making the correct decision concerning how to get to the lunchroom; acknowledging the need to use a walker and using it faithfully.

3. When coding, identify the most representative level of function, not necessarily the highest**.** Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's typical level of function.
4. There must be documentation to support all coding on the MDS. The look-back period for this item is seven days.

Note: A resident who makes a poor decision is still making a decision.

Coding Instructions:

Check the numbered box for the most representative level of function, not necessarily the highest**.** Staff must use clinical judgment to decide if a single observation provides sufficient information on the resident's typical level of function.

- **Code 0:** If the resident's decisions were consistent and reasonable (reflecting lifestyle, culture, and values), the resident organized their daily routine and made decisions in a consistent, reasonable, and organized fashion.
- **Code 1:** If the resident organized their daily routine and made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations. If there have been no new tasks or situations within the look back, this choice cannot be coded.
- **Code 2:** If the resident's decisions were poor, the resident required reminders, cues, and supervision in planning, organizing, and conducting daily routines.
- **Code 3:** If the resident's decision-making was severely impaired, the resident never made independent decisions. If the resident does not respond to reminders, cues, or supervision, the resident is dependent on others for everyday decision-making.

3.6 Section D: Mood

D0100. Indicators of Depression, Anxiety, Sad Mood

D0100. Indicators of Depression, Anxiety, Sad Mood		
A. **Exhibited -** Indicate the frequency of the symptom(s) observed in the **LAST 14 DAYS**, regardless of the cause: 0. **Not exhibited at least one day per week** 1. **Exhibited 1 - 5 days per week** 2. **Exhibited 6 - 7 days per week**	B. **Persistence -** Indicate how easily altered the mood indicator was over the **LAST 14 DAYS**: 0. **Not exhibited** 1. **Indicator present** *(easily altered)* 2. **Indicator present** *(not easily altered)*	
A. **Exhibited:**	B. **Persistence:**	
☐	☐	a. **Resident made negative statements -** Including self-deprecation
☐	☐	b. **Repetitive questions -** Including repetitive statements, repetitive anxious complaints and/or concerns that are non-health related
☐	☐	c. **Persistent anger with self or others**
☐	☐	d. **Repetitive health complaints -** Includes repetitive anxious complaints and/or concerns
☐	☐	e. **Trouble falling or staying asleep, sleeping too much**
☐	☐	f. **Crying, tearfulness**
☐	☐	g. **Withdrawal from activities of interest and/or change in level of social interaction**
☐	☐	h. **Statements that life is not worth living, statements of wanting to die, attempts to harm self**

Item Rationale:

- To record the frequency of indicators observed and reported in the last 14 days (or since admission if less than 14 days), regardless of the assumed cause of the behavior.
- Mood distress is a serious condition and is associated with declines in health and functional status. Associated factors include poor adjustment to the assisted housing facility, functional impairment, resistance to daily care, inability to participate in or withdraw from activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain.
- It is particularly important to identify signs and symptoms of mood distress among elderly residents because they are very treatable. In addition, case management and other services are available for persons with persistent mental illness, including depression.
- In most facilities, staff has not received specific training to evaluate residents with distressed mood or behavioral symptoms. Therefore, many problems are underdiagnosed and under-treated.
- The goal of the following items is to assist staff in recognizing signs and symptoms so that, if needed, residents can be referred for further evaluation and services.

Steps for Assessment:

1. Review daily staff documentation. Daily staff documentation for all shifts is the preferred method to support the coding of these indicators. If daily documentation is not utilized,

results of the staff consultations and/or interviews must be documented in the resident's record to support the entire 14-day look back.

2. If withdrawal from activities of interest and/or change in the level of social interaction occurred during the look-back period but is not a change in the usual pattern for the resident, this information could be referenced in the monthly summary or other areas of documentation in the resident's clinical record. It would not be coded on the MDS. Evaluation of staff documentation will allow the facility to be aware of changes in the resident's moods.
3. Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and may tell someone about their feelings of distress or tell someone only when asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel or lack insight or cognitive capacity). Observe residents carefully for any indicators. Consult with or interview direct-care staff across all shifts and, if possible, family with direct knowledge of the resident's moods.
4. Be aware that staff may fail to note these signs and symptoms or think they are "normal" for the resident. Asking a resident about sad or anxious mood, depression, or even suicidal feelings will not "create" those feelings, although it may allow the resident to voice those feelings for the first time.

Definitions:

- **Resident made negative statements:** Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.
- **Repetitive questions:** Non-health-related questions such as, "Where do I go? What do I do?
- **Persistent anger with self or others:** Easily annoyed, anger at placement in a care home; persistent anger at care received.
- **Repetitive health complaints:** Persistently seeking medical attention, obsessive concern with body functions.
- **Insomnia or change in usual sleep patterns:** Difficulty falling asleep, less or more hours of sleep than normal, waking up too early, and unable to fall back to sleep.

- **Withdrawal from activities of interest and/or change in level of social interaction:** No interest in long-standing activities or being with family/friends.
- **Statements that life is not worth living:** Statements of wanting to die, attempts to harm self.

Coding Instructions for D0100A:

Record the code that indicates how often the symptom(s) were observed in the last 14 days, regardless of the assumed cause.

- **Code 0:** If symptoms were not exhibited, at least ONE DAY per week.
- **Code 1:** If symptoms were exhibited 1-5 DAYS per week.
- **Code 2:** If symptoms were exhibited 6-7 DAYS per week.

Coding Instructions for D0100B:

Record the code that shows how easily the signs of depression, anxiety, or sad mood changed over the last 14 days.

- **Code 0:** If symptoms were not exhibited.
- **Code 1:** If symptoms were present but were easily altered.
- **Code 2:** If symptoms were present and not easily altered.

D0200. Verbal Expressions of Distress

D0200. Verbal Expressions of Distress		
A. **Exhibited -** Indicate the frequency of the symptom(s) observed in the **LAST 14 DAYS**, regardless of the cause: 0. **Not exhibited at least one day per week** 1. **Exhibited 1 - 5 days per week** 2. **Exhibited 6 - 7 days per week**		B. **Persistence -** Indicate how easily altered the mood indicator was over the **LAST 14 DAYS**: 0. **Not exhibited** 1. **Indicator present** *(easily altered)* 2. **Indicator present** *(not easily altered)*
A. **Exhibited:**	B. **Persistence:**	
☐	☐	a. **Repetitive verbalizations** *(e.g., calling out for help, "God help me")*
☐	☐	b. **Self-deprecation** *(e.g., "I am nothing; I am no use to anyone.")*
☐	☐	c. **Expressions of what appear to be unrealistic fears** *(e.g., fear of being abandoned, left alone, being with others)*
☐	☐	d. **Recurrent statements that something terrible is about to happen** *(e.g. believes he or she is about to die, have a heart attack)*
☐	☐	e. **Repetitive anxious complaints/concerns** - Non-health related *(e.g., persistently seeks attention/reassurance on schedules, meals, laundry, relationship issues, etc.)*
☐	☐	f. **Unpleasant mood in the morning**
☐	☐	g. **Insomnia/change in usual sleep pattern**
☐	☐	h. **Sad, pained, worried facial expressions** *(e.g., furrowed brows)*
☐	☐	i. **Repetitive physical movements** *(e.g., restlessness, fidgeting, picking)*
☐	☐	j. **Reduced social interaction**
☐	☐	k. **Inflated self-worth, exaggerated self-opinion, belief in one's own ability, etc.**
☐	☐	l. **Excited behavior, motor excitation** *(e.g., heightened physical activity, pressured speech; increased reactivity)*

Steps for Assessment:

1. Review daily staff documentation. Daily staff documentation for all shifts is the preferred method to support the coding of these indicators. If daily documentation is not utilized, results of the staff consultations and/or interviews must be documented in the resident's record to support the entire 14-day look back.
2. If withdrawal from activities of interest and/or change in the level of social interaction occurred during the look-back period but is not a change in the usual pattern for the resident, this information could be referenced in the monthly summary or other areas of documentation in the resident's clinical record. It would not be coded on the MDS. Evaluation of staff documentation will allow the facility to be aware of changes in the resident's moods.
3. Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and may tell someone about their feelings of distress or tell someone only when asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel or lack insight or cognitive capacity). Observe residents carefully for any indicators. Consult with or interview direct-care staff across all shifts and, if possible, family who have direct knowledge of the resident's moods.
4. Be aware that staff may fail to note these signs and symptoms or think they are "normal" for the resident. Asking a resident about sad or anxious mood, depression, or even suicidal feelings will not "create" those feelings, although it may allow the resident to voice those feelings for the first time.

Coding Instructions for D0200A:

Record the code that indicates how often the symptom(s) were observed in the last 14 days, regardless of the assumed cause.

- **Code 0:** If symptoms were not exhibited, at least ONE DAY per week.
- **Code 1:** If symptoms were exhibited 1-5 DAYS per week.
- **Code 2:** If symptoms were exhibited 6-7 DAYS per week.

Coding Instructions for D0200B:

Record the code that shows how easily the signs of depression, anxiety, or sad mood changed over the last 14 days.

- **Code 0:** If symptoms were not exhibited.
- **Code 1:** If symptoms were present but were easily altered.
- **Code 2:** If symptoms were present and not easily altered.

3.7. Section E: Behaviors

E0100. Potential Indicators of Psychosis

E0100. Potential Indicators of Psychosis	
Check all that apply within the LAST 7 DAYS:	
☐	A. **Hallucinations** *(perceptual experiences in the absence of real external sensory stimuli)*
☐	B. **Delusions** *(misconceptions or beliefs that are firmly held, contrary to reality)*
☐	Z. **None of the above**

Item Rationale:

- Reversible and treatable causes of psychosis should be identified and addressed promptly.
- When the cause is not reversible, management strategies should focus on minimizing the amount of disability and distress.

Definitions:

- **Hallucination:** The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes, or touch.
- **Delusion:** A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
    - Hallucinations and delusions may:
        - be distressing to residents and families,
        - cause disability,
        - interfere with the delivery of medical, nursing, rehabilitative, and personal care, and
        - lead to dangerous behavior or possible harm.
- **Psychotic symptoms may be associated with:**
    - delirium,
    - dementia,
    - adverse drug effects,
    - psychiatric disorders, and
    - hearing or vision impairment.

Steps for Assessment:

1. Review the resident's medical record for the 7-day look-back period.
2. Interview staff members and others who have had the opportunity to observe the resident in a variety of situations during the 7-day look-back period.

3. Observe the resident during conversations and structured interviews in other assessment sections and listen for statements indicating an experience of hallucinations or the expression of false beliefs (delusions).
4. Documentation must include a description of the delusions and evidence that the resident's delusion was false. A resident's repetitive delusions should be referenced on the service false. A resident's repetitive delusions should be referenced in the service plan.
5. The documentation must describe the hallucinations. The service plan should also reference resident care requirements.
6. Clarify potentially false beliefs: When a resident expresses a belief that is plausible but alleged by others to be false (e.g., history indicates that the resident's spouse died 20 years ago, but the resident states their spouse has been visiting them every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.
7. When a resident expresses a belief that is plausible but alleged by others to be false (e.g., history indicates that the resident's spouse died 20 years ago, but the resident states their spouse has been visiting them every day), try to verify the facts to determine whether there is reason to believe that it could have happened or whether it is likely that the belief is false.
8. When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) or demonstration of evidence to the contrary. Do not, however, challenge the resident.
9. The resident's response to offering a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed.

Coding Instructions:

Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. Check all that apply.

- **Code A:** If hallucinations were present in the last 7 days.
- **Code B:** If delusions were present in the last 7 days.
- **Code Z:** If no hallucinations or delusions were present in the last 7 days.

Coding Tips and Special Populations:

- If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion.
- If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do not code it as a delusion.
- If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion.

E0200. Behavioral Symptoms (Presence & Frequency)

E0200. Behavioral Symptoms *(Presence & Frequency)*	
Note the presence of symptoms and their frequency within the LAST 7 DAYS:	
Enter code ☐	A. **Physical, behavioral symptoms directed toward others:** *(e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually* 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurs daily**
Enter code ☐	B. **Verbal behavioral symptoms directed toward others:** *(e.g., threatening others, screaming at others, cursing at others)* 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**
Enter code ☐	C. **Other behavioral symptoms NOT directed toward others:** *(e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds)* 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of behavioral symptoms in the last seven days that cause distress to the resident or are disruptive to the facility resident or staff members.
- Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provides the basis for further evaluation and delivery of consistent, appropriate care that will allow appropriate management of the behavioral symptoms and identify residents who may need mental health services.
- Once the frequency of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

- New onset of behavioral symptoms warrants prompt evaluation, assurance of resident safety, relief of distressing symptoms, and compassionate response to the resident.
- Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.
- Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems—and may, therefore, require service planning and intervention—from those behaviors that are not problematic.
- These behaviors may indicate unrecognized needs, preferences, or illness.
- Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact.
- Subsequent assessments and documentation can be compared to baseline to identify changes in the resident's behavior, including response to interventions.

Definitions:

- **Physical, behavioral symptoms:** Physical, behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- **Verbal behavioral symptoms:** Verbal behaviors directed toward others (e.g., threatening, screaming at, or cursing at others)
- **Other behavioral symptoms NOT directed towards others:** Other behavior symptoms not directed toward others (e.g., self-injurious behaviors such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, or disruptive sounds)

Steps for Assessment:

1. Review the medical record for the 7-day look-back period.
2. Interview staff and/or review medical record documentation across all shifts, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident.
3. Observe the resident in a variety of situations during the 7-day look-back period.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours throughout the day and evening during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E0300, Wandering
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurred daily.

Coding Tips and Special Populations:

- Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause, or the assessor's judgment that the behavior can be explained or should be tolerated.
- Code as present, even if staff have become used to the behavior or view it as typical or tolerable.

E0300. Wandering (Presence & Frequency)

E0300. Wandering *(Presence & Frequency)*	
Enter code ☐	**Has the resident wandered in the LAST 7 DAYS?** 0. **Behavior not exhibited** → Skip to E0600, Socially Inappropriate Behavior *(Presence & Frequency)* 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of wandering symptoms in the last seven days that may cause distress to the resident or are disruptive to the facility resident or staff members.

Definitions:

- **Wandering:** Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be walking or by wheelchair. Do not include pacing as wandering behavior.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording based on documentation of any behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?
3. Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to them. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).
4. Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E0600, Socially Inappropriate Behavior.
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E0400. Wandering (Impact on Resident)

E0400. Wandering *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- Behaviors identified in item E0300 impact the resident's risk for significant injury, interfere with care, or their participation in activities or social interactions.
- Identification of the impact of the behaviors noted in E0300 may require service planning and intervention.
- Subsequent assessments and documentation can be compared to a baseline to identify changes in the resident's behavior, including response to interventions.

Steps for Assessment:

1. Consider the review of the medical record, staff interviews across all shifts and disciplines, interviews with others who had close interactions with the resident, and previous observations of the behaviors identified in E0300 for the 7-day look-back period.
2. Code E0400A, E0400B, E0400C and E0400D based on the behavioral symptoms coded in E0300.
3. Determine whether those behaviors put the resident at significant risk of physical illness or injury, whether the behaviors significantly interfered with the resident's care, and/or whether the behaviors significantly interfered with the resident's participation in activities or social interactions.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E0500. Wandering (Impact on Others)

E0500. Wandering *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of wandering symptoms in the last seven days that cause distress to the resident or are disruptive to the facility resident or staff members.
- Behaviors identified in item E0300 put others at risk for significant injury, intruding on their privacy or activities, and/or disrupting their care or living environments. The impact on others is coded here in item E0500.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

Coding Tips and Special Populations:

- For E0500A, the code is based on whether the behavior placed others at significant risk for physical injury. Physical injury is trauma that results in pain or other distressing physical symptoms, impaired organ function, physical disability, or other adverse consequences, regardless of the need for medical, surgical, nursing, or rehabilitative intervention.
- For E0500B, the code is based on whether the behavior violates other residents' privacy, interrupts other residents' performance of activities of daily living, or limits engagement in or enjoyment of informal social or recreational activities to such an extent that it

causes the other residents to experience distress (e.g., displeasure or annoyance) or inconvenience, whether the other residents complain.

- For E0500C, the code is based on whether the behavior interferes with the staff's ability to deliver care or conduct organized activities, interrupts receipt of care or participation in organized activities by other residents, and/or causes other residents to experience distress or adverse consequences.

E0600. Socially Inappropriate/Disruptive Behavior (Presence & Frequency)

E0600. Socially Inappropriate/Disruptive Behavior *(Presence & Frequency)*	
Enter code ☐	**Has the resident exhibited socially inappropriate/disruptive behaviors in the LAST 7 DAYS?** 0. **Behavior not exhibited** → Skip to E0900, Resists, Rejects, or Refuses Care *(Presence & Frequency)* 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of socially inappropriate/disruptive behavioral symptoms in the last seven days that cause distress to the resident or are disruptive to the facility resident or staff members.

Definitions:

- **Socially Inappropriate/Disruptive Behavioral Symptoms:** Includes disruptive sounds, excessive noise, screams, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings, self-abusive acts, substance abuse or self-mutilation.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of any behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?

3. Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).
4. Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on what has been the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E0900, Resists, Rejects, or Refuses Care
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E0700. Socially Inappropriate/Disruptive Behavior (Impact on Resident)

E0700. Socially Inappropriate/Disruptive Behavior *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of socially inappropriate/disruptive behavioral symptoms in the last seven days that may distress the resident or are disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.

- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E0800. Socially Inappropriate/Disruptive Behavior (Impact on Others)

E0800. Socially Inappropriate/Disruptive Behavior *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of socially inappropriate/disruptive behavioral symptoms in the last seven days that cause distress to the resident or are disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E0900. Resists, Rejects, or Refuses Care (Presence & Frequency)

E0900. Resists, Rejects, or Refuses Care *(Presence & Frequency)*	
	Has the resident resisted, rejected, or refused care in the LAST 7 DAYS?
Enter code ☐	0. **Behavior not exhibited** → Skip to E1200, Intimidating Behavior *(Presence & Frequency)*
	1. **Behavior of this type occurred 1 to 3 days**
	2. **Behavior of type occurred 4 to 6 days, but less than daily**
	3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency that the resident resisted, rejected, or refused care in the last seven days that caused distress to the resident or was disruptive to the facility resident or staff members.

Definitions:

- **Resists Care:** Resists taking medications/injections, ADL assistance, or help with eating. This category does not include instances where a resident has made an informed choice

not to follow a course of care (e.g., the resident has exercised his or her right to refuse treatment and reacts negatively as staff try to reinstitute treatment).

- Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing the caregiver away, scratching the caregiver).
- These behaviors are not necessarily positive or negative but are intended to provide information about the resident's responses to care interventions and to prompt further investigation of causes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, experience with medication errors and unacceptable care, desire to modify care being provided).

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of any behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?
3. Observe the resident and how he or she responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).
4. Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on what has been the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E1200, Intimidating Behavior
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E1000. Resists, Rejects, or Refuses Care (Impact on Resident)

E1000. Resists, Rejects, or Refuses Care *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency that the resident resisted, rejected, or refused care in the last seven days that caused distress to the resident or was disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E1100. Resists, Rejects, or Refuses Care (Impact on Others)

E1100. Resists, Rejects, or Refuses Care *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency that the resident resisted, rejected, or refused care in the last seven days.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E1200. Intimidating Behavior (Presence & Frequency)

E1200. Intimidating Behavior *(Presence & Frequency)*	
	Has the resident exhibited intimidating behaviors in the LAST 7 DAYS?
Enter code ☐	0. **Behavior not exhibited** → Skip to E1500, Elopement *(Presence & Frequency)* 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of intimidating behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Definitions:

- **Intimidating behavior:** Actions or gestures that made other residents or staff uncomfortable, feel unsafe, at risk, or feel their privacy was invaded. Signs of intimidating behavior would include when a resident approaches someone in a threatening way, continues to be "in the face" of another, or aggressively pursues another person.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of any behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not

pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?

3. Observe the resident and how he or she responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).
4. Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on what has been the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E1500, Elopement.
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E1300. Intimidating Behavior (Impact on Resident)

E1300. Intimidating Behavior *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of intimidating behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.

- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E1400. Intimidating Behavior (Impact on Others)

E1400. Intimidating Behavior *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of intimidating behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E1500. Elopement (Presence & Frequency)

E1500. Elopement *(Presence & Frequency)*	
Enter code ☐	**Has the resident eloped in the LAST 7 DAYS?** 0. **Behavior not exhibited** → Skip to E1800, Dangerous, Non-violent Behaviors *(Presence & Frequency)* 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of elopement behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Definitions:

- **Elopement:** Resident has attempted to "run away" from the facility, town, or city of residence.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of these behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?
3. Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts). Asymptomatic behavior can be present, and the Assessment Coordinator might not see it because it occurs during care on another shift. Therefore, it is especially important to solicit input from all caregivers having contact with the resident.
4. Also, be alert to the possibility that staff might not report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on what has been the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E1800, Dangerous, Non-violent Behaviors.
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.

- **Code 3:** If the described behavioral symptom occurs daily.

E1600. Elopement (Impact on Resident)

E1600. Elopement *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of elopement behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E1700. Elopement (Impact on Others)

E1700. Elopement *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of elopement behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.

- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E1800. Dangerous, Non-violent Behaviors (Presence & Frequency)

E1800. Dangerous, Non-violent Behaviors *(Presence & Frequency)*	
Enter code ☐	**Has the resident exhibited dangerous, non-violent behaviors in the LAST 7 DAYS?** 0. **Behavior not exhibited** → Skip to E2100, Dangerous, Violent Behaviors *(Presence & Frequency)* 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of dangerous non-violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Definitions:

- **Dangerous non-violent behavior:** Falling asleep while smoking, leaving walker behind when walking, taking oxygen off when in use, not calling for help when transferring. There must be documentation to support the coding of this item.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of these behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?
3. Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).

4. Also, be alert to the possibility that staff might not report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on what has been the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program). Skip to E2100, Dangerous, Violent Behaviors.
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E1900. Dangerous, Non-violent Behaviors (Impact on Resident)

E1900. Dangerous, Non-violent Behaviors *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of dangerous non-violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E2000. Dangerous, Non-violent Behaviors (Impact on Others)

E2000. Dangerous, Non-violent Behaviors *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of dangerous non-violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).
- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E2100. Dangerous, Violent Behaviors (Presence & Frequency)

E2100. Dangerous, Violent Behaviors *(Presence & Frequency)*	
	Has the resident exhibited dangerous, violent behaviors in the LAST 7 DAYS?
Enter code ☐	0. **Behavior not exhibited** → Skip to F0100, Resident Preferences 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of type occurred 4 to 6 days, but less than daily** 3. **Behavior of this type occurred daily**

Item Rationale:

- To identify the presence and frequency of dangerous, violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Definitions:

- **Dangerous, violent behavior:** Destruction of personal property that could potentially cause harm to self or others. The resident could smash or throw furniture, objects, or anything that could be considered a projectile. The behavior may or may not be intended towards self or others but could result in harm.

Steps for Assessment:

1. Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to code the assessment based on documentation of these behavioral symptoms.
2. The fact that staff have become used to the behavior and minimized the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptoms or not? Is the resident combative during personal care and strikes out at staff or not?
3. Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care throughout the day and night (e.g., on all three shifts).
4. Also, be alert to the possibility that staff might not report a behavioral symptom if it is part of the norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.).
5. Focus staff attention on the individual resident's actual behavior over the last 7 days.

Coding Instructions:

Record the frequency of behavioral symptoms manifested by the resident over 24 hours, throughout the day and evening, during the 7-day look-back period.

- **Code 0:** If the described behavioral symptom was not exhibited in the last 7 days (including those whose behavioral symptoms are fully managed by psychotropic drugs or a behavior-management program).
- **Code 1:** If the described behavioral symptom occurred 1-3 days per week.
- **Code 2:** If the described behavioral symptom occurred 4-6 days per week but not daily.
- **Code 3:** If the described behavioral symptom occurs daily.

E2200. Dangerous, Violent Behaviors (Impact on Resident)

E2200. Dangerous, Violent Behaviors *(Impact on Resident)*	
Check all that apply:	
☐	A. **The behavior was alterable**
☐	B. **The behavior put the resident at significant risk for physical illness or injury**
☐	C. **The behavior significantly interfered with the resident's care**
☐	D. **The behavior significantly interfered with the resident's participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of dangerous, violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If the behavior is alterable.
- **Code B:** If the behavior puts the resident at significant risk for physical illness or injury.
- **Code C:** If the behavior significantly interfered with the resident's care.
- **Code D:** If the behavior significantly interfered with the resident's participation in activities or social interactions.

E2300. Dangerous, Violent Behaviors (Impact on Others)

E2300. Dangerous, Violent Behaviors *(Impact on Others)*	
Check all that apply:	
☐	A. **The behavior put others at significant risk for physical illness or injury**
☐	B. **The behavior significantly interfered with others' care**
☐	C. **The behavior significantly interfered with others' participation in activities or social interactions**

Item Rationale:

- To identify the presence and frequency of dangerous, violent behavioral symptoms in the last seven days that caused distress to the resident or were disruptive to the facility resident or staff members.

Coding Instructions:

- **Code A:** If any of the identified behavioral symptom(s) placed staff, visitors, or other residents at significant risk for physical injury.
- **Code B:** If any of the identified behavioral symptom(s) kept other residents from enjoying privacy or engaging in informal activities not organized or run by staff (including coming in uninvited, invading, or forcing oneself on others' private activities).

- **Code C:** If any of the identified behavioral symptom(s) created a climate of excessive noise or interfered with the receipt of care or participation in organized activities by other residents.

E2400. Intervention Program for Mood, Behavior, Cognitive Loss

E2400. Intervention Programs for Mood, Behavior, Cognitive Loss	
Check all that apply in the 7-day lookback period unless otherwise specified:	
☐	A. **Special behavior symptom evaluation program**
☐	B. **Special behavior management program**
☐	C. **Evaluation by a licensed mental health specialist in LAST 90 DAYS**
☐	D. **Group therapy**
☐	E. **Resident-specific deliberate changes in the environment to address mood/behavior patterns** *(e.g., providing a bureau in which to rummage)*
☐	F. **Reorientation** *(e.g., cueing)*
☐	G. **Validation/Redirection**
☐	H. **Crisis intervention in the facility**
☐	I. **Crisis stabilization unit in LAST 90 DAYS**
☐	J. **Other** *(specify)* _____
☐	Z. **None of the above**

Note: This item is temporarily included in the MDS-AH to allow PNMI-C to continue utilizing the former payment methodology until a new time study has been completed and implemented. This item will be removed when a new payment methodology has been implemented. This item may contribute to the Behavioral Health Groups for PNMI-C facilities in the current payment methodology. There are four ways a resident could meet the qualifications for the Behavior Health RUG groups: MA1, MB1, MC1 – the resident must meet one of the following: three or more of the items listed in E2400, two or more D0100 – D0200 items, delusions, or hallucinations.

Item Rationale:

- To record all interventions and strategies used in the last 7 days (unless a different time frame is specified).
- The clinical record must contain the following:
    - Documentation on the service/care plan that includes:
        - the problem, situation, or challenge being addressed,
        - the goal of the program, and
        - Approaches to be used.
- Documentation that the strategy was used within the 7-day look-back period.

- Evaluation of the E2400 programming at the time of the MDS completion.
    - How is the program working, and should it be continued or revised?
    - This must be documented before the assessment completion date (Z0200).
- There must be documented evidence of review and update with every assessment and as needed.
- The service/care plan should be treated as a living document that is changed as the resident's care needs change.

Definitions:

- **Special behavior symptom evaluation program** – An ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms. The purpose of such a program is to evaluate the need to implement strategies to understand the "meaning" behind the resident's health and functional status in a social and physical environment.
- **Special behavior management program**: An ongoing, interdisciplinary management of behavioral symptoms, such as items coded in E0200 through E2300.
- **Evaluation and/or treatment by a Licensed Mental Health Specialist within the last 90 days**: An assessment of a mood, behavior disorder, or other mental health problem by a qualified professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on your state's practice acts. Do not check this item for routine visits by the facility social worker. Evaluation may occur at the facility, private office, clinic, community mental health center, etc.
- **Group therapy**: Group therapy as an intervention must be referenced in the service/care plan. The sessions may occur in or outside the facility (e.g., a group program at a community mental health center, an Alcoholics Anonymous meeting at a local church, a Parkinson's Disease support group at a local hospital, etc.). This item does not include group recreational or leisure activities. If there is a group that the facility feels may meet the requirements for "group therapy, " document the group's purpose, goals, and objectives.
- **Validation/redirection**: Validation is an approach to dementia care that focuses on empathy and listening to help people with dementia feel respected and cared for. It's based on the idea that it's more beneficial to enter the reality of someone with dementia rather than trying to bring them back into our own reality. This is used as an intervention

with cognitively impaired clients. The technique provides the residents with an acceptance of where they are. Redirection may follow validation as it attempts to guide the resident into alternative activities or behavior patterns.

- Example: A 90-year-old resident with severe dementia is crying and inconsolable because she cannot find her mother. The staff tells the resident, "That must make you feel sad" (validation). After the resident has time to respond, a staff member tells her, "It is time for our coffee break. Let's see what they have baked to go with our coffee" (redirection).

Coding Instructions:

- **Code A:** If the resident used a special behavior symptom evaluation program in the last 7 days.
- **Code B:** If the resident used a special behavior management program in the last 7 days.
- **Code C:** If the resident received an evaluation and/or treatment by a Licensed Mental Health Specialist within the last 90 days.
- **Code D:** If the resident regularly attends therapy group sessions aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. This may include any group with goals and objectives but does not include recreational or leisure activity groups.
- **Code E:** If the resident experienced any deliberate environmental changes to address mood and/or behavior patterns. These changes would be included in the care/service plan with documentation to support the effectiveness, evaluation, and need for continued implementation.
- **Code F:** If the resident received individual or group reorientation interventions that aimed to reduce disorientation due to confusion. This may include environmental cueing in which all staff involved with the resident provide orienting information and reminders.
- **Code G:** If the resident required validation and/or redirection.
- **Code H:** If the resident's behavior escalated to a point where staff needed to implement an internal crisis plan utilizing facility staff to diffuse the behavior. This plan must be included in the service/care plan, with periodic evaluation to determine if the plan needs modification to continue to be effective.

- **Code I:** If the resident was evaluated and treated out of the facility in a crisis stabilization unit in the last 90 days.
- **Code J:** If the resident used any other interventions not listed above, they are designed to manage their mood, behavior, or cognitive loss. These interventions must be included in the service/care plan, and periodic evaluation must be performed to determine if the plan needs modification to continue to be effective.
- **Code Z:** If none of the above applies to the resident.

3.8. Section F: Preferences for Customary Routine and Activities

F0100. Resident Preferences

F0100. Resident Prefers	
Check all that apply:	
☐	A. **Staying up past 8:00 p.m.**
☐	B. **Family or significant other involvement in care discussions**
☐	C. **Reading books, newspapers, or magazines**
☐	D. **Listening to music**
☐	E. **Being around animals such as pets**
☐	F. **Keeping up with the news**
☐	G. **Doing things with groups of people**
☐	H. **Cards/other games**
☐	I. **Crafts/arts**
☐	J. **Exercise/sports**
☐	K. **Spiritual/religious activity**
☐	L. **Trips/shopping**
☐	M. **Watching TV**
☐	N. **Gardening or plants**
☐	O. **Computer activities**
☐	Z. **None of the above**

Item Rationale:

- To determine activity circumstances/settings that the resident prefers, including (but not limited to) circumstances in which the resident is at ease.

Steps for Assessment:

1. Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful but only provides part of the answer.
2. Do not limit the preference list to only those areas or settings to which the resident now has access.
3. Try to discover the range of possibilities for the resident's preferred setting(s).
4. Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?"
5. Ask staff members to identify settings that the resident frequents or where he or she appears to be most at ease or very ill at ease.

Coding Instructions:

- Check all responses that apply.

- If the resident does not wish to be in any of these settings, check none of the above

3.9. Section G

G0100. Self-Care Activities (7-day look back)

G0100. Self-Care Activities *(see above instructions)*			
1.	2.	3.	
☐☐	☐	☐	A. **Eating -** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐	☐	B. **Oral hygiene -** The ability to use suitable items to clean teeth or dentures
☐☐	☐	☐	C. **Toileting hygiene -** The ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐	☐	D. **Shower/bathe self** - The ability to bathe self, including washing, rinsing, and drying self *(excludes washing of back and hair)*
☐☐	☐	☐	E. **Upper body dressing -** The ability to dress and undress above the waist, including fasteners, if applicable.
☐☐	☐	☐	F. **Lower body dressing -** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐	☐	G. **Putting on/taking off footwear -** The ability to put on and take off socks and shoes or other footwear appropriate for safe mobility, including fasteners.
☐☐	☐	☐	H. **Personal hygiene -** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands *(excludes baths, showers, and oral hygiene)*.

Item Rationale: Many residents are at risk of physical decline. Many elderly residents have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit the ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care, such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency, particularly for residents with chronic mental illness or others who may be taking psychotropic medications. Individualized service plans can be successfully developed only when the resident's self-performance has been accurately assessed, and the amount and type of support being provided to the resident by others has been evaluated. There must be documented evidence of review and updates with every assessment and as needed. The service plan should be treated as a living document that is updated as the resident's care needs change.

Steps for Assessment:

1. Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from care staff or family as documented in the resident's medical record during the assessment period.

2. Residents should be allowed to perform activities as independently as possible as long as they are safe.
3. For the purposes of completing Section G, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, staff direct caregiver students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only facility staff should be considered when scoring according to the amount of assistance provided.
4. Activities may be completed with or without assistive device(s). The use of assistive device(s) to complete an activity should not affect the coding of the activity.

Coding Instructions for Column 1, Resident Performance:

When coding the resident's performance and level of staff assistance required, in Column 1, use the six-point scale or one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.

- **Code 06:** If the resident completes the activity by themselves without assistance from a helper OR staff provided oversight or assistance only one or two times during the seven-day look back.
- **Code 05:** If the helper sets up or cleans up, then the resident completes the activity without additional assistance three or more times. The helper assists only prior to or following the activity but not during it. For example, the resident may require assistance cutting up food, opening containers, or setting up hygiene item(s) or assistive device(s).
- **Code 04:** If the helper provides verbal cues or touching/steadying/contact guard assistance as the resident completes the activity. Assistance may be provided throughout the activity or intermittently three or more times. For example, the resident may require verbal cueing, coaxing, or general supervision for safety in completing the activity, or the resident may require only incidental help such as a contact guard or steadying assistance during the activity.
- **Code 03:** If the helper does LESS THAN HALF the effort three or more times. The helper lifts, holds, or supports the trunk or limbs but provides less than half the total

effort required to complete the task. This would include weight-bearing assistance from the helper.

- **Code 02:** If the helper does MORE THAN HALF the effort three or more times. Helper lifts or holds trunk or limbs and provides more than half the effort. This would include weight-bearing assistance from the helper.
- **Code 01:** If the helper does ALL of the effort, and the resident makes no effort to complete the activity. Coding "Dependent" on the MDS means the resident did not participate in any aspect of the ADL activity during the entire look-back period.

Note: The exception to this rule is for 1 (dependent), 6 (independent), or any of the exception codes listed below. Dependent (1) and the Exception codes would need to be documented during the entire look-back period to code those choices on the MDS-AH.

Exception Codes:

- **Code 07:** If the resident refused to complete the activity.
- **Code 08:** If the activity was not attempted and the resident did not perform this activity during the look-back period.
- **Code 09:** If the resident did not attempt this activity due to environmental limitations during the look-back period, such as lack of equipment or weather constraints.
- **Code 99:** If the activity was not attempted due to the resident's medical condition or safety concerns.

Instructions for the Rule of 3:

When an ADL activity has occurred three or more times, apply the steps of the Rule of 3 below (keeping the ADL coding level definitions and the above exceptions in mind) to determine the code to enter in Column 1, ADL Self-Performance. **These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario** (e.g., if #1 applies, stop and code that level).

1. When an activity occurs three or more times at any one level, code that level.
2. When an activity occurs three or more times at multiple levels, code the most dependent level that occurred three or more times.
3. When an activity occurs three or more times and at multiple levels but not three times at any one level, apply the following:

   a. Convert episodes of Dependent (1) to Substantial or maximal assistance (2) when applying the third Rule of 3, as long as the Dependent episodes did not occur every time the ADL was performed in the 7-day look-back period.
   b. When there is a combination of Dependent (1), Substantial or maximal assistance (2), and Partial or moderate assistance (3) that total three or more times—code Partial or moderate assistance (3).
4. When there is a combination of Substantial or maximal assistance (2), Partial or moderate assistance (3), and Supervision or Touching (4) that total three or more times—code supervision or Touching (4).
5. When there is a combination of Partial or moderate assistance (3) and Supervision or Touching (4) and Set-up/ Clean-up (5) that total three or more times—code Partial or moderate assistance (3).
6. If none of the above are met, code set up/clean-up (5).

Coding Instructions for Column 2, Staff Support:

- **Code 0:** If two or more helpers (physical assistance) are NOT required for the resident to complete the activity.
- **Code 1:** If two or more helpers (physical assistance) are required for the resident to complete the activity.

Coding Instructions for Column 3, Cognitive Impairment Impact:

- **Code 0:** If the resident did NOT require multiple reminders or multiple single-step cues to complete the ADL task due to dementia or cognitive impairment.
- **Code 1:** If the resident did require multiple reminders or multiple single-step cues to complete the ADL task due to dementia or cognitive impairment.

Coding Tips:

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item G0100A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code the MDS-AH based on the resident's need

for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into the mouth, risk of falling).

- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the seven-day look-back period, code the reason the activity was not attempted (using Exception Codes). For example, code 07 if the resident refused to attempt the activity; code 08 if the activity is not applicable to the resident (the activity did not occur at the time of the assessment and within the seven-day look back); code 09 if the resident was not able to attempt the activity due to environmental limitations; or code 99 if the resident was not able to attempt the activity, during the seven-day look back, due to medical condition or safety concerns. Coding is based on the amount of staff assistance provided.
- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- To clarify your understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific.
- A dash ("-") indicates "No information is available." The State expects dash use to be rare.
- Documentation in the medical record must support the coding of Section G on the MDS. Data entered should be consistent with staff documentation in the resident's medical record.
- There is not an all-inclusive list of assistive devices that may be used when coding self-care and mobility activities. This may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible, as addressed in the service/care plan.

Tips for Coding the Resident's Performance:

- When coding the resident's performance, "effort" refers to the type and amount of assistance a helper provides for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

- Code based on the resident's performance and need for assistance to complete a task. Do not record the staff's opinion of the resident's potential ability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section G should be based on the rule of three and the exception codes.

Coding Tips for G0100A, Eating:

- The intent of G0100A, Eating, is to assess the resident's ability to bring food and/or liquid to the mouth and swallow it once the meal is placed before the resident.
- The administration of or assistance with tube feedings is not considered when coding eating.
- The following is guidance for some situations in which a resident receives tube feedings:
    - If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings because of a new (recent onset) medical condition, code G0100A as 99, Not attempted due to medical condition or safety concerns.
    - If the resident did not eat or drink anything by mouth (NPO) during the look back, code G0100A as 08, Not applicable—Not attempted.
    - If the resident eats and drinks, even small amounts, by mouth and relies partially on obtaining nutrition and liquids via tube feedings, code Eating based on the amount of assistance the resident requires to eat and drink by mouth.
- If a resident requires assistance (e.g., supervision or cueing) to swallow safely, code based on the type and amount of assistance required for feeding and safe swallowing.
- If a resident swallows safely without assistance, exclude swallowing from consideration when coding G0100A, Eating.
- If the resident eats finger foods using their hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with their hands independently, for example, the resident would be coded as 06, Independent.
- For a resident taking only fluids by mouth, the item may be coded based on the ability to bring the liquid to the mouth and swallow the liquid once the drink is placed in front of the resident.
- Supervision of eating involves direct supervision of the resident. Oversight of all residents in the dining room cannot be coded as supervision for each individual resident.

The service/care plan must describe the reason supervision is needed and the resident-specific interventions required, i.e., related to the risk of choking, the resident needs direct cueing in order to eat, etc.

- Examples of Supervision required for eating:
    - Resident with a history of choking ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).
    - Resident is blind and confused. He ate independently once staff oriented him to the types and whereabouts of food on his tray and instructed him to eat.
    - Cognitively impaired resident ate independently when given one food item at a time and was monitored to ensure adequate intake of each item.

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity, while others describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for G0100A, Eating:

1. Resident S has a condition that affects their endurance and strength. Resident S prefers to feed themself as much as they are capable. During all meals, after eating three-fourths of the meal by themself, Resident S usually becomes extremely fatigued and requests assistance from staff to feed them the remainder of the meal.
    a. **Coding:** G0100A would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The staff provides less than half the effort for the resident to complete the activity of eating for all meals.
2. Resident M has upper extremity weakness and fine motor impairments. The occupational therapist recommended an adaptive device on Resident M's hand that supports the eating utensil within their hand. At the start of each meal, Resident M can bring food and liquids to their mouth. Resident M then tires and the staff feeds them more than half of each meal.
    a. **Coding:** G0100A would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

3. The staff opens all of Resident S's cartons and containers on their food tray before leaving the resident. There are no safety concerns regarding Resident S's ability to eat. Resident S eats the food themself, bringing the food to their mouth using appropriate utensils and swallowing the food safely.
    a. **Coding:** G0100A would be coded 05, Setup or clean-up assistance.
    b. **Rationale:** The helper provided setup assistance prior to the eating activity.
4. Resident H does not have any food consistency restrictions but often needs to swallow 2 or 3 times so that the food clears their throat due to difficulty with swallowing. They require verbal cues from the staff to use the strategy of extra swallows to clear the food.
    a. **Coding:** G0100A would be coded 04, Supervision or touching assistance.
    b. **Rationale:** Resident H swallows all types of food consistently and requires verbal cueing and supervision from the helper.
5. Resident R has been unable to take food or liquids by mouth since they had a stroke. They receive nutrition through a gastrostomy tube (G-tube), which is administered by staff, the resident, trained staff, or the family.
    a. **Coding:** G0100A would be coded 99, Not attempted due to medical condition or safety concerns.
    b. **Rationale:** The resident does not eat or drink by mouth at this time due to their stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to their medical condition, the activity is coded as 99, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

Coding Tips for G0100B, Oral hygiene:

- Determine the resident's abilities based on performance.
- For a resident who is edentulous (without teeth), code Oral hygiene based on the type and amount of assistance required from a helper to clean the resident's gums.

Examples for G0100B, Oral hygiene:

1. Before bedtime, the staff provides steadying assistance to Resident S as they walk to the bathroom. The staff applies toothpaste onto Resident S's toothbrush. Resident S then brushes their teeth at the sink in the bathroom without physical assistance or supervision.

Once Resident S is done brushing their teeth and washing their hands and face, the staff returns and provides steadying assistance as the resident walks back to their bed.

   a. **Coding:** G0100B would be coded 05, Setup or clean-up assistance.
   b. **Rationale:** The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Resident S brushes their teeth. Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.

2. At night, the staff provides Resident K with water and toothpaste to clean their dentures. Resident K cleans their upper denture plate. Resident K then cleaned half of their lower denture plate but stated they were tired and unable to finish cleaning their lower denture plate. The staff finishes cleaning the lower denture plate, and Resident K replaces the dentures in their mouth.
   a. **Coding:** G0100B would be coded 03, Partial/moderate assistance.
   b. **Rationale:** The helper provided less than half the effort to complete oral hygiene.
3. Resident W is edentulous (without teeth), and their dentures no longer fit their gums. In the morning and evening, Resident W begins to brush their upper gums after the helper applies toothpaste to their toothbrush. Resident W brushes their upper gums but cannot finish due to fatigue. The staff completes the oral hygiene activity by brushing their back upper gums and their lower gums.
   a. **Coding:** G0100B would be coded 02, Substantial/maximal assistance.
   b. **Rationale:** The resident begins the activity. The helper completes the activity by performing more than half the effort.
4. Resident D has had a stroke. They can brush their teeth while sitting on the side of the bed, but when the staff hands them the toothbrush and toothpaste, they look up at them, puzzled about what to do next. The staff cues Resident D to put the toothpaste on the toothbrush and instructs them to brush their teeth. Resident D then completes the task of brushing their teeth.
   a. **Coding:** G0100B would be coded 04, Supervision or touching assistance.
   b. **Rationale:** The helper provides verbal cues to assist the resident in completing the activity of brushing their teeth.

Coding Tips for G0100C, Toileting hygiene:

- Toileting hygiene takes place before and after the use of the toilet, commode, bedpan, or urinal.
- If the resident completes a bowel toileting program in bed, code the item Toileting hygiene based on the resident's need for assistance managing clothing and perineal cleansing related to the bowel training program.
- Toileting Hygiene includes:
    - Performing perineal hygiene.
    - Managing clothing (including undergarments and incontinence products, such as incontinence briefs or pads) before and after voiding or having a bowel movement.
    - Adjusting clothing relevant to the individual resident.
- If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving their bowels.
- When the resident requires different levels of assistance to perform toileting hygiene after voiding versus after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity. It is up to the facility to determine how often direct care staff document ADL care provided during a shift.
- If a resident manages an ostomy, toileting hygiene includes wiping the opening of the ostomy or colostomy bag, but not management of the equipment.
- If a resident has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment. For example, if the resident has an indwelling urinary catheter and has bowel movements, code Toileting hygiene based on the type and amount of assistance needed by the resident before and after moving their bowels. This may include the need to perform perineal hygiene at the indwelling urinary catheter site after the bowel movement.

Examples for G0100C, Toileting hygiene:

1. Resident J uses a bedside commode. The staff provides steadying (touching) assistance as Resident J pulls down their pants and underwear before sitting down on the commode. When Resident J is finished voiding or having a bowel movement, the staff provides

steadying assistance as Resident J wipes their perineal area and pulls up their pants and underwear without assistance.

a. **Coding:** G0100C would be coded 04, Supervision or touching assistance.
b. **Rationale:** The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

2. Resident J is morbidly obese and has a diagnosis of debility. They request the use of a bedpan when voiding or having bowel movements and require two staff to pull down their pants and underwear and mobilize them onto and off the bedpan. Resident J is unable to complete any of their perineal/perianal hygiene. Both staff help Resident J pull up their underwear and pants.
    a. **Coding:** G0100C would be coded 01, Dependent.
    b. **Rationale:** Two helpers were needed to complete the toileting hygiene activity.
3. Resident C has Parkinson's disease and significant tremors that intermittently make it difficult for them to perform perineal hygiene after having a bowel movement in the toilet. They walk to the bathroom with close supervision and lower their pants, but they ask the staff to help them with perineal hygiene after moving their bowels. They then pull up their pants without assistance.
    a. **Coding:** G0100C would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by themself. Walking to the bathroom is not considered when scoring toileting hygiene.
4. Resident Q has a progressive neurological disease that affects their fine and gross motor coordination, balance, and activity tolerance. Resident Q uses a bedside commode as they steady themself in standing with one hand and initiates pulling down their underwear with the other hand but need assistance to complete this activity due to their coordination impairment. After voiding, Resident Q wipes their perineal area without assistance while sitting on the commode. When Resident Q has a bowel movement, a staff performs perineal hygiene as Resident Q needs to steady themself with both hands to stand for this activity. Resident Q is usually too fatigued at this point and requires full assistance to pull up their underwear.
    a. **Coding:** G0130C would be coded 02, Substantial/maximal assistance.

b. **Rationale:** The helper provided more than half the effort needed for the resident to complete the toileting hygiene activity.

Coding Tips for G0100D, Shower/bathe self:

- Showering/bathing oneself includes full body washing, rinsing, and drying the face, upper and lower body, perineal area, and feet. It does not include washing, rinsing, and drying the resident's back or hair, and it does not include transferring in/out of a tub/shower.
- Assessment of Shower/bath self can take place in any location, including a shower or bath, at a sink, or in bed (e.g., full-body sponge bath). Bathing can be assessed by having the resident sit on a tub bench.
- Code 05, Setup or clean-up assistance, if the resident can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks.
- Code 05, Setup or clean-up assistance, if the only help the resident requires is assistance before the bathing activity to cover wounds or devices for water protection during bathing.
- If the resident cannot bathe their entire body because of a medical condition (e.g., a cast or a non-removable dressing), then code Shower/bathe themself based on the amount of assistance needed to complete the activity.

Examples for G0100D, Shower/bathe self:

1. Resident J sits on a tub bench as they wash, rinse, and dry themself. A staff stays with them to ensure their safety, as Resident J has had instances of losing their sitting balance. The staff also provides lifting assistance as Resident J gets onto and off the tub bench.
    a. **Coding:** G0100D would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides supervision as Resident J washes, rinses, and dries themself. The transfer onto or off the tub bench is not considered when coding the Shower/bathe self-activity.
2. Resident E has a progressive neurological condition that has affected their endurance as well as their fine and gross motor skills. They are transferred to the shower bench with partial/moderate assistance. Resident E showers while sitting on a shower bench and washes their arms and chest using a wash mitt. Staff then must help wash the remaining parts of their body because of Resident E's fatigue to complete the activity. Resident E

uses a hand-held showerhead to rinse themself but tires halfway through the task. The staff dries Resident E's entire body.

a. **Coding:** G0100D would be coded 02, Substantial/maximal assistance.
b. **Rationale:** The helper assists Resident E with more than half of the showering task, which includes bathing, rinsing, and drying their body. The transfer onto the shower bench is not considered in coding this activity.

3. Resident Y has limited mobility due to multiple medical conditions. They prefer to wash their body while sitting in front of the sink in their bathroom. A helper assists with washing, rinsing, and drying Resident Y's arms/hands, upper legs, lower legs, buttocks, and back.

a. **Coding:** G0100D would be coded 02, Substantial/maximal assistance.
b. **Rationale:** The helper completed more than half the activity. Full-body bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the resident's back. Y

Coding Tips for G0100E, Upper body dressing, G0100F, Lower body dressing, and G0100G, Putting on/taking off footwear:

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses themself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing elastic stockings, an orthosis, or prosthesis occurs while the resident is dressing/undressing, then count the elastic stocking, orthotic, or prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items: Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
- Lower body dressing examples: knee brace, stump sock/shrinker, lower-limb prosthesis.
- Footwear examples: ankle-foot orthosis (AFO), foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).

- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dress, sweatshirt, sweater, nightgown, and pajama top.
- If a resident requires assistance with dressing, including assistance with buttons, fasteners, and/or fastening a bra, code based on the type and amount of assistance required to complete the entire dressing activity.
- Lower body dressing items used for coding include underwear, incontinence briefs, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.
- For residents with a single lower extremity amputation with or without the use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb. If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
- If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based on the amount of assistance needed to complete the activity.

Examples for G0100E, Upper body dressing:

1. Resident Y has right-side upper extremity weakness because of a stroke. During the day, they require staff to place their clothing next to their bedside. Resident Y can now use compensatory strategies to put on their bra and top without any assistance. At night, they remove their top and bra independently and put the clothes on the nightstand, and the staff puts them away in their dresser.
    a. **Coding:** G0100E would be coded 05, Setup or clean-up assistance.
    b. **Rationale:** Resident Y dresses and undresses their upper body and requires a helper only to retrieve and put away their clothing, that is, setting up the clothing for their use. The description refers to Resident Y as “independent” (when removing clothes). Still, they need setup assistance, so they are not independent with regard to the entire activity of upper body dressing.
2. Resident Z wears a bra and a sweatshirt most days. They require assistance from staff to initiate the threading of their arms into their bra. Resident Z completes the placement of the bra over their chest. The helper hooks the bra clasps. Resident Z pulls the sweatshirt

over their arms, head, and trunk. When undressing, Resident Z removes the sweatshirt, with the helper assisting them with one sleeve. Resident Z slides the bra off once the helper has unclasped it.

   a. **Coding:** G0100E would be coded 03, Partial/moderate assistance.
   b. **Rationale:** The helper threads Resident Z's arms into their bra, hooks and unhooks their bra clasps, and removes one sleeve of the sweatshirt. Resident Z performs more than half of the effort.

3. Resident K sustained a spinal cord or other injury that has affected both movement and strength in both upper extremities. They place their left hand into one-third of the left sleeve of their shirt with much time and effort and are unable to continue with the activity. A staff member then completes Resident K's remaining upper body dressing.
   a. **Coding:** G0100E would be coded 02, Substantial/maximal assistance.
   b. **Rationale:** Resident K can perform a small portion of the upper body dressing activity but requires assistance from a helper for more than half of the effort.

Examples of G0100F, Lower body dressing:

1. Resident D is required to follow hip precautions because of recent hip surgery. An occupational therapist in a skilled nursing facility instructed them in the use of adaptive equipment to facilitate lower-body dressing. They require a helper to retrieve their clothing from the closet. Resident D uses their adaptive equipment to assist in threading their legs into their pants. Because of balance issues, Resident D needs a helper to steady them when standing to manage pulling on or pulling down their pants/undergarments. Resident D also needs some assistance to put on and take off their socks and shoes.
   a. **Coding:** G0100F would be coded 04, Supervision or touching assistance.
   b. **Rationale:** A helper steadies Resident D when they are standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower-body dressing.

Examples for G0100G, Putting on/taking off footwear:

1. Putting on/taking off footwear: Resident M wears an ankle-foot orthosis that they put on their foot and ankle after they put on their socks but before they put on their shoes. They always place their AFO, socks, and shoes within easy reach of their bed. While sitting on

the bed, they need to bend over to put on and take off their AFO, socks, and shoes, and they occasionally lose their sitting balance, requiring staff to place their hands on them to maintain their balance while performing this task.

   a. **Coding:** G0100G would be coded 04, Supervision or touching assistance.
   b. **Rationale:** Resident M puts on and takes off their AFO, socks, and shoes by themself; however, because of occasional loss of balance, they need a helper to provide touching assistance when they are bending over.

2. Putting on/taking off footwear: Resident F experiences visual impairment, fine motor coordination, and endurance issues. They require setup assistance for retrieving their socks and shoes, which they prefer to keep in the closet. Resident F often drops their shoes and socks as they attempt to put them onto their feet or as they take them off. Often, staff must first thread their socks or shoes over their toes, and then Resident F can complete the task. Resident F needs the staff to initiate taking off their socks and unstrapping the fasteners on their shoes.

   a. **Coding:** G0100G would be coded 02, Substantial/maximal assistance.
   b. **Rationale:** A helper assists Resident F in initiating putting on and taking off footwear because of their limitations regarding fine motor coordination. The helper completes more than half of the effort with this activity.

Coding Tips for G0100H, Personal hygiene:

Personal hygiene involves the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands, and peri care not associated with toileting (excludes baths, showers, and oral hygiene). A partial body bath, not full body, would be coded as personal hygiene.

Examples for G0100H, Personal hygiene:

1. A staff takes Resident L's comb, razor, and shaving cream from the drawer and places them at the bathroom sink. Resident L combs their hair and shaves daily. During the observation period, they required cueing to complete their shaving tasks.

   a. **Coding:** G0100H would be coded 04, Supervision or touching assistance.
   b. **Rationale:** A staff placed grooming devices at the sink for the resident's use and provided cueing during the look-back period.

2. Resident J is unable to brush and style their hair or wash and dry their face due to elbow pain. A staff completes these tasks for them.
    a. **Coding:** G0100H would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** Resident J was unable to complete their personal hygiene tasks and required staff to do so during the assessment period. The staff provided more than half the effort to complete the personal hygiene tasks.

G0200. Mobility

G0200. Mobility *(see above instructions)*			
1.	2.	3.	
☐☐	☐	☐	A. **Roll left and right -** Resident can roll left and roll right, move from lying on their back to the left and right side, and return to lying on their back on the bed.
☐☐	☐	☐	B. **Sit to lying -** Move from sitting on the side of the bed to lying flat on the bed.
☐☐	☐	☐	C. **Lying to sitting on the side of the bed -** Move from lying on the back to sitting on the side of the bed with no back support.
☐☐	☐	☐	D. **Sit to stand -** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐	☐	E. **Chair/bed-to-chair transfer -** The ability to transfer to and from a bed to a chair *(or wheelchair)*.
☐☐	☐	☐	F. **Toilet transfer -** The ability to get on and off a toilet or commode.
☐☐	☐	☐	G. **Tub/shower transfer -** The ability to get in and out of a tub/shower.
☐☐	☐	☐	H. **Locomotion 10 feet in a room, corridor, or similar space while standing**
☐☐	☐	☐	I. **Locomotion 50 feet with two turns** *(shorter distance outside of the room)*
☐☐	☐	☐	J. **Locomotion 150 feet in a room, corridor, or similar space while standing**
☐☐	☐	☐	K. **Car transfer -** The ability to transfer in and out of a vehicle on the passenger side *(does not include the ability to open/close the door or fasten the seat belt)*

Item Rationale:

- Residents may have mobility limitations on admission and be at risk of further functional decline during their stay in the facility.
- A resident's functional status can be impacted by the environment or situations encountered at the facility.
- Observing the resident's activities and interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status.

Steps for Assessment:

1. Direct care staff must record the resident's ability to perform each activity, every shift, and every day to capture the resident's functional status.
2. The MDS Coordinator will analyze staff documentation to determine the frequency with which the resident required assistance with each ADL being reviewed.

Coding Instructions for Column 1, Resident Performance:

When coding the resident's performance and level of staff assistance required, in Column 1, use the six-point scale or one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.

- **Code 06:** If the resident completes the activity by themselves without assistance from a helper OR staff provided oversight or assistance only one or two times during the seven-day look back.
- **Code 05:** If the helper sets up or cleans up, then the resident completes the activity without additional assistance three or more times. The helper assists only prior to or following the activity but not during it. For example, the resident may require assistance cutting up food, opening containers, or setting up hygiene item(s) or assistive device(s).
- **Code 04:** If the helper provides verbal cues or touching/steadying/contact guard assistance as the resident completes the activity. Assistance may be provided throughout the activity or intermittently three or more times. For example, the resident may require verbal cueing, coaxing, or general supervision for safety in completing the activity, or the resident may require only incidental help such as a contact guard or steadying assistance during the activity.
- **Code 03:** If the helper does LESS THAN HALF the effort three or more times. The helper lifts, holds, or supports the trunk or limbs but provides less than half the total effort required to complete the task. This would include weight-bearing assistance from the helper.
- **Code 02:** If the helper does MORE THAN HALF the effort three or more times. Helper lifts or holds trunk or limbs and provides more than half the effort. This would include weight-bearing assistance from the helper.
- **Code 01:** If the helper does ALL of the effort, and the resident makes no effort to complete the activity. Coding "Dependent" on the MDS means the resident did not participate in any aspect of the ADL activity during the entire look-back period.

Note: The exception to this rule is for 1 (dependent), 6 (independent), or any of the exception codes listed below. Dependent (1) and the Exception codes would need to be documented during the entire look-back period in order to code those choices on the MDS-AH.

Exception Codes:

- **Code 07:** If the resident refused to complete the activity.
- **Code 08:** If the activity was not attempted and the resident did not perform this activity during the look-back period.
- **Code 09:** If the resident did not attempt this activity due to environmental limitations during the look-back period, such as lack of equipment or weather constraints.
- **Code 99:** If the activity was not attempted due to the resident's medical condition or safety concerns.

Instructions for the Rule of 3:

When an ADL activity has occurred three or more times, apply the steps of the Rule of 3 below (keeping the ADL coding level definitions and the above exceptions in mind) to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs three or more times at any one level, code that level.
   When an activity occurs three or more times at multiple levels, code the most dependent level that occurred three or more times.
2. When an activity occurs three or more times and at multiple levels but not three times at any one level, apply the following:
   a. Convert episodes of Dependent (1) to Substantial or maximal assistance (2) when applying the third Rule of 3, as long as the Dependent episodes did not occur every time the ADL was performed in the 7-day look-back period.
   b. When there is a combination of Dependent (1), Substantial or maximal assistance (2), and Partial or moderate assistance (3) that total three or more times—code Partial or moderate assistance (3).
3. When there is a combination of Substantial or maximal assistance (2), Partial or moderate assistance (3), and Supervision or Touching (4) that total three or more times—code Supervision or Touching (4).
4. When there is a combination of Partial or moderate assistance (3) and Supervision or Touching (4) and Set up/ Clean-up (5) that total three or more times—code Partial or moderate assistance (3).

5. If none of the above are met, code set up/clean-up (5).

Coding Instructions for Column 2, Staff Support:

- **Code 0:** If two or more helpers are NOT required for the resident to complete the activity.
- **Code 1:** If two or more helpers are required for the resident to complete the activity.

Coding Instructions for Column 3, Cognitive Impairment Impact:

- **Code 0:** If the resident did NOT require multiple reminders or multiple single-step cues to complete the ADL task due to dementia or cognitive impairment.
- **Code 1:** If the resident did require multiple reminders or multiple single-step cues to complete the ADL task due to dementia or cognitive impairment.

Coding Tips:

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing G0200I, Walk 50 feet with two turns and determine the type and amount of assistance required as the resident walks 50 feet.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, fall risk due to increased mobility activities).
- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- Ask probing questions, beginning with the general and proceeding to the more specific, to clarify your understanding and observations about a resident's performance in an activity.
- A dash ("-") indicates "No information." The State expects dash use to be rare.
- Documentation in the medical record must support the coding of Section G and should be consistent with the staff documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State regulations.
- The State does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility activities. Assessments may include any device or

equipment that the resident can use to allow them to safely complete the activity as independently as possible.

Tips for Coding the Resident's Performance:

- When coding the resident's performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential ability to perform the activity.

Examples and Coding Tips:

The following are coding examples and coding tips for mobility items.

Coding Tip for G0200A: Roll left and right:

- If the resident does not sleep in a bed, staff should assess bed mobility activities using the alternative furniture on which the resident sleeps (for example, a recliner).

Examples for G0200A, Roll left and right:

1. Resident R has a history of skin breakdown. A staff instructs them to turn onto their right side, and then roll onto their right side. Resident R attempts to roll with the use of the bedrail but indicates they cannot perform the task. The staff then rolls them onto their right side. Next, Resident R is instructed to return to lying on their back, which they successfully complete. Resident R then requires physical assistance from staff to roll onto their left side and to return to lying on their back to complete the activity.
    a. **Coding:** G0200A would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** staff provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the staff provides physical assistance to move Resident R's body weight to turn onto their right side. The staff provides the same assistance when Resident R turns to their left side and when they return to their back. Resident R can return to lying on their back on their right side by themself.
2. A staff helps Resident K turn onto their right side by instructing them to bend their left leg and roll onto their right side. The staff then instructs them on how to position their limbs to return to lying on their back and repeat a similar process for rolling onto their left side

and then returning to lying on their back. Resident K completes the activity without physical assistance from the staff.

   a. **Coding:** G0200A would be coded 04, Supervision or touching assistance.
   b. **Rationale:** The staff provides verbal cues (i.e., instructions) to Resident K as they roll from their back to their right side and return to lying on their back, and then again as they perform the same activities with respect to their left side. The staff does not provide any physical assistance.

3. Resident M fell and sustained left shoulder contusions and a fractured left hip and underwent surgery on the left hip. They were recently admitted to the residential care facility after being discharged from a skilled nursing facility. A staff assists Resident M in rolling onto their right side by instructing them to bend their left leg while rolling to their right side. Resident M needs physical assistance from the staff to initiate rolling right because of their left arm weakness when grasping the right bed rail to assist in rolling. Resident M returns to lying on their back without assistance and uses their right arm to grasp the left bed rail to slowly roll onto their left hip and then return to lying on their back.

   a. **Coding:** G0200A would be coded 03, Partial/moderate assistance.
   b. **Rationale:** The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

Examples for G0200B, Sit to lying:

1. Resident H requires assistance from a staff to transfer from sitting at the edge of the bed to lying flat on the bed because of hemiparesis/hemiplegia on their right side. The helper lifts and positions Resident H's right leg. Resident H uses their arms to position their upper body and lowers themself to a lying position flat on their back.

   a. **Coding:** G0200B would be coded 03, Partial/moderate assistance.
   b. **Rationale:** A helper lifts Resident H's right leg and helps them position it as they move from a seated to a lying position; the helper performs less than half of the effort.

2. Resident F requires assistance from staff to get from a sitting position to lying flat on the bed. The staff cradles and supports their trunk and right leg to transition Resident F from sitting at the side of the bed to lying flat on the bed. Resident F assists themself a small

amount by bending their elbows and left leg while pushing their elbows and left foot into the mattress, only to straighten their trunk while transitioning into a lying position.

a. **Coding:** G0200B would be coded 02, Substantial/maximal assistance.
b. **Rationale:** The helper provided more than half the effort for the resident to complete the activity of sitting to lying.

3. Resident H requires assistance from two staff to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on their right side, obesity, and cognitive limitations. One of the staff explains to Resident H each step of the sitting to lying activity. Resident H is then fully assisted to get from sitting to a lying position on the bed. Resident H does not attempt to assist when asked to perform the incremental steps of the activity.

a. **Coding:** G0200B would be coded 01, Dependent.
b. **Rationale:** The resident did not attempt to assist when asked to perform the activity, and Two staff were needed to complete the sit-to-lie activity, code as 01, Dependent in Column and code Column 2 to indicate two staff were needed for the resident to perform the activity.

Coding Tips for G0200C, Lying to sitting on the side of the bed:

- The activity includes resident transitions from lying on their back to sitting on the side of the bed without back support. The resident's ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity are assessed.
- For item G0200C, Lying to sitting on the side of the bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.
- Back support refers to an object or person providing support for the resident's back.
- If the staff determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities G0200A, Roll left and right, G0200B, Sit to lying, and G0200C, Lying to sitting on the side of the bed, as 99, Not attempted due to a medical condition or safety concern.

Examples for G0200C, Lying to sitting on the side of the bed:

1. Resident B pushes up from the bed to get themself from lying to a seated position. The staff provides steadying (touching) assistance as Resident B scoots themself to the edge of the bed and lowers their feet onto the floor.
    a. **Coding:** G0200C would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides touching assistance as the resident moves from lying to sitting.
2. Resident B pushes up on the bed to attempt to get themself from a lying to a seated position as the staff provides much of the lifting assistance necessary for them to sit upright. The staff provides additional lifting assistance as Resident B scoots themself to the edge of the bed and lowers their feet to the floor.
    a. **Coding:** G0200C would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to a sitting position.
3. Full assistance from the staff is needed to move Resident P from a lying position to sitting on the side of their bed because they usually have pain in their lower extremities upon movement.
    a. **Coding:** G0200C would be coded 01, Dependent.
    b. **Rationale:** The helper fully completed the activity of lying to sitting on the resident's side of the bed.
4. The staff steadies Resident P's trunk as they get to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Resident P then scoots toward the edge of the bed and places both feet flat on the floor. Resident P completes most of the effort to get from lying to sitting on the side of the bed.
    a. **Coding:** G0200C would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on the side of the bed.

Coding Tips for G0200D, Sit to stand:

- The activity includes the resident coming to a standing position from any sitting surface.

- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code for the amount of staff support required in Column 1 and Code yes in Column 2 if the resident requires two staff to complete the task.
- Code as 05, Setup or clean-up assistance, if the only help a resident requires to complete the sit-to-stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle-foot orthosis.

Examples for G0200D, Sit to stand:

1. Resident M has osteoarthritis. Resident M transitions from a sitting to a standing position with the steadying (touching) assistance of the staff's hand on Resident M's trunk.
    a. **Coding:** G0200D would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides touching assistance only.
2. Resident L has multiple sclerosis, requiring two staff to assist them in standing up from sitting in a chair.
    a. **Coding:** G0200D would be coded with the code that most appropriately describes the amount of assistance required in Column 1 and Code "yes" in Column 2 if two staff were required to complete the task.
    b. **Rationale:** Resident L requires partial to maximal assistance and two helpers to complete the activity.
3. Resident Z has a prominent foot drop in their left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The staff applies Resident Z's AFO and places the platform walker in front of them; Resident Z uses the walker to steady themself once standing. The staff provides lifting assistance to get Resident Z to a standing position and must also provide assistance to steady Resident Z's balance to complete the activity.
    a. **Coding:** G0200D would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sitting to standing.
4. Resident R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The staff brings Resident R their crutches and helps them to stand at the side of the bed. The staff provides some lifting assistance to get Resident R to a standing position but provides less than half the effort to complete the activity.
    a. **Coding:** G0200D would be coded 03, Partial/moderate assistance.

b. **Rationale:** The helper provided lifting assistance, which required less than half the effort for the resident to complete the sit-to-stand activity.

Coding Tips for G0200E, Chair/bed-to-chair transfer:

- For item G0200E, Chair/bed-to-chair transfer: When assessing the resident moving from the chair/bed to the chair, the assessment begins with the resident sitting at the edge of the bed (or alternative sleeping surface) and ends with the resident sitting in a chair or wheelchair.
- G0200B, Sit to Lie, and G0200C, Lying to Sit on the Side of the Bed, are separate activities that are not assessed as part of G0200E.
- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code Column 1 to indicate the amount of assistance required and code Column 2 to indicate if two staff were required for the resident to complete the task.

Examples for G0200E, Chair/bed-to-chair transfer:

1. Resident L uses a wheelchair for mobility. When Resident L gets out of bed, the staff moves the wheelchair into the correct position and locks the brakes so that Resident L can transfer into the wheelchair safely. Resident L had been observed several other times to determine any safety concerns, and it was documented that they transferred safely without the need for supervision. Resident L transfers into the wheelchair by themself (no helper) after the staff leaves the room.
    a. **Coding:** G0200E would be coded 05, Setup or clean-up assistance.
    b. **Rationale:** Resident L is not able to walk, so when getting out of bed, he or she transfers from his or her bed to a wheelchair. The helper provides setup assistance only. Resident L transfers safely and does not need supervision or physical assistance during the transfer.
2. Resident C is sitting on the side of the bed. They stand and pivot into the chair as the staff provides contact guard (touching) assistance. The staff reports that once, Resident C only required verbal cues for safety, but usually, Resident C requires touching assistance.
    a. **Coding:** G0200E would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides touching assistance during the transfers.

3. Resident F's medical conditions include morbid obesity and diabetes mellitus. Resident F requires full assistance with transfers from the bed to the wheelchair using a full-body mechanical lift. Two staff are required for safety when using the device to transfer Resident F from the bed to a wheelchair. Resident F is unable to assist in the transfer from their bed to the wheelchair.
    a. **Coding:** G0200E would be coded 01, dependent on Column 1, as the resident was unable to assist with the transfer, and Column 2 would be coded to indicate two staff members were required for the resident to complete the task.
    b. **Rationale:** The two helpers completed all the effort for the chair/bed-to-chair transfer activity.
4. Resident P has a condition severely affecting their ability to use their lower and upper extremities during daily activities. Resident P is motivated to assist with their transfers from the side of their bed to the wheelchair. Resident P pushes themself up from the bed to begin the transfer while another helper provides limited trunk support with weight-bearing assistance. Once standing, Resident P shuffles their feet, turns, and slowly sits down into the wheelchair, with the staff providing trunk support with weight-bearing assistance.
    a. **Coding:** G0200E would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The helper provided less than half of the effort required for the resident to complete the chair/bed-to-chair transfer activity.

Coding Tips for G0200F, Toilet transfer:

- Toilet transfer includes the resident's ability to get on and off a toilet (with or without a raised toilet seat) or bedside commode.
- Toileting hygiene, clothing management, and transferring on and off a bedpan are not considered part of the Toilet transfer activity.
- Code as 05, Setup or clean-up assistance, if the resident requires a helper to position/set up the bedside commode before and/or after the resident's bed-to-commode transfers (place at an accessible angle/location next to the bed) and the resident does not require helper assistance during Toilet transfers.

Examples for G0200F, Toilet transfer:

1. The staff moves the wheelchair footrests up so that Resident T can safely transfer from the wheelchair onto the toilet by themselves. The staff is not present during the transfer because supervision is not required. Once Resident T completes the transfer from the toilet back to the wheelchair, they flip the footrests back down themselves.
    a. **Coding:** G0200F would be coded 05, Setup or clean-up assistance.
    b. **Rationale:** The helper provides setup assistance (moving the footrest out of the way) before Resident T can transfer safely onto the toilet.
2. The staff provides steadying (touching) assistance as Resident Z lowers their underwear and then transfers onto the toilet. After voiding, Resident Z cleanses themself. They then stand up as the helper steadies them, and Resident Z pulls up their underwear as the helper steadies them to ensure Resident Z does not lose their balance.
    a. **Coding:** G0200F would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item G0100C, Toilet hygiene, and is not considered when rating the Toilet transfer item.
3. The staff supports Resident M's trunk with a gait belt by providing weight-bearing as Resident M pivots and lowers themself onto the toilet.
    a. **Coding:** G0200F would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.
4. Resident W has peripheral vascular disease, resulting in lower extremity pain and weakness. Resident W uses a bedside commode when having a bowel movement. The staff raises the bed to a height that facilitates the transfer activity. Resident W initiates lifting their buttocks from the bed and, in addition, requires some of their weight to be lifted by the staff to stand upright. Resident W then reaches and grabs onto the armrest of the bedside commode to steady themself. The staff provides weight-bearing assistance as they slowly rotate and lower Resident W onto the bedside commode.
    a. **Coding:** G0200F would be coded 02, Substantial/maximal assistance.

   b. **Rationale:** The helper provided more than half of the effort required for the resident to complete the toilet transfer activity.

5. Resident S uses a bedpan for bladder and bowel management.
   a. **Coding:** G0200F would be coded 99, Not attempted due to medical condition or safety concerns.
   b. **Rationale:** The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

Coding Tips for G0200G, Tub/shower transfer:

- Tub/shower transfers involve the ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing activities in this item.

Examples for G0100G, Tub/shower transfer:

1. During the observation period, Resident M took one shower. They received physical help from two staff members to get into and out of the shower.
   a. **Coding:** G0100G would be coded in Column 1 to indicate the amount of assistance required and could be coded in Column 2 to indicate two staff were required for the resident to complete the task.
   b. **Rationale:** Resident M required two staff members to assist with shower transfers during the observation period.

Coding Tips for G0200H–G0200J Walking Items:

- Assessment of the walking activities starts with the resident in a standing position.
- A walking activity cannot be completed without some level of resident participation that allows resident ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a resident.

  During a walking activity, a resident may take a brief *standing* rest break. If the resident needs to sit to rest during a Section G walking activity, consider the resident unable to complete the walking activity and use the appropriate activity not attempted code.
- When coding G0200J, Walk 150 feet if the resident's environment does not accommodate a walk of 150 feet without turns, but the resident demonstrates the ability to walk, with or without assistance, 150 feet with turns without jeopardizing the resident's safety, code using the 6-point scale.

Examples for G0200H, Walk 10 feet:

1. Resident C has Parkinson's disease and walks with a walker. A staff member must advance the walker for Resident C at each step. The staff assists Resident C by physically initiating the stepping movement forward and advancing Resident C's foot during the activity of walking 10 feet.
    a. **Coding:** G0200H would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** A helper provides more than half the effort as the resident completes the activity.

Examples for G0200I, Walk 50 feet:

1. Staff provides steadying assistance as Resident W gets up from a sitting position to a standing position. After a helper places Resident W's walker within reach, Resident W walks 60 feet down the hall with two turns without any assistance from the staff. No supervision is required while they walk.
    a. **Coding:** G0200I would be coded 05, Setup or clean-up assistance.
    b. **Rationale:** Resident W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item G0200D, Sit to stand (04, Supervision or touching assistance).
2. Resident P walks 70 feet with a quad cane, completing two turns during the walk. The staff provides steadying assistance only when Resident P turns.
    a. **Coding:** G0200I would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.
3. Resident L is unable to bear their full weight on their left leg. As they walk 60 feet down the hall with their crutches and make two turns, the staff supports their trunk, providing weight-bearing assistance.
    a. **Coding:** G0200I would be coded 03, Partial/moderate assistance.
    b. **Rationale:** The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. Resident T walks 50 feet with the helper, providing trunk support. They also require a second helper who provides supervision and follows closely behind with a wheelchair for safety. Resident T walks 50 feet with two turns with the assistance of two helpers.
    a. **Coding:** G0200I would be coded in Column 1 to indicate the amount of staff assistance required for the resident to complete the task; code in Column 2 to indicate if two or more staff were required for the resident to complete the task.
    b. **Rationale:** Resident T requires partial/moderate assistance and two helpers to complete the activity.
5. Resident U has severe rheumatoid arthritis and uses an orthotic device, such as an ankle/foot orthotic (AFP). Resident U is assisted to stand and, after walking 10 feet, requires progressively more help as they near the 50-foot mark. Resident U is unsteady and typically loses their balance when turning, requiring significant support to remain upright.
6. The helper provides significant trunk support for about 30 to 35 feet.
    a. **Coding:** G0200I would be coded 02, Substantial/maximal assistance.
    b. **Rationale:** The helper provided more than half of the effort for the resident to complete the activity of walking 50 feet with two turns.

Examples for G0200J, Walk 150 feet:

1. Resident D walks down the hall using their walker, and the staff usually needs to provide touching assistance to Resident D, who intermittently loses their balance while using the walker.
    a. **Coding:** G0200J would be coded 04, Supervision or touching assistance.
    b. **Rationale:** The helper provides touching assistance intermittently throughout the activity.
2. Resident R has endurance limitations due to heart failure and has only walked about 30 feet during the look-back period. They have not walked 150 feet or more during the assessment period, including with staff who have been working with Resident R.
    a. **Coding:** G0200J would be coded 99, Not attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item G0200I.

   b. **Rationale:** The activity was not attempted. The resident did not complete the activity, and a helper cannot complete the activity for the resident. A resident who walks less than 50 feet would be coded in item G0200I, Walk 10 feet, but not coded at G0200I, Walk 50 feet or G0200J, Walk 150 feet.

3. Resident T has an unsteady gait due to balance impairment. Resident T walks the length of the hallway using their quad cane in their right hand. The staff supports their trunk, helping them to maintain their balance while ambulating. The helper provides less than half of the effort to walk the 160-foot distance.
   a. **Coding:** G0200J would be coded 03, Partial/moderate assistance.
   b. **Rationale:** The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.
4. Resident W, who has Parkinson's disease, walks the length of the hallway using their rolling walker. The staff provides trunk support and advances Resident W's right leg in longer strides with each step. The helper occasionally prevents Resident W from falling as they lose their balance during the activity.
   a. **Coding:** G0200J would be coded 02, Substantial/maximal assistance.
   b. **Rationale:** The helper provides more than half the effort for the resident to complete the activity of walking 150 feet.

Coding Tips for G0200K, Car transfer

- The Car transfer does not include getting to or from the vehicle, opening/closing the car door, or fastening/unfastening the seat belt.
- If the resident remains in a wheelchair and does not transfer in and out of a car or van seat, then the activity is not considered complete, and the appropriate "activity not attempted" code will be used.
- The setup and/or clean-up of an assistive device that is used for walking to and from the car but not used for the transfer in and out of the car seat would not be considered when coding the Car transfer activity.

Examples for G0200K, Car transfer

1. Resident W uses a wheelchair and ambulates for only short distances. They require lifting assistance to get from a seated position in the wheelchair to a standing position. Staff provides trunk support when Resident W takes several steps during the transfer turn.

Resident W lowers themself into the car seat with steadying assistance from staff. They lift their legs into the car with support from staff.

a. **Coding:** G0200K would be coded 02, Substantial/maximal assistance.

b. **Rationale:** Although Resident W also contributed effort to complete the activity, the helper contributed more than half the effort needed to transfer Resident W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** Resident N works with staff on transfers in and out of the passenger side of a car. When performing car transfers, Resident N requires verbal reminders for safety and light-touching assistance. Staff instructs them on strategic hand placement while Resident N transitions to sitting in the car's passenger seat. The therapist opens and closes the door.

a. **Coding:** G0200K would be coded 04, Supervision or touching assistance.

b. **Rationale:** The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

G0300. Mobility Devices

G0300. Mobility Devices	
Check all that apply in the LAST 7 DAYS:	
☐	A. **Cane/crutch**
☐	B. **Walker**
☐	C. **Wheelchair** *(manual or electric)*
☐	D. **Limb prosthesis**
☐	Z. **None of the above**

Item Rationale:

- Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.
- A resident's ability to move about their room, unit, or facility may be directly related to the use of devices. It is critical that staff members ensure that the resident's independence is optimized by making mobility devices available daily if needed.

Steps for Assessment:

1. Review the medical record for references to locomotion during the 7-day observation period.

2. Talk with staff members who work with the resident and family/significant others about the mobility devices the resident used during the observation period.
3. Observe the resident during locomotion.

Coding Instructions:

Record the type(s) of mobility devices the resident normally uses for locomotion (in the room and the facility). Check all that apply:

- **Check A:** if the resident used a cane or crutch, including single-prong, tripod, quad cane, etc.
- **Check B:** if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with or without a posterior seat and lap cushion. Also, check this item to see if the resident walks while pushing a wheelchair for support.
- **Check C:** If the resident normally sits in a wheelchair when moving about. Include wheelchairs that are hand-propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.
- **Check D:** If the resident used an artificial limb to replace a missing extremity.
- **Check Z:** If the resident used none of the mobility devices listed in G0300 or locomotion did not occur during the observation period.

Examples:

1. The resident uses a quad cane daily to walk in the room and on the unit. Because of their issues with endurance, they also use a standard push wheelchair that they self-propel when leaving the unit.
    a. **Coding:** G0300A, Cane/crutch**,** and G0300C, Wheelchair, would be checked.
    b. **Rationale:** The resident uses a quad cane in their room and on the unit and a wheelchair off the unit.
2. The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied, the resident can ambulate independently.
    a. **Coding:** G0300D, Limb prosthesis**,** would be checked.
    b. **Rationale:** The resident uses a leg prosthesis for ambulating.

G0400. IADL Self-Performance

G0400. IADL Self-Performance	
Enter code ☐	A. **Resident arranged for suitable transportation to get to appointments, outings, and necessary engagements in the LAST 30 DAYS:** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	B. **Resident managed finances, including banking, handling checkbooks, and paying bills in the LAST 30 DAYS:** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	C. **Resident managed cash and personal needs allowance in the LAST 30 DAYS:** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	D. **Resident used phone in the LAST 30 DAYS:** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days

Item Rationale:

- Record the resident's self-care performance in IADL - Instrumental Activities of Daily Living (i.e., what the resident actually did for himself or herself and/or how much help was required by staff members) each time the activity occurred during the last 30 days.

Definitions:

- **IADL Self-Performance:** Measures what the resident actually did (not what he or she might be capable of doing) each time the activity occurred within each IADL category over the last 30 days according to a performance-based scale.
- **Arranging Transportation:** How the resident plans or makes arrangements to get to appointments or to accomplish shopping and other errands.
- **Managing Finances:** How the resident handles finances. The way the resident performs bank transactions (cashing or depositing checks), writes checks, manages checkbooks, and pays bills does not include handling cash.
- **Managing Cash:** How the resident handles cash, including personal needs allowance. Lack of money (e.g., except for a personal needs allowance) does not mean dependence. The way the resident manages cash should be assessed (e.g., recognizes change or bills as

money and can calculate the amount to pay when given a bill). If a resident has no money, you may code it as "activity did not occur."

- **Telephone:** How the resident uses the phone. This includes locating phone numbers, dialing the correct number, and communicating by phone.

Coding Instructions:

- **Code 1:** If no help or staff oversight was provided during the past 30 days.
- **Code 2:** If support is necessary for the resident to perform the function adequately, at least some of the time.
- **Code 3:** If the resident is not involved in performing the activity, however, others perform the function on behalf of the resident.
- **Code 9:** If the IADL activity did not occur at all over the last 30 days.

Note: This is the coding on the MDS, by the MDS coordinator, that reflects the Resident's self-performance over the 30-day look-back period. Staff documentation would capture whether the activity occurred each shift, the resident's level of self-performance, and the level of staff support provided.

G0410 IADL Self-Performance – Part 2

G0410 IADL Self-Performance – Part 2	
Check all that apply in the LAST 30 DAYS:	
Enter code ☐	A. **Resident arranged for shopping for clothing, snacks, and other incidentals.** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	B. **Resident shopped for clothing, snacks, or other incidentals** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	C. **Resident prepared snacks and light meals.** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	D. **Resident did light housework such as making their own bed, dusting, or taking care of belongings.** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days
Enter code ☐	E. **Resident sorted, folded, or washed their own laundry.** 0. **Independent -** No help provided *(with/without assistive devices)* 1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)* 2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)* 9. **None of the above -** Activity did not occur in the last 30 days

Coding Instructions:

- **Code 1:** If no help or staff oversight was provided during the past 30 days.
- **Code 2:** If support is necessary for the resident to perform the function adequately, at least some of the time.
- **Code 3:** If the resident is not involved in performing the activity, however, others perform the function on behalf of the resident.
- **Code 9:** If the IADL activity did not occur at all over the last 30 days.

Note: This is the coding on the MDS, by the MDS coordinator, that reflects the Resident's self-performance over the 30-day look-back period. Staff documentation would capture whether the activity occurred each shift, the resident's level of self-performance, and the level of staff support provided.

G0500. Transportation

G0500. Transportation	
Check all that apply in the LAST 30 DAYS:	
☐	A. **Resident drove a car or used public transportation independently** to get to medical or dental appointments, necessary engagements, or other activities.
☐	B. **Resident rode to destination** (*with staff, family, or others*) but did NOT require support to attend medical or dental appointments, necessary engagements, or other activities.
☐	C. **Resident rode to destination** (*with staff, family, or others*) *and* required support to attend medical or dental appointments, necessary engagements, or other activities.
☐	Z. **None of the above**

Item Rationale:

- Access to transportation for ongoing health care and medication access needs is essential for effective care management.
- Understanding resident transportation needs can help organizations assess barriers to care and facilitate connections with available community resources.
- Assessing transportation barriers will facilitate better care coordination and discharge planning for follow-up care.

Steps for Assessment:

1. A resident's self-performance for transportation may vary from day to day, engagement to engagement, or by distance traveled. Many possible reasons for these variations include mood, medical condition, relationship issues, and medications.
2. The assessor's responsibility, therefore, is to capture the total picture of the resident's self-performance over the 30-day period and consider various types of transportation needed—i.e., not only how the evaluating staff person sees the resident but also how the resident performs at other times as well.
3. To evaluate a resident's Transportation Self-Performance, begin by reviewing the documentation in the resident's or facility's records (e.g., the resident's service or care plan, staff and physician notes or instructions).
4. Talk with staff from day and evening shifts to determine what the resident does for themselves relative to transportation. As previously noted, be alert to differences in resident performance from day to day or shift to shift and CHECK ALL ITEMS that capture these differences.
5. Residents who have difficulty getting between buildings and vehicles or who have difficulty locating their destination are coded based on their need for assistance beyond simply driving a vehicle or using public transportation.

a. For example, a resident may be able to drive to local shopping areas for routine activities but may require someone else to drive them to appointments that are out of town and escort them into unfamiliar buildings to locate a new doctor's office. In this case, the resident's situation would be recorded by checking for both items "a." The resident drove the car independently… and "c." The Resident rode to the destination with others and was accompanied…"

Coding Instructions:

For each transportation category, check all answers that represent the resident's functioning during the past 30 days.

- **Code A:** If the resident was not accompanied by a driver, staff, family, or other individual expected to assist the resident in their travel to appointments or other engagements.
- **Code B:** If the resident was accompanied by a driver or other individual expected to assist the resident while in the vehicle, the individual accompanying the resident did not leave the vehicle or provide physical assistance into or out of buildings. Individuals accompanying the resident may have supervised the resident by observing that the resident managed to gain access to the destination building safely.
- **Code C:** If the resident was accompanied by an individual (who may have been the driver of a second individual) who escorted the resident into and out of buildings, within buildings, and accompanied the resident to appointments or while they conducted business or participated in other activities.
- **Code Z:** If, over the last 30 days, the resident did not use any transportation at all.

3.10. Section H: Bladder and Bowel

H0100. Appliances

H0100. Appliances	
Check all that apply:	
☐	A. **Indwelling catheter** *(including suprapubic catheter and nephrostomy tube)*
☐	B. **External catheter**
☐	C. **Ostomy** *(including urostomy, ileostomy, and colostomy)*
☐	D. **Intermittent catheterization**
☐	Z. **None of the above**

Item Rationale:

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote resident dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risks and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.
- Care planning should include interventions that are consistent with the resident's goals and minimize complications associated with appliance use and based on the physician's orders for the appliance in use.

Definitions:

- **Indwelling catheter:** A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
- **Suprapubic catheter:** An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

- **Nephrostomy tube:** A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.
- **External catheter:** Device attached to the shaft of the penis like a condom or a receptacle pouch that fits around the labia majora and is connected to a drainage bag.
- **Ostomy:** Any surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.
- **Urostomy:** A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.
- **Ileostomy:** A stoma that has been constructed by bringing the end or loop of the small intestine (the ileum) out onto the surface of the skin.
- **Colostomy:** A stoma that has been constructed by connecting a part of the colon to the anterior abdominal wall.
- **Intermittent catheterization:** Insertion and removal of a catheter through the urethra for bladder drainage.

Coding Instructions:

Check next to each appliance that was used at any time in the past 7 days.

- **Code A:** If the resident used an indwelling catheter (including suprapubic catheter and nephrostomy tube)
- **Code B:** If the resident used an external catheter.
- **Code C:** If the resident used an ostomy (including urostomy, ileostomy, and/or colostomy).
- **Code D:** If the resident used intermittent catheterization.
- **Code Z:** If none of the above applies to the resident.

Coding Tips and Special Populations:

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters and external urinary pouches are often used intermittently or at night only; these should be coded as external catheters.

- Do not code gastrostomies (a tube inserted into the stomach) or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterizations for urine specimen collection or other diagnostic exams (e.g., to measure post-void residual) during the look-back period as intermittent catheterization.
- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

H0200. Urinary Continence in the past seven days

H0200. Urinary Continence	
Enter code ☐	**Select the one category that best describes the resident:** 0. **Always continent -** No episodes of incontinence 1. **Bladder incontinence episodes once a week or less** 2. **Incontinent episodes two or more times a week but not daily** 3. **Incontinent daily -** Some control present 4. **Bladder incontinence episodes occur multiple times daily** 9. **None of the above -** Resident had a catheter *(indwelling, condom, urinary ostomy)* or no urine output for the entire 7 days

Item Rationale:

- Incontinence can interfere with participation in activities, be socially embarrassing and lead to increased feelings of dependency, increase risk of skin rashes and breakdown, increase risk of repeated urinary tract infections, and increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.
- For many residents, incontinence can be resolved or minimized by identifying and treating underlying and potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence).
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the service plan should establish a plan to maintain skin dryness and minimize exposure to urine.

Definitions:

- **Urinary incontinence:** Any time urine lays against the skin due to leakage from the urethra or a catheter of any type.
- **Continence:** Any void that occurs voluntarily or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Coding Instructions:

- **Code 0:** If, throughout the 7-day look-back period, the resident has been contaminated with urine without any episodes of incontinence,
- **Code 1:** If during the 7-day look-back period, the resident had bladder incontinent episodes once a week or less.
- **Code 2:** If during the 7-day look-back period, the resident was incontinent two or more times a week but not daily. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 3:** If during the 7-day look-back period, the resident tended to be incontinent daily, but some control present (e.g., on the day shift). This includes incontinence of any amount of urine, daytime and nighttime.
- **Code 4:** If during the 7-day look-back period, bladder incontinent episodes occur multiple times daily.
- **Code 9:** If during the 7-day look-back period, the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days. If the resident has a catheter with intermittent leaking due to any cause, this would be coded with a "9" due to the presence of the catheter rather than coding incontinence. The issue of urine laying against the skin must still be addressed in the service/care plan to address skin care concerns.

Coding Tips and Special Populations:

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

H0300. Urinary Toileting Program

H0300. Urinary Toileting Program	
Enter code ☐	**Is a toileting program currently being used to manage the resident's urinary continence?** *(e.g., scheduled toileting, prompted voiding, or bladder training)* 0. **No** 1. **Yes**

Item Rationale:

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.

- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.
- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence.
- Completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence and implementing appropriate, individualized interventions and modify them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one-quarter to one-third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.
- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence, changing their brief if needed, and providing good skin care).

Coding Instructions:

- **Code 0:** If an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- **Code 1:** For residents who are being managed during 4 or more days of the 7-day look-back period with some systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer

not to be awakened for toileting during sleeping hours. If that resident, however, is on a toileting program during the day, code "yes."

H0400. Use and Management of Incontinence Supplies

H0400. Use and Management of Incontinence Supplies	
Enter code ☐	**Resident's use and management of incontinence supplies in the LAST 7 DAYS:** *(pads, briefs, ostomy, catheter)* 0. **Incontinence supplies not used** 1. **Resident is incontinent** and able to manage incontinence supplies independently 2. **Resident is incontinent** and requires assistance to manage incontinence supplies 3. **Resident is incontinent** and unable to manage incontinence supplies

Item Rationale:

- To determine and record the resident's ability to manage incontinence supplies, including pads, briefs, an ostomy, or a catheter, in the last 7 days.
- To "manage supplies" means to change the pad or brief, empty catheter, and/or ostomy bag; it does not refer to ordering supplies or putting them away when supplies arrive.

Steps for Assessment:

1. Review the resident's record.
2. Consult with direct care staff and the client.
3. Determine if the resident is not using incontinence supplies (i.e., hiding underwear).

Coding Instructions:

- **Code 0:** If the resident does not use incontinence supplies.
- **Code 1:** If the resident is incontinent and able to manage supplies independently.
- **Code 2:** If the resident is incontinent and receives assistance with managing supplies.
- **Code 3:** If the resident is incontinent and is unable to manage incontinence supplies.

H0500. Bowel Continence

H0500. Bowel Continence	
Enter code ☐	**Select one category that best describes the resident in the LAST 7 DAYS:** 0. **Continent of bowel on all occasions** of bowel movements, without any episodes of incontinence. 1. **Incontinent of bowel once -** Includes incontinence of any amount of stool day or night. 2. **Incontinent of the bowel more than once** but had at least one continent bowel movement. 3. **Incontinent of bowel for all bowel movements** and had no continent bowel movements. 9. **None of the Above -** Resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale:

- Incontinence can interfere with participation in activities,
- be socially embarrassing and lead to increased feelings of dependency,
- increase risk of long-term institutionalization,
- increase risk of skin rashes and breakdown and

- increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.
- For many residents, incontinence can be resolved or minimized by - identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence), and eliminating environmental, physical barriers to accessing commodes, bedpans, and urinals.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Coding Instructions:

- **Code 0:** If during the 7-day look-back period, the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
- **Code 1:** If during the 7-day look-back period, the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
- **Code 2:** If during the 7-day look-back period, the resident was incontinent of the bowel more than once but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
- **Code 3:** If during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.
- **Code 9:** If during the 7-day look-back period, the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation)

Coding Tips and Special Populations:

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

H0600. Bowel Toileting Program

H0600. Bowel Toileting Program	
Enter code ☐	**Is a toileting program currently being used to manage the resident's bowel continence?** *(e.g., scheduled toileting)* 0. **No** 1. **Yes**

Item Rationale:

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences associated with incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.
- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skincare).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program, the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement.

Coding Instructions:

- **Code 0:** If the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1:** If the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0700. Bowel Elimination Pattern

H0700. Bowel Elimination Pattern		
Check all that apply:		
	☐	A. **Constipation**
	☐	B. **Diarrhea**
	☐	C. **Fecal impaction**
	☐	Z. **None of the above**

Item Rationale:

- If the resident is coded for any of the above problems, interventions should be described in the service/care plan.
- Constipation may be a manifestation of serious conditions such as dehydration due to a medical condition or inadequate access to and intake of fluid and
- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Fecal impaction is caused by chronic constipation.

Coding Instructions:

- **Code A:** If the resident has two or fewer bowel movements during the 7-day look-back period or if, for most bowel movements, their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).
- **Code B:** If the resident has frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).
- **Code C:** If the resident has a large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction. **Note:** A digital exam is only performed by a licensed professional nurse or the physician
- **Code Z:** None of the Above

3.11. Section I: Active Diagnoses

Active Diagnoses

CANCER		
	☐	**I0100. Cancer** *(with or without metastasis)*
HEART/CIRCULATION		
	☐	**I0200. Anemia** *(e.g., aplastic, iron deficiency, pernicious, and sickle cell)*
	☐	**I0300. Atrial Fibrillation or Other Dysrhythmias** *(e.g., bradycardias and tachycardias)*
	☐	**I0400. Coronary Artery Disease** *(CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease)*
	☐	**I0500. Deep Venous Thrombosis** *(DVT)***, Pulmonary Embolus** *(PE)***, or Pulmonary Thrombo-Embolism** *(PTE)*
	☐	**I0600. Heart Failure** *(e.g., congestive heart failure [CHF] and pulmonary edema)*
	☐	**I0700. Hypertension**
	☐	**I0800. Orthostatic Hypotension**
	☐	**I0900. Peripheral Vascular Disease** *(PVD)* **or Peripheral Arterial Disease** *(PAD)*
GASTROINTESTINAL		
	☐	**I1000. Cirrhosis**
	☐	**I1100. Gastroesophageal Reflux Disease** *(GERD)* **or Ulcer** *(e.g., esophageal, gastric, and peptic ulcers)*
	☐	**I1200. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**
GENITOURINARY		
	☐	**I1300. Benign Prostatic Hyperplasia** *(BPH)*
	☐	**I1400. Neurogenic Bladder**
	☐	**I1500. Obstructive Uropathy**
	☐	**I1600. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease** *(ESRD)*
INFECTIONS		
	☐	**I1700. Multidrug-Resistant Organism** *(MDRO)*
	☐	**I1800. Pneumonia**
	☐	**I1900. Septicemia**
	☐	**I2000. Tuberculosis**
	☐	**I2100. Urinary Tract Infection** *(UTI)* **- LAST 30 DAYS**
	☐	**I2200. Viral Hepatitis** *(e.g., Hepatitis A, B, C, D, and E)*
	☐	**I2300. Wound Infection** *(other than foot)*
METABOLIC		
	☐	**I2400. Diabetes Mellitus** *(DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)*
	☐	**I2500. Hyperkalemia**
	☐	**I2600. Hyperlipidemia** *(e.g., hypercholesterolemia)*
	☐	**I2700. Hyponatremia**
	☐	**I2800. Thyroid Disorder** *(e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)*
MUSCULOSKELETAL		
	☐	**I2900. Arthritis** *(e.g., degenerative joint disease [DJD], osteoarthritis, and rheumatoid arthritis [RA])*
	☐	**I3000. Hip Fracture -** Any hip fracture that has a relationship to current status, treatments, or monitoring *(e.g., sub-*

NEUROLOGICAL	
☐	**I3300. Acquired Brain Injury**
☐	**I3400. Alzheimer's Disease**
☐	**I3500. Aphasia**
☐	**I3600. Cerebral Palsy**
☐	**I3700. Cerebrovascular Accident** *(CVA)*, **Transient Ischemic Attack** *(TIA)*, **or Stroke**
☐	**I3800. Hemiplegia or Hemiparesis**
☐	**I3900. Huntington's Disease**
☐	**I4000. Multiple Sclerosis** *(MS)*
☐	**I4100. Non-Alzheimer's Dementia** *(e.g., Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)*
☐	**I4200. Paraplegia**
☐	**I4300. Parkinson's Disease**
☐	**I4400. Quadriplegia**
☐	**I4500. Seizure Disorder or Epilepsy**
☐	**I4600. Tourette's Syndrome**
☐	**I4700. Traumatic Brain Injury** *(TBI)*
NUTRITIONAL	
☐	**I4800. Malnutrition** *(protein or calorie)* **or at risk for malnutrition**
PSYCHIATRIC/MOOD DISORDER	
☐	**I4900. Anxiety Disorder**
☐	**I5000. Bipolar Disorder**
☐	**I5100. Depression** *(other than bipolar)*
☐	**I5200. Post Traumatic Stress Disorder** *(PTSD)*
☐	**I5300. Schizophrenia** *(e.g., schizoaffective and schizophreniform disorders)*
☐	**I5400. Substance Abuse Disorder**
PULMONARY	
☐	**I5500. Asthma, Chronic Obstructive Pulmonary Disease** *(COPD)*, **or Chronic Lung Disease** *(e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)*
☐	**I5600. Respiratory Failure**
VISION	
☐	**I5700. Cataracts, Glaucoma, or Macular Degeneration**
NONE OF ABOVE	
☐	**I5800. None of the above active diagnoses within the LAST 7 DAYS**

Item Rationale:

- The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, staff and/or nurse monitoring, or risk of death.
- One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

Steps for Assessment:

There are two look-back periods for this section:

- **Step 1:** Diagnosis identification is a 12-month look-back period.

- **Step 2:** Diagnosis status: Active or Inactive is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).

Step 1 - Identify diagnoses:

- The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 12 months.
- Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem lists, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.
- Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
- Diagnostic information, including history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

Step 2 - Determine whether diagnoses are active:

- Once a diagnosis is identified, it must be determined if the diagnosis is active.
- Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
- Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's service/care plan during the 7-day look-back period, as these would be considered inactive diagnoses.
- Item I2100 UTI has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-5 for specific coding instructions for Item I2100 UTI.
- Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses:
    - transfer documents
    - physician progress notes

- recent history, physical and/or assessments
- recent discharge summaries
- service or care plans
- doctor's orders and/or medication sheets
- consults
- official diagnostic reports
- and other sources as available

Coding Instructions:

Code diseases that have a documented diagnosis within the last 12 months and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, staff monitoring, or risk of death during the 7-day look-back period.

Note: Except for Item I2100 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2100 UTI, Page I-5 for specific coding instructions.

Coding Tips:

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS. There may be specific documentation of active diagnosis in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.

- The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
- For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.

  Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, or documentation of service/care plan interventions for functional limitations caused by arthritis.
- A medication indicates active disease if that medication is prescribed to manage an ongoing condition.

- Active diagnoses may include items coded in Section I, and may include other diagnoses not included in Section I. All active diagnoses may be addressed in the service/care plan if the diagnosis affects the care required by the resident.

Coding Tips for I2100 Urinary tract infection (UTI):

- The UTI has a look-back period of 30 days for active disease instead of 7 days.
- Code only if the following is met in the last 30 days:
- A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
- In accordance with requirements at State of Maine, Rule Chapters for the Department of Health and Human Services, Chapter 113: Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Infection Prevention and Control, Major Substantive Rule: Infection Prevention and Control Program The facility must establish, implement, and maintain an Infection Prevention and Control Plan (IPCP) to control the transmission of infectious diseases amongst residents, staff, visitors, and other individuals providing services under a contractual arrangement. These rules would apply to any type of infection, including wound infections, urinary tract infections (UTIs), or other communicable conditions such as viral illnesses.
- If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, a documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.
- In response to questions regarding the resident with colonized MRSA, the Centers for Disease Control (CDC) 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 assessments to determine the appropriateness and continuation of antimicrobial treatment. 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 that the appropriate antimicrobial is prescribed to treat the infection.

- The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate the colonization of MRSA or any other antimicrobial-resistant organism.
- You will find information related to UTIs and many other issues related to infections in LTC. http://www.cdc.gov/hai/

Coding Tips for Item I4400 Quadriplegia:

- Quadriplegia primarily refers to the paralysis of all four limbs, arms, and legs caused by spinal cord injury.
- Coding I4400 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
- Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc., can also cause functional paralysis that may extend to all limbs, hence the diagnosis of functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I3600 Cerebral Palsy and not in I4400, Quadriplegia.

Examples of Active Disease:

1. A resident is prescribed an antihypertensive medication for hypertension. The resident requires regular blood pressure monitoring to determine whether the current regimen achieves blood pressure goals. Physician's progress notes document hypertension.
    a. **Coding:** Hypertension item (I0700) would be checked.
    b. **Rationale:** This would be considered an active diagnosis because of the need for ongoing monitoring of blood pressure measurements to ensure treatment efficacy.
2. Warfarin (Coumadin) is prescribed for a resident with atrial fibrillation to decrease the risk of stroke. The resident requires monitoring for a change in heart rhythm, bleeding, and anticoagulation.
    a. **Coding:** Atrial fibrillation item (I0300) would be checked.

b. **Rationale:** This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy and to monitor for side effects related to the medication.

3. A resident with a history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (*NSAID*) medication for arthritis. The physician also prescribes a medication to decrease the risk of peptic ulcer disease (*PUD*) from NSAID treatment.
    a. **Coding:** Arthritis item (I2900) would be checked.
    b. **Rationale:** Arthritis would be considered an active diagnosis because of the need for medical treatment. Given that the resident has a history of a healed peptic ulcer without current symptoms, the medication prescribed is preventive, and therefore, PUD would not be coded as an active disease.

Examples of Inactive Diagnoses (do not code):

1. The admission history states that the resident had pneumonia six months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look-back period.
    a. **Coding:** Pneumonia item (I1800) would not be checked.
    b. **Rationale:** The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.
2. The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.
    a. **Coding:** Schizophrenia item (I5300) would not be checked.
    b. **Rationale:** Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation in accordance with professional standards of the resident's mental, physical,

psychosocial, and functional status and persistent behaviors for the time period required.

3.12. Section J

J0100. Problem Conditions

J0100. Problem Conditions	
Check all that apply:	
☐	A. **Fever**
☐	B. **Vomiting**
☐	C. **Dehydrated**
☐	D. **Internal bleeding**
☐	E. **Dizziness/vertigo**
☐	F. **Edema**
☐	Z. **None of the above**

Item Rationale:

- Timely assessment is needed to identify underlying causes and risk for complications.
- The intent is to record specific problems or symptoms that affect or could affect the resident's health or functional status and to identify risk factors for illness, accident, and functional decline.
- Implementation of service or care plans to treat underlying causes and avoid complications is critical.

Definitions:

- **Fever:** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date in accordance with facility policy.
- **Vomiting:** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).
- **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 (visible blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding.

Coding Instructions:

Check all that apply within the seven-day look-back period.

- **Code A:** If the resident has a temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) OR a temperature 2.4 degrees F higher than baseline.
- **Code B:** If the resident has experienced vomiting.
- **Code C:** If the resident has experienced dehydration.
- **Code D:** If the resident has experienced internal bleeding.
- **Code E:** If the resident has experienced dizziness/vertigo.
- **Code F:** If the resident has experienced edema.
- **Code Z:** If none of the above apply to the resident.

Coding Tips:

- **Dehydrated:** Check this item if the resident presents with two or more of the following potential indicators for dehydration:
    - Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups).
    - Resident has one or more potential clinical signs (indicators) of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
    - Resident's fluid loss (output) exceeds the amount of fluids they take in (intake) (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

J0200. Shortness of Breath

J0200. Shortness of Breath *(dyspnea)*	
Check all that apply:	
☐	A. **Shortness of breath or trouble breathing with exertion** *(e.g., walking, bathing, transferring)*
☐	B. **Shortness of breath or trouble breathing when sitting at rest**
☐	C. **Shortness of breath or trouble breathing when lying flat**
☐	Z. **None of the above**

Item Rationale:

- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.

- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.
- Shortness of breath can be an indication of a change in a condition requiring further assessment and should be reported to the resident's physician.
- The service or care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as staff interventions to limit the impact of shortness of breath on the resident.

Coding Instructions:

Check all that apply during the 7-day look-back period.

Note: Any evidence of the presence of a symptom of shortness of breath should be captured in this item. A resident may have any combination of these symptoms.

- **Code A:** If shortness of breath or trouble breathing is present when the resident is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code shortness of breath as present.
- **Code B:** If shortness of breath or trouble breathing is present when the resident is sitting at rest.
- **Code C:** If shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also, code this as present if the resident avoids lying flat or sleeping with the head of the bed elevated because of shortness of breath. It is important to ask and observe the resident directly, if possible, since the health problems being experienced by the resident can often be remedied.
- **Code Z:** If the resident reports no shortness of breath or trouble breathing and the medical record and staff interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

J0300. Current Tobacco Usage

J0300. Current Tobacco Use	
Enter code ☐	**Does the resident use tobacco products?** 0. **No** 1. **Yes**

Item Rationale:

- The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life.
- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.
- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.
- If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.

Coding Instructions:

- **Code 0:** If there are no indications that the resident used any form of tobacco.
- **Code 1:** If the resident or any other source indicates that the resident used tobacco in some form during the seven-day look-back period.

J0400. Prognosis

J0400. Prognosis	
Enter code ☐	**Does the resident have a condition or chronic disease that may result in a life expectancy of LESS THAN 6 MONTHS?** (*Requires physician documentation*) 0. **No** 1. **Yes**

Item Rationale:

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months have special needs and may benefit from palliative or hospice services in the facility.
- If primary care provider documentation indicates that life expectancy is less than 6 months, service or care planning should be based on the resident's preferences for goals and interventions of care whenever possible.
- In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to the point that the

average resident with that level of illness would not be expected to survive more than 6 months.

- A physician's progress note must substantiate this judgment. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on the typical or average life expectancy of residents with a similar level of disease burden as this resident.
- Not all residents who have a terminal prognosis choose to receive specialized services from a Medicare/Medicaid-certified hospice agency. These specialized services may include registered nurse services for assessment and care planning, social worker services, and home health aide services to supplement ADL services provided by the facility. The facility continues to have the primary responsibility for providing personal care services. Hospice services are intended to provide support with death and dying for the resident, the resident's family, and facility staff.
- Provision of services by a Medicare/Medicaid certified hospice agency is coded in Section O, Special Treatments, Procedures, and Programs.

Coding Instructions:

- **Code 0:** If the medical record does not contain physician documentation that the resident is terminally ill.
- **Code 1:** If the medical record includes physician documentation that the resident is terminally ill.

J0500. Indicators of Pain or Possible Pain

J0500. Indicators of Pain or Possible Pain	
Check all that apply over the LAST 5 DAYS:	
☐	A. **Non-verbal sounds** *(e.g., crying, whining, gasping, moaning, or groaning)*
☐	B. **Vocal complaints of pain** *(e.g., that hurts, ouch, stop)*
☐	C. **Facial expressions** *(e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)*
☐	D. **Protective body movements or postures** *(e.g., bracing, guarding, rubbing or massaging a body part/ area, clutching or holding a body part during movement)*
☐	Z. **None of the above**

Item Rationale:

- Residents who cannot verbally communicate about their pain are at particularly high risk for under-detection and undertreatment of pain.

- Severe cognitive impairment may affect the ability of residents to verbally communicate, thus limiting the availability of self-reported information about pain. In this population, fewer complaints may not mean less pain.
- Individuals who are unable to communicate verbally may be more likely to use alternative methods of expression to communicate their pain.
- Even in this population, some verbal complaints of pain may be made and should be taken seriously.
- A consistent approach to observation improves the accuracy of pain assessment for residents who are unable to communicate their pain verbally.
- Particular attention should be paid to using the indicators of pain during activities when pain is most likely to be demonstrated (e.g., bathing, transferring, dressing, walking, and potentially during eating).
- Staff must carefully monitor, track, and document any possible signs and symptoms of pain.
- Identification of these pain indicators may:
    - provide a basis for more comprehensive pain assessment,
    - provide a basis for determining appropriate treatment, and
    - provide a basis for ongoing monitoring of pain presence and treatment response.
- If pain indicators are present, the assessment and resulting service or care plan should identify factors that make the pain better or worse.

Coding Instructions:

Check all that apply in the last 5 days based on staff observation of pain indicators and there must be documentation in the medical record to support all coding on the MDS-AH.

- **Code A:** If, including, but not limited to, crying, whining, gasping, moaning, or groaning were observed or reported in the last 5 days.
- **Code B:** If, including, but not limited to, the resident was observed to or reported to have made vocal complaints of pain (e.g., “that hurts,” “ouch,” or “stop”) in the last 5 days.
- **Code C:** If, including, but not limited to, grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth, or jaw were observed or reported in the last 5 days.

- **Code D:** If, including, but not limited to, bracing, guarding, rubbing, or massaging a body part/area, or clutching or holding a body part during movement were observed or reported in the last 5 days.
- **Code Z:** If none of these signs were observed or reported in the last 5 days.

Coding Tips:

- Behavior change, depressed mood, rejection of care, and decreased activity participation may be related to pain.
- These behaviors and symptoms are identified in other sections and not reported here as pain screening items. However, the presence of pain should be considered when following up on those symptoms and behaviors.

J0600. Frequency of Indicator of Pain or Possible Pain in the past 5 days

J0600. Frequency of Indicator of Pain or Possible Pain	
Enter code ☐	**Frequency with which resident complains or shows evidence of pain or possible pain in the LAST 5 DAYS:** 1. **Indicators of pain or possible pain observed 1 to 2 days** 2. **Indicators of pain or possible pain observed 3 to 4 days** 3. **Indicators of pain or possible pain observed daily**

Item Rationale:

- Unrelieved pain adversely affects function and mobility, contributing to dependence, skin breakdown, contractures, and weight loss.
- Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence, and self-esteem, as well as to an increase in behavior problems, particularly for cognitively impaired residents.
- Assessment of pain frequency provides:
    - A basis for evaluating treatment needs and response to treatment.
    - Information to aid in identifying the optimum timing of treatment.

Coding Instructions:

Code for pain frequency in the last 5 days.

- **Code 1:** If, based on staff observation, the resident complained or showed evidence of pain for 1 to 2 days.
- **Code 2:** If, based on staff observation, the resident complained or showed evidence of pain for 3 to 4 days.

- **Code 3:** If, based on staff observation, the resident complained or showed evidence of pain daily.

J0700 Pain Management over the past 5 days

J0700. Pain Management	
Check all that apply over the **PAST 5 DAYS:**	
☐	A. **Received scheduled pain medication regimen**
☐	B. **Received PRN or unscheduled pain medication**
☐	C. **Was offered and declined pain medication**
☐	D. **Received non-medication intervention for pain**
☐	Z. **None of the above**

Coding Instructions:

Check all that apply.

- **Check A:** If scheduled dose(s) of medication to relieve pain or discomfort were administered to the resident, as ordered by a physician.
- **Check B:** If unscheduled (PRN) dose(s) of medication to relieve pain or discomfort were administered to the resident, as ordered by a physician.
- **Check C:** If the resident showed possible signs of pain and was offered medication and declined.
- **Check D:** If the resident received non-medication interventions such as massage, energy healing, TENS unit, ice, etc.
- **Check Z:** If none of the above

J0800. Number of Falls Since Admission/Entry, Reentry or Prior Assessment

J0800. Number of Falls Since Admission/Entry, Reentry or Prior Assessment		
1. Number of falls within **PAST 30 DAYS:**	2. Number of falls within **DAYS 31-180:**	
Enter code ☐	Enter code ☐	A. **No injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls
Enter code ☐	Enter code ☐	B. **Minor injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls
Enter code ☐	Enter code ☐	C. **Major injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls

Item Rationale:

- Falls are a leading cause of injury, morbidity, and mortality in older adults.

- A previous fall, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.
- Determine the potential need for further assessment and intervention, including evaluation of the resident's need for rehabilitation or assistive devices.
- Evaluate the physical environment as well as staffing needs for residents who are at risk for falls.
- Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation or ambulation aids and of the need for monitoring or modification of the physical environment.

Definitions:

- **Fall:** Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital, or in a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident or is knocked down by a door).
- **Fracture related to a fall:** Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by the history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.
- **Injury related to a fall:** Any documented injury that occurred as a result of or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

- **Minor Injury:** Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains, or any fall-related injury that causes the resident to complain of pain.
- **Major Injury:** Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Coding Instructions for Column 1 and Column 2:

- **Code 0**: If the resident had no falls without injury, fall with a minor injury, or fall with major injury since the admission/entry or reentry (if less than the look-back period) or prior assessment. Code the appropriate response for items A, B, and C.
- **Code 1**: If the resident had one fall without injury, fall with a minor injury, or fall with major injury since the admission/entry or reentry (if less than the look-back period) or prior assessment. Code the appropriate response for items A, B, and C.
- **Code 2**: If the resident had two or more falls without injury, fall with a minor injury, or fall with major injury since the admission/entry or reentry (if less than the look-back period) or prior assessment. Code the appropriate response for items A, B, and C.

3.13. Section K: Swallowing/Nutritional Status

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

K0100. Height and Weight

K0100. Height and Weight *(while measuring, if the number is X.1-X.4, round down; X.5 or greater, round up)*	
Enter number ☐☐	A. **Height** *(in inches)* **-** Record the most recent height measure since the most recent admission/entry or reentry.
Enter number ☐☐☐	B. **Weight** *(in pounds)* **-** Base weight on the most recent measure in the **LAST 30 DAYS**; measure weight consistently, according to standard facility practice *(e.g., in a.m. after voiding, before a meal, with shoes off, etc.).*

Item Rationale:

- Diminished nutritional and hydration status can lead to debility that can adversely affect health and safety as well as the quality of life.
- Height and weight measurements assist staff with assessing the resident's nutrition and hydration status by providing a mechanism for monitoring weight stability over time.
- Weight measurement is one guide for determining nutritional status.

Steps for Assessment for K0100A, Height:

1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (e.g., shoes off).
3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again.

Coding Instructions for K0100A, Height:

- Record height to the nearest whole inch.
- Use mathematical rounding (i.e., if the height measurement is X.5 inches or greater, round the height upward to the nearest whole inch. If the height measurement number is X.1 to X.4 inches, round down to the nearest whole inch).
    - For example, a height of 62.5 inches would be rounded to 63 inches, and a

height of 62.4 inches would be rounded to 62 inches.

Steps for Assessment for K0100B, Weight:

1. Base weight on the most recent measure in the last 30 days.
2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment.
4. If the last recorded weight was taken more than 30 days before the ARD of this assessment or the previous weight is not available, weigh the resident again.
5. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding Instructions for K0100B, Weight:

- Use mathematical rounding (i.e., If weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound).
    - For example, a weight of 152.5 lbs. would be rounded to 153 lbs., and a weight of 152.4 lbs. would be rounded to 152 lbs.
- If a resident cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

K0200. Weight Loss

K0200. Weight Loss	
Enter number ☐	**Loss of 5% or more in the last month or loss of 10% or more in the LAST 6 MONTHS:** 0. **No or unknown** 1. **Yes -** On a physician-prescribed weight-loss regimen 2. **Yes -** NOT on a physician-prescribed weight-loss regimen

Item Rationale:

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight should be monitored on a continuing basis; weight loss should be assessed, and care should be planned at the time of detection and not delayed until the next MDS assessment.
- Weight loss could be the result of poor or inadequate intake accompanied by recent participation in a fitness program.

Steps for Assessment:

- This item compares the resident's weight in the current observation period with their weight at two snapshots in time:
- At a point closest to 30 days preceding the current weight.
- At a point closest to 180 days preceding the current weight.

For a New Admission:

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is less than the previous weight, calculate the percentage of weight loss.
4. Complete the same process to determine and calculate weight loss, comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments:

1. From the medical record, compare the resident's weight in the current observation period to their weight 30 days ago.
2. If the current weight is less than the weight 30 days ago, calculate the percentage of weight loss.
3. From the medical record, compare the resident's current weight to their weight 180 days ago.

4. If the current weight is less than the weight 180 days ago, calculate the percentage of weight loss.

Coding Instructions:

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- **Code 0:** If the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- **Code 1:** If the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to any physician-ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics.
- **Code 2:** If the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was NOT planned and pursuant to any physician-ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics.

Coding Tips:

- A resident may experience weight variances between the snapshot time periods. Although these require follow-up at the time, they are not captured on the MDS.
- If the resident is losing a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem.
- Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt an assessment of the resident's nutritional status and/or report to the resident's primary care physician, as indicated.
- To code K0200 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.

Examples:

1. Resident J has been on a physician-ordered calorie-restricted diet for the past year. They and their physician agreed to a plan of weight reduction. Their current weight is 169 lbs. Their weight 30 days ago was 172 lbs. Their weight 180 days ago was 192 lbs.
    a. **Coding:** K0200 would be coded 1, yes, on a physician-prescribed weight-loss regimen.

b. **Rationale:** The 30-day calculation is 172 x 0.95 (95%) = 163.4. Since the resident's current weight of 169 lbs. is more than 163.4 lbs., which is the 5% point, they have not lost 5% body weight in the last 30 days.

c. **180-day calculation:** 192 x .90 (90%) = 172.8. Since the resident's current weight of 169 lbs. is less than 172.8 lbs., which is the 10% point, they have lost 10% or more of body weight in the last 180 days.

2. Resident S has had an increasing need for assistance with eating over the past 6 months. Their current weight is 195 lbs. Their weight 30 days ago was 197 lbs. Their weight 180 days ago was 185 lbs.

   a. **Coding:** K0200 would be coded 0, No.

   b. **Rationale:** 30-day calculation: 197 x 0.95 = 187.15. Because the resident's current weight of 195 lbs. is more than 187.15 lbs., which is the 5% point, they have not lost 5% body weight in the last 30 days.

   c. **180-day calculation:** Resident S's current weight of 195 lbs. is greater than their weight 180 days ago, so there is no need to calculate their weight loss. They have gained weight over this time period.

K0300. Weight Gain

K0300. Weight Gain	
Enter number ☐	**Gain of 5% or more in the last month or gain of 10% or more in the LAST 6 MONTHS:** 0. **No or unknown** 1. **Yes -** On a physician-prescribed weight-gain regimen 2. **Yes -** NOT on a physician-prescribed weight-gain regimen

Item Rationale:

- Weight gain can result in debility and adversely affect health, safety, and quality of life.
- Weight gain may be an important indicator of a change in the resident's health status or environment.
- If significant weight gain is noted, the interdisciplinary team should review possible causes, such as changed intake, caloric need, medication (e.g., steroidal), or fluid volume status.
- Weight should be monitored on a continuing basis, weight gain should be assessed, and care should be planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment:

1. This item compares the resident's weight in the current observation period with their weight at two snapshots in time:
    a. At a point closest to 30 days preceding the current weight.
    b. At a point closest to 180 days preceding the current weight.
2. This item does not consider weight fluctuation outside of these two time points. However, the resident's weight should be monitored on a continual basis, and weight gain should be assessed and addressed in the care plan as necessary.

For a New Admission:

1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.
4. Complete the same process to determine and calculate weight gain, comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments:

1. From the medical record, compare the resident's weight in the current observation period to their weight 30 days ago.
2. If the current weight is more than the weight 30 days ago, calculate the percentage of weight gain.
3. From the medical record, compare the resident's weight in the current observation period to their weight 180 days ago.
4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.

Coding Instructions:

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- **Code 0:** If the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days.

- **Code 1:** If the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician-ordered diet plan, K0300 can be coded as 1.
- **Code 2:** If the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips:

- A resident may experience weight variances in between the snapshot time periods. Although these require follow-up at the time, they are not captured on the MDS.
- If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0300 as 1, yes, the expressed goal of the weight gain diet must be documented.

K0400. Nutritional Problems or Approaches

K0400. Nutritional Problems or Approaches	
Check all that apply:	
☐	A. **Leaves 50% of food uneaten at most meals**
☐	B. **Noncompliance with diet**
☐	C. **Feeding tube** *(e.g., nasogastric or abdominal (PEG))*
☐	D. **Mechanically altered diet -** Requires a change in the texture of food or liquids *(e.g., pureed food, thickened liquids)*
☐	E. **Therapeutic diet** *(e.g., low salt, diabetic, low cholesterol)*
☐	Z. **None of the above**

Item Rationale:

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

Steps for Assessment:

1. Review the medical record to determine if any of the listed nutritional approaches were performed during the look-back period.
2. If none apply, check K0400Z, None of the above.

Coding Instructions:

Check all that apply:

- **Code A:** If the resident leaves 50% of food uneaten at most meals.
- **Code B:** If the resident is noncompliant with diet.
- **Code C:** If the resident uses a feeding tube to receive nutrition – nasogastric or abdominal (PEG).
- **Code D:** If the resident receives a mechanically altered diet – requires a change in the texture of food or liquids (e.g., pureed food, thickened liquids).
- **Code E:** If the resident requires a therapeutic diet (e.g., low salt, diabetic, low cholesterol).
- **Code Z:** If none of the above applies to the resident.

Coding Tips for K0400A:

- K0400A is used when the resident eats less than 50 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day.

Coding Tips for K0400B:

- K0400B is used when a resident does not comply with specific diet orders.

Coding Tip for K0400C:

- K0400 C codes only feeding tubes used to deliver nutritional substances and/or hydration during the assessment period.

Coding Tips for K0400D:

- Assessors should not capture a trial of a mechanically altered diet (e.g., pureed food, thickened liquids) during the observation period in K0400D.

Coding Tips for K0400E:

- Therapeutic diets are not defined by the content of what is provided or when it is served but by why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition that is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration. Food elimination diets related to food allergies (e.g., peanut allergy, seafood, tree nuts, etc.) can be coded as a therapeutic diet. Food allergies and therapeutic diets must be addressed on the service/care plan to ensure staff are notified.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status does not constitute a therapeutic diet but may be part of one. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0400E, Therapeutic Diet, when they are being administered *and ordered* as part of a therapeutic diet to manage problematic health conditions (e.g., supplement for protein-calorie malnutrition).

K0500. Swallowing Disorder

K0500. Swallowing Disorder	
Signs and symptoms of possible swallowing disorder Check all that apply:	
☐	A. **Loss of liquids/solids from mouth when eating or drinking**
☐	B. **Holding food in mouth/cheeks or residual food in mouth after meals**
☐	C. **Coughing or choking during meals or when swallowing medications**
☐	D. **Complaints of difficulty or pain with swallowing**
☐	Z. **None of the above**

Item Rationale

- The ability to swallow safely can be affected by many disease processes and functional decline.
- Alterations in the ability to swallow can result in choking and aspiration, which can increase the resident's risk for malnutrition, dehydration, and aspiration pneumonia.
- Service or care planning should include provisions for monitoring the resident during mealtimes and functions/activities that involve food and liquid consumption. Monitoring or oversight of the dining room is not the same as monitoring the resident.
- When necessary, the resident should be evaluated by the physician, speech-language

pathologist, and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids. These services could be provided on an outpatient basis or by a home health agency.

- Assess for signs and symptoms that suggest a swallowing disorder that has not been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.
- A care plan should be developed to assist the resident in maintaining safe and effective swallowing by using compensatory techniques, altering diet consistency, and positioning during and following meals.

Coding Instructions:

Check all that apply.

- **Code A:** If the resident has food or liquid in their mouth, the food or liquid dribbles down the chin or falls out of the mouth.
- **Code B:** If the resident holds food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food is left in the mouth because the resident failed to completely empty their mouth.
- **Code C:** If the resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."
- **Code D:** If the resident refuses food because it is painful or difficult to swallow.
- **Code Z:** If none of the K0500A through K0500D signs or symptoms were present during the look-back period.

Coding Tips:

- Do not code a swallowing problem if interventions have been successful in treating it and, therefore, the signs/symptoms of the problem (K0500A through K0500D) did not occur during the 7-day look-back period.
- Code even if the symptom occurred only once in the 7-day look-back period.

3.14: Section L: Oral/Dental Status

Intent: This item is intended to record any dental problems present in the 7-day look-back period.

L0100. Dental

L0100. Dental	
Check all that apply:	
☐	A. **Has well-fitting dentures or removable bridge**
☐	B. **Broken or loosely fitting full or partial denture** *(chipped, cracked, uncleanable, or loose)*
☐	C. **No natural teeth or tooth fragment(s)** *(edentulous)*
☐	D. **Abnormal mouth tissue** *(ulcers, masses, oral lesions, including under denture or partial if one is worn)*
☐	E. **Obvious or likely cavity or broken natural teeth**
☐	F. **Inflamed or bleeding gums or loose natural teeth**
☐	G. **Mouth or facial pain, discomfort, or difficulty chewing**
☐	H. **Unable to examine**
☐	Z. **None of the above**

Item Rationale:

- Poor oral health has a negative impact on:
  - quality of life
  - overall health
  - nutritional status
- Assessment can identify periodontal disease that contributes to or causes systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor diabetes control.
- Assessing dental status can help identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes.

Coding Instructions:

- **Check A:** If the resident wears dentures or has a removable bridge.
- **Check B:** If the denture or partial is chipped, cracked, uncleanable, or loose, it is coded as loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens their mouth, or the denture moves when the resident tries to talk.
- **Check C:** If the resident is edentulous, he or she lacks all-natural teeth or parts of teeth.
- **Check D:** Select if any ulcer, mass, or oral lesion is noted on any oral surface.
- **Check E:** If any cavity or broken tooth is seen.

- **Check F:** If the gums appear irritated, red, swollen, or bleeding, they are coded as loose. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- **Check G:** If the resident reports any pain in the mouth or face or discomfort with chewing.
- **Check H:** If the resident's mouth cannot be examined.
- **Check Z:** If none of the conditions A through F are present.

Coding Tips:

- Mouth or facial pain coded for this item should also be coded in Section J, items J0500 through J0600, in any items in which the coding requirements of Section J are met.
- The dental status for a resident who has some, but not all, of their natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above.
- Many residents have dentures or partials that fit well and work properly. However, for service or care planning purposes, consideration should be taken for these residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication passes, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and assuring that they continue to fit properly throughout the resident's stay.

3.15. Section M: Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section notes other skin ulcers, wounds, or lesions and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize all areas at risk of constant pressure. A complete skin check is essential to an effective pressure ulcer prevention and skin treatment program. It is imperative to determine the cause of all wounds and lesions, as this will define and direct the proper treatment and management of the wound.

An array of terms are used to describe skin integrity alterations related to pressure. These terms include pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use documentation that may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure and documentation accurately reflects the status of the wound at the time of the documentation. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

M0100. Unhealed Pressure Ulcers/Injuries

M0100. Unhealed Pressure Ulcers/Injuries	
Enter code ☐	**Does this resident have one or more unhealed pressure ulcers/injuries?** 0. **No** → Skip to M0300, Number of Venous and Arterial Ulcers 1. **Yes**

Item Rationale:

- Pressure ulcers/injuries and other wounds or lesions affect the quality of life for residents because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- The definitions of pressure ulcer/injury used in the MDS-AH Manual have been adapted from those recommended by the National Pressure Injury Advisory Panel (NPIAP) 2016 Pressure Injury Staging System (www.NPIAP.com).
- An existing pressure ulcer/injury identifies residents at risk for further complications or skin injury. Identify all areas at risk for skin breakdown related to pressure.
- For MDS assessment, the initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or deep tissue injury (DTI), should be

coded in terms of what is assessed (seen or palpated, i.e., visible tissue, palpable bone) during the seven-day look-back period. Facilities may adopt the NPIAP guidelines in their clinical practice and documentation. The definitions in this manual do not perfectly correlate with each stage as described by NPIAP, and you must code the MDS-AH according to the instructions in this manual.

- Pressure ulcer/injury staging is a system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.
- The comprehensive service/care plan should be reevaluated and updated with each MDS assessment and as needed to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

Coding Instructions:

Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days.

- **Code 0:** If the resident did not have a pressure ulcer/injury in the 7-day look-back period, skip to M0400, Number of Venous and Arterial Ulcers.
- **Code 1:** If the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.

Coding Tips:

Note: The MDS Coordinator may coordinate with the facility's RN consultant, a home health agency RN, or a physician for assessment to obtain the necessary information to code the resident's MDS assessment. The MDS Coordinator would code pressure ulcer/injury based on the presence of documentation in the clinical record by a registered nurse or physician.

- Observe the resident and report any wounds to an RN or MD to determine if further clinical evaluation is required.
- If an ulcer/injury arises from a combination of factors primarily caused by pressure, the area should be included in this section as a pressure ulcer/injury.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for

example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here. Mucosal ulcers caused by pressure should not be coded in Section M. Oral mucosal ulcers are captured in item L0100D, Abnormal mouth tissue.

- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary cause should be considered when coding whether a resident with DM has an ulcer/injury caused by pressure or other factors.
    - If a resident with DM has a heel ulcer/injury from pressure and it is present during the 7-day look-back period, code 1 and proceed to code items in M0300 as appropriate for the pressure ulcer/injury.
    - If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals (toes) and the ulcer is present in the 7-day look-back period, code 0 and proceed to M0400 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location. This should also be confirmed by the resident's primary care physician (PCP)
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab comprises dried blood cells and serum on the top of the skin and forms overexposed wounds, such as wounds with granulating surfaces (like pressure ulcers, lacerations, avulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2; therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues make it easy to distinguish from a scab. It is extremely important to have staff trained in wound assessment and can distinguish scabs from eschar.
- If two pressure ulcers/injuries occur on the same bony prominence and are separated superficially by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.
- Do not code a pressure ulcer or injury on the assessment if the pressure ulcer/injury healed during the look-back period of the current assessment.

- Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

M0200. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0200. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Record the number of pressure ulcers:	
Enter number ☐	A. **Stage 1 -** Intact skin with non-blanchable redness of a localized area, usually over a bony prominence *(darkly pigmented skin may not have visible blanching; in dark skin tones only, it may appear with blue or purple hues)*
Enter number ☐	B. **Stage 2 -** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough *(may also present as an intact or open/ruptured blister)*
Enter number ☐	C. **Stage 3 -** Full-thickness tissue loss *(subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. This may include undermining and tunneling)*
Enter number ☐	D. **Stage 4 -** Full-thickness tissue loss with exposed bone, tendon, or muscle *(slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling)*
Enter number ☐	E. **Unstageable – Due to non-removable dressing/device**: Not stageable due to non-removable dressing/device.
Enter number ☐	F. **Unstageable – Due to slough and/or eschar**: Not stageable due to coverage of wound bed by slough and/or eschar
Enter number ☐	G. **Unstageable -** Deep tissue injury

Item Rationale:

- Pressure ulcers affect the quality of life for residents because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Stage 1 pressure injuries may deteriorate to more severe pressure ulcers/injuries without adequate intervention; as such, they are an important risk factor for further tissue damage.
- Stage 2 pressure ulcers may worsen without proper interventions.
- Development of a Stage 1 pressure injury should be one of multiple factors that initiate pressure ulcer/injury prevention interventions.
- Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should include interventions to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher-stage pressure ulcers.
- The care plan should include individualized interventions and evidence that the interventions have been utilized, monitored, and modified appropriately.

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff-intensive.
- If a pressure ulcer fails to show evidence of healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

Coding Instructions for M0200A:

- **Enter the number** of Stage 1 pressure injuries that are currently present.
- **Enter 0** if no Stage 1 pressure injuries are currently present.

Coding Instructions for M0200B:

- **Enter the number** of Stage 2 pressure ulcers first noted during the seven-day look-back period.
- **Enter 0** if no Stage 2 pressure ulcers were noted during the seven-day look-back period.

Coding Tips M0200B:

- Stage 2 pressure ulcers, by definition, have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.
- Do not code skin tears, tape burns, moisture-associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. If a deep tissue injury is determined, do not code it as Stage 2.

Coding Instructions for M0200C:

- **Enter the number** of these Stage 3 pressure ulcers noted at Stage 3 during the seven-day look-back period.
- **Enter 0** if no Stage 3 pressure ulcers were noted during the seven-day look-back period.

Coding Tips M0200C:

- The depth of a Stage 3 pressure ulcer varies by anatomical location. They can be shallow, particularly in areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput (the back of the head or skull), and malleolus (ankle).
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Coding Instructions for M0200D:

- **Enter the number** of these Stage 4 pressure ulcers noted at Stage 4 during the seven-day look-back period.
- **Enter 0** if no Stage 4 pressure ulcers were noted during the seven-day look-back period.

Coding Tips for M0200D:

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput (the back of the head), and malleolus (ankle) do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule), making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers with exposed cartilage should be classified as Stage 4.

Coding Instructions for M0200E:

- **Enter the number** of unstageable pressure ulcers/injuries related to a non-removable dressing/device noted during the seven-day look-back period.
- **Enter 0** if no unstageable pressure ulcers/injuries related to non-removable dressing/device were noted at the time of admission/entry or reentry.

Coding Instructions for M0200F:

- **Enter the number** of unstageable pressure ulcers related to slough and/or eschar noted during the seven-day look-back period.
- **Enter 0** if no unstageable pressure ulcers related to slough and/or eschar were noted during the seven-day look-back period.

Coding Tips for M0200F:

- Pressure ulcers covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover." It should only be removed after careful

clinical consideration, including ruling out ischemia and consultation with the resident's physician, nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all sloughs and/or eschar tissue to reclassify the stage.

Coding Instructions for M0200G:

- **Enter the number** of these unstageable pressure injuries related to deep tissue injury noted during the seven-day look-back period.
- **Enter 0** if no unstageable pressure injuries related to deep tissue injury were noted during the seven-day look-back period.

Coding Tips for M0200G:

- Once a deep tissue injury has opened to an ulcer, reclassify it into the appropriate stage and code it for the reclassified stage.

M0300. Number of Venous and Arterial Ulcers

M0300. Number of Venous and Arterial Ulcers	
Enter number ☐	**Enter the total number of venous or arterial ulcers present** (*enter "0" if none are present*)

Item Rationale:

- Skin wounds and lesions affect residents' quality of life because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- The presence of venous and arterial ulcers should be accounted for in the service/care plan. Venous and arterial ulcers result from impaired circulation in veins or arteries.
- This information identifies residents at risk for further complications or skin injury.

Definitions:

- **Arterial Ulcers:** Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence but can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer; however, for some residents, pressure may play a part.

Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent. These determinations would require assessment by an RN or physician.

- **Venous Ulcers:** The wound may start with some minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Steps for Assessment:

1. Review the medical record, including skin tracking forms.
2. Speak with direct care staff to confirm conclusions from the medical record review.
3. Observe the resident and report any wounds to an RN or MD to determine if further clinical evaluation is required.

   The MDS Coordinator may coordinate with the facility's RN consultant, a home health agency RN, or a physician for assessment to obtain the necessary information to code the resident's MDS assessment. The MDS Coordinator would code venous/arterial ulcers based on the presence of documentation in the clinical record by a registered nurse or physician.
4. Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area). Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
5. Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. Due to hemosiderin staining, the surrounding tissues may be erythematous or reddened or appear brown-tinged. Leg edema may also be present.
6. Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.
7. There must be a physician-documented diagnosis of venous or arterial vascular disease and the specific type of ulcer.

Coding Instructions:

- **Enter the number** of venous and arterial ulcers present.

- **Enter 0** if there were no venous or arterial ulcers present.

Coding Tips:

- Pressure ulcers, diabetic ulcers, and other skin conditions should not be coded here.

M0400. Other Ulcers, Wounds and Skin Problems

M0400. Other Ulcers, Wounds and Skin Problems	
Foot Problems - Check all that apply:	
☐	A. **Infection of the foot** *(e.g., cellulitis, purulent drainage)*
☐	B. **Diabetic foot ulcer(s)**
☐	C. **Other open lesion(s) on the foot**
Other Skin Problems - Check all that apply:	
☐	D. **Open lesion(s) other than ulcers, rashes, or cuts** (*e.g., cancer lesion*)
☐	E. **Surgical wound(s)**
☐	F. **Burn(s)** *(second or third degree)*
☐	G. **Skin tear(s)**
☐	H. **Moisture Associated Skin Damage** *(MASD)* (*e.g., incontinence-associated dermatitis [IAD], perspiration, drainage*)
None of the Above:	
☐	Z. **None of the above**

Item Rationale:

- Skin wounds and lesions affect residents' quality of life because they may limit activity, be painful, and require time-consuming treatments and dressing changes.
- Many ulcers, wounds, and skin problems can worsen or increase the risk of local and systemic infections.
- This list represents only a subset of skin conditions or changes that facilities may monitor and evaluate in residents. There may be some skin conditions that cannot be coded on the MDS-AH.
- The presence of wounds and skin changes should be accounted for in the service/care plan.
- This information identifies residents who may be at risk for further complications or skin injury.

Steps for Assessment:

1. Review the medical record, including skin tracking forms.
2. Speak with direct care staff and staff providing wound treatment to confirm conclusions from the medical record review.

3. Observe the resident and report any wounds to an RN or MD to determine if further clinical evaluation is required. Key areas for diabetic foot ulcers include the foot's plantar (bottom) surface, especially the metatarsal heads (the ball of the foot).

Coding Instructions:

Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.

- **Code A:** If the resident has an infection of the foot (e.g., cellulitis, purulent drainage).
- **Code B:** If the resident has diabetic foot ulcer(s).
- **Code C:** If the resident has other open lesion(s) on foot (e.g., cuts, fissures).
- **Code D:** If the resident has open lesion(s) other than ulcers, rashes, or cuts (e.g., bullous pemphigoid).
- **Code E:** If the resident has surgical wound(s).
- **Code F:** If the resident has burn(s)(second or third degree).
- **Code G:** If the resident has skin tear(s).
- **Code H:** If the resident has Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis (IAD), perspiration, drainage).
- **Code Z:** None of the above applied to the resident.

Coding Tips:

- Pressure ulcers should not be coded here.

M0400B Diabetic Foot Ulcers:

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for a foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on the other foot.

- Do not include pressure ulcers/injuries that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M0400D Open Lesion(s) Other than Ulcers, Rashes, Cuts:

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do **not** code rashes, abrasions, or cuts/lacerations here. Although not recorded on the MDS-AH assessment, the service/care plan should consider these skin conditions.
- Do **not** code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

M0400E Surgical Wounds:

- This category does not include healed surgical sites and stomas or lacerations requiring suturing or butterfly closure as surgical wounds. PICC, central line, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item. Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer but a surgical wound.

M0400F Burns (Second or Third Degree):

- Do not include first-degree burns (changes in skin color only).

M0400G Skin Tear(s):

- Skin tears result from shearing, friction, or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item.
- Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, the service/care plan should consider these skin conditions.

M0400H Moisture Associated Skin Damage (MASD):

- MASD, or maceration, includes incontinence-associated dermatitis, intertriginous dermatitis, peri-wound moisture-associated dermatitis, and peristomal moisture-associated dermatitis.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Providing optimal skincare and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and has irregular edges. Inflammation of the skin may also be present.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable, diffuse, and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.
- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0100.

Examples:

1. Resident J was reaching over to get a magazine off of their bedside table and sustained a skin tear on their wrist from the edge of the table when they pulled the magazine back towards them.

   Coding: Check M0400G, Skin Tear(s).

   Rationale: The resident sustained a skin tear while reaching for a magazine.

2. Resident S, who is incontinent, is noted to have a large, red, and excoriated area on their buttocks and interior thighs with serous drainage, which is starting to cause skin glistening.

   Coding: Check M0400H, Moisture Associated Skin Damage (MASD).

   Rationale: Resident S's skin assessment reveals characteristics of incontinence-associated dermatitis.

3. Resident F complained of discomfort in their right great toe, and when their stocking and shoe were removed, it was noted that their toe was red, inflamed, and had pus draining from the edge of their nail bed. The podiatrist determined that Resident F had an infected ingrown toenail.

   Coding: Check M0400A, Infection of the foot.

Rationale: Resident F has an infected right great toe due to an ingrown toenail.

M0500. Skin and Ulcer/Injury Treatments

M0500. Skin and Ulcer/Injury Treatments	
Check all that apply:	
☐	A. **Pressure-reducing device for chair**
☐	B. **Pressure-reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention to manage skin problems**
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings other than to feet** *(with or without topical medications)*
☐	H. **Applications of ointments/medications other than to feet**
☐	I. **Application of dressings to feet** *(with or without topical medications)*
☐	Z. **None of the above**

Item Rationale:

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.
- These general skin treatments include basic pressure ulcer/injury prevention and skin health interventions that provide quality care and are consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific service/care plan interventions.
- If skin changes are not improving or worsening, the care/interventions should be reviewed and changed as needed.

Steps for Assessment:

1. Review the medical record, including treatment records, health care provider notes, and orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents. So, check the nursing facility's policies and procedures and indicate if these treatments were administered during the look-back period.
2. Speak with direct care and treatment staff to confirm conclusions from the medical record review.
3. There must be documentation to support all treatments, such as the use of pressure relief devices, i.e., documentation on treatment records or medication records.

Coding Instructions:

Check all that apply in the last 7 days. Check Z: None of the above were provided if none applied in the past 7 days.

- **Code A:** If the resident uses a pressure-reducing device for the chair. Pressure-reducing device(s)is equipment that aims to relieve pressure away from areas of high risk, including foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Pressure-relieving, pressure-reducing, and pressure-redistributing devices are available for use with beds and seating.
- **Code B:** If the resident uses a pressure-reducing device for bed.
- **Code C:** If the resident uses a turning/repositioning program. A turning/ repositioning program includes a consistent program for changing the resident's position and realigning the body. A "Program" is defined as a specific approach organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.
- **Code D:** If the resident receives nutrition or hydration intervention to manage skin problems. Nutrition or hydration intervention to manage skin problems is defined as dietary measures the resident receives to prevent or treat specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high-calorie diet with added supplementation to prevent skin breakdown, and high-protein supplementation for wound healing.
- **Code E:** If the resident receives pressure ulcer/injury care.
- **Code F:** If the resident receives surgical wound care.
- **Code G:** If the resident applies non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids.
- **Code H:** If the resident applies ointments/medications other than to feet.
- **Code I:** If the resident applies dressings to feet (with or without topical medications).
- **Code Z:** None of the above were provided to the resident.

Coding Tips:

M0500A/M0500B Pressure Reducing Devices:

- Pressure-reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer/injury. The appropriate pressure-reducing device should be selected based on the resident's individualized needs.

- Do not code egg crate cushions of any type in this category.
- Do not code doughnut cushions or ring devices in chairs.

M0500C Turning/Repositioning Program:

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., repositioning on the side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (according to facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M0500D Nutrition or Hydration Intervention to Manage Skin Problems:

- The determination of whether a resident should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment.
- Vitamin and mineral supplementation should only be employed to manage skin problems, including pressure ulcers/injuries, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment by a physician or dietician.
- If it is determined that nutritional supplementation, that is, adding additional protein, calories, or nutrients, is warranted, the dietician or clinician making that determination should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall.

M0500E Pressure Ulcer/Injury Care:

- Pressure ulcer care includes any intervention for treating pressure ulcers coded in the Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage (M0300A–G).

M0500F Surgical Wound Care:

- Does not code post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer to facilitate healing. Thus, any wound care associated with pressure ulcer debridement would be coded in M0500E Pressure Ulcer Care. A surgical wound would only be

created if the pressure ulcer itself was excised and a flap and/or graft were used to close the pressure ulcer.

- Surgical wound care may include any intervention for treating or protecting any surgical wound. Examples may include topical cleansing, wound irrigation, antimicrobial ointment application, dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M0500G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet:

- Do not code application of non-surgical dressings for pressure ulcers/injuries other than to feet in this item; use M0500E, Pressure ulcer/injury care.
- Dressings do not have to be applied daily to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should code that MDS item.
- This category may include but is not limited to, dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

M0500H Application of Ointments/Medications Other than to Feet:

- Do not code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use M0500E, Pressure ulcer/injury care.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations).
- Ointments/medications may include topical creams, powders, and liquid sealants to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitro paste for chest pain, testosterone cream).

M0500I Application of Dressings to the Feet (with or without Topical Medications):

- Includes interventions to treat any foot wound or ulcer other than a pressure ulcer/injury.
- Do not code application of dressings to pressure ulcers/injuries on the foot; use M0500E, Pressure ulcer/injury care.
- Do not code the application of dressings to the ankle. The ankle is not considered part of the foot.

3.16. Section N: Medications

Intent: The items in this section intend to record the number of days during the last seven days (or since admission/entry or reentry if less than seven days) that the resident received any injection, insulin, and/or select medications. This section also provides information about new or changed medications within the last 90 days.

N0100. New or Changed Medications

N0100. New or Changed Medications	
Enter code ☐	A. **The resident is currently receiving new medications that were started within the LAST 90 DAYS:** 0. **No** 1. **Yes**
Enter code ☐	B. **The resident received changes to existing medications within the LAST 90 DAYS:** 0. **No** 1. **Yes**

Item Rationale:

- Frequency of medication changes can indicate the stability of a resident's health status and/or complexity of care needs.

Coding Instructions for N0100A:

- **Code 0:** If the resident is not receiving new medications started within the last 90 days.
- **Code 1:** If the resident receives new medications within the last 90 days.

Coding Instructions for N0100B:

- **Code 0:** If the resident did not receive medication, changes started within the last 90 days.
- **Code 1:** If the resident did receive medication changes that were started within the last 90 days.

N0200. Injections

N0200. Injections	
Enter number ☐	**Record the number of days that injection of any type was received** within the **LAST 7 DAYS** or since admission/entry or reentry if less than 7 days.

Item Rationale:

- Frequency of medication administration via injection can indicate stability of a resident's health status and/or complexity of care needs.
- Monitor for adverse effects of injected medications.
- Although antigens and vaccines are not considered medications per se, it is important to track when they are given to monitor for localized or systemic reactions.

Steps for Assessment:

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other healthcare locations where the resident may have received injections while a facility resident (e.g., flu vaccine in a physician's office, in the emergency room – as long as the resident was not admitted).
3. Determine if the resident received any medication via injection. If received, determine the number of days during the look-back period they were received.

Coding Instructions:

- Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any medication, antigen, vaccine, etc., by injection.
- Insulin injections are counted in this item and Item N0300.
- Count the number of days the resident received any injection while a facility resident.
- In Item N0200, record the number of days that any injection (e.g., subcutaneous, intramuscular, or intradermal) was received.

Coding Tips and Special Populations:

- For subcutaneous pumps, code only the number of days the resident required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on one day, and another vaccine is provided on the next day, the number of days the resident received injections would be coded as 2 days.
- If two injections were administered on the same day, the number of days the resident received injections would be coded as 1 day.

Examples:

1. During the **7**-day look-back period, Resident T received an influenza shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B12 injection on Wednesday.
    a. **Coding:** N0200 would be coded 3.
    b. **Rationale:** The resident received injections on 3 separate days during the **7**-day look-back period.

2. During the **7**-day look-back period, Resident C received an influenza shot and a vitamin B12 injection on Thursday.
    a. **Coding:** N0200 would be coded 1.
    b. **Rationale:** The resident received injections on one day during the **7**-day look-back period.

N0300. Insulin

N0300. Insulin	
Enter number ☐	A. **Insulin injections -** Record the number of days that insulin injections were received within the **LAST 7 DAYS** or since admission/entry or reentry if less than 7 days.
Enter number ☐	B. **Orders for insulin -** Record the number of days the physician *(or authorized assistant or practitioner)* changed the resident's insulin orders within the **LAST 7 DAYS** or since admission/entry or reentry if less than 7 days.

Item Rationale:

- Insulin is a medication used to treat diabetes mellitus (DM).
- Individualized meal plans should be created with the residents' input to ensure appropriate meal intake. Residents who have input on food choices are more likely to comply with their DM diet.
- Orders for insulin may change depending on the resident's condition (e.g., fever or other illness) and/or laboratory results.
- Ensure that dosage and time of injections, including meals, activity, etc., are considered based on an individualized resident assessment.
- Monitor for adverse effects of insulin injections (e.g., hypoglycemia).
- Monitor HbA1c, blood glucose levels, and fingerstick blood sugars, as ordered by the physician, to ensure appropriate amounts of insulin are administered.

Steps for Assessment:

1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Determine if the resident received insulin injections during the look-back period.
3. Determine if the physician (nurse practitioner, physician assistant, or clinical nurse specialist, if allowable under state licensure laws) changed the resident's insulin orders during the look-back period.
4. Count the number of days insulin injections were received and/or insulin orders changed.

Coding Instructions for N0300A

- Enter in Item N0300A: The number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

Coding Instructions for N0300B

- Enter in Item N0300B: The number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders.

Coding Tips and Special Populations

- For sliding-scale orders: A sliding-scale dosage schedule that is written to cover different dosages depending on fingerstick blood sugars does not count as an order change simply because a different dose is administered based on the sliding-scale guidelines.
- If the sliding scale order is new, discontinued, or the first sliding scale order for the resident, these days can be counted and coded.
- For subcutaneous insulin pumps, code only the number of days the resident required a subcutaneous injection to restart the pump.

N0400. High-Risk Drug Classes: Use

N0400. High-Risk Drug Classes: Use	
Check all that apply:	
☐	A. **Antipsychotic**
☐	B. **Antianxiety**
☐	C. **Antidepressant**
☐	D. **Hypnotic**
☐	E. **Antibiotic**
☐	F. **Diuretic**
☐	G. **Opioid**
☐	H. **Anticoagulant or antiplatelet**
☐	I. **Medications used to treat Diabetes** *(including insulin)*
☐	J. **Dementia medications**
☐	K. **Anticonvulsant**
☐	Z. **None of the above**

Item Rationale:

- Medications are an important part of the care provided to residents. They are administered to achieve various outcomes, such as curing an illness, treating a disease or

condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.

- Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
- While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.
- Staff who administer medications should be informed about the possible adverse effects of these medications.
- Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

Definitions:

- **Indication:** The identified, documented clinical reason for administering a medication based on a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.
- **Dose:** The total amount/strength/ concentration of a medication given at one time or over a period. The individual dose is the amount/strength/ concentration received at each administration. The amount received over a 24-hour may be called the "daily dose."
- **Monitoring:** The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or the treatments and support decisions about adding, modifying, continuing, or discontinuing any interventions.
- **Sleep hygiene:** Practices, habits, and environmental factors that promote and/or improve sleep patterns.
- **Medication interaction:** The impact of medication or other substances (such as nutritional supplements, including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution,

metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Steps for Assessment:

1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other healthcare settings where the resident may have received any of these medications while a facility resident (e.g., medications or antibiotics given in the emergency room).

Coding Instructions:

Code all high-risk drug-class medications according to their pharmacological classification, not how they are being used. (Check with the pharmacist or a current drug book to determine a drug's classification.

Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).

- **Code A:** If the resident took antipsychotic medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code B:** If the resident took an anxiolytic medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code C:** If the resident took antidepressant medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code D:** If the resident took hypnotic medication to assist with sleep at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code E:** If the resident took an anticoagulant or antiplatelet medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code F:** If the resident took an antibiotic medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code G:** If the resident took diuretic medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

- **Code H:** If the resident took an opioid medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- **Code I:** If the resident took hypoglycemic medication at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
- **Code J:** If the resident took medication to treat dementia or memory at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). This does not include medications administered to treat *behaviors* related to dementia.
- **Code K:** If the resident took anticonvulsants (used to treat seizure disorder and some other conditions) at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
- **Code Z:** If the resident took none of the medications above at any time during the observation period (or since admission/entry or reentry if less than 7 days).

Coding Tips and Special Populations:

- Code medications in Item N0400 according to their therapeutic category and/or pharmacological classification, not how they are used. For example, although oxazepam may be prescribed for use as a hypnotic for sleep, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.
- Include any of these medications given to the resident by any route in any setting (e.g., in a hospital emergency room) while the resident is a resident of the nursing home.
- Code a medication even if it was given only once during the look-back period.
- Count long-acting medications, such as fluphenazine decanoate (Prolixin or Modecate) or haloperidol decanoate (Haldol), that are given every few weeks or monthly only if they are given during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Transdermal patches are generally worn for and release medication over several days. To code N0400, only capture the medication if the transdermal patch was applied to the resident's skin during the observation period. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0400H Opioid would be checked because the application occurred during the look-back period.

- Medications with more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.
- In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or the medication package insert available through the facility's pharmacy or the manufacturer's website. If necessary, request input from the consulting pharmacist.
- Herbal and alternative medicine products are dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., not reviewed for safety and effectiveness like medications), and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root). Remember that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and monitor their potential effects as they can interact with the medications the resident takes. For more information, consult the FDA website at
    - http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/
- Opioid medications can be an effective intervention in a resident's pain management plan but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted before initiation of opioid medication, and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.
- Residents who are on antidepressants should be closely monitored for worsening depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.

- When residents have difficulty sleeping, staff administering medications should explore non-pharmacological interventions (e.g., sleep hygiene approaches that individualize the sleep and wake times to accommodate the person's wishes and customary routine) to improve sleep before initiating pharmacologic interventions.
- Many psychoactive medications (may include antipsychotics, antidepressants, antianxiety, opioids, and/or hypnotics) increase confusion, sedation, and falls. For those residents who are already at risk for these conditions, staff should develop plans of care that address these risks.
- Psychoactive medication doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident's function, well-being, safety, and quality of life.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances and duration of use. Certain anticoagulants require monitoring via laboratory results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]). Multiple medication interactions exist with the use of anticoagulants, which may significantly increase PT/INR results to levels associated with life-threatening bleeding, decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.

Example:

1. The Medication Administration Record for Resident P reflects the following during the 7-day observation period: Risperidone 0.5 mg PO BID PRN: It was received once a day on Monday, Wednesday, and Thursday for bipolar disorder. Lorazepam 1 mg PO QAM: Received every day for bipolar disorder. Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.
    a. **Coding:** Medications in N0400 would be coded as follows:
        i. **N0400A, Antipsychotic:** Risperidone is an antipsychotic medication, and an indication of use for bipolar disorder was noted.

ii. **N0400B, Antianxiety:** Lorazepam is an antianxiety medication, and an indication of use for bipolar disorder was noted.

iii. **N0400D, Hypnotic:** Temazepam is a hypnotic medication.

N0500. Self-Administered Medications

N0500. Self-Administered Medications	
Did the resident self-administer any of the following in the LAST 7 DAYS? Check all that apply:	
☐	A. **Oxygen**
☐	B. **Inhaler**
☐	C. **Over-the-counter medications of any type**
☐	D. **Other** *(specify)* _____
☐	Z. **None of the above**

Item Rationale:

- To record whether the resident self-administered any of the following medications in the last 7 days: insulin, oxygen, inhalers, or over-the-counter meds. Please specify if there were any other self-administered medications.
- Over-the-counter medications do not require a prescription to obtain but do require a physician's order to be administered in a facility.
- There is a possibility of interaction between over-the-counter medications and prescription medications.

Coding Instructions:

- Check all applicable responses. If the resident does not self-administer any medications, check Z, none of the above.

N0600. Medication Preparation Administration

N0600. Medication Preparation Administration	
Enter code ☐	**Did the resident prepare and administer their own medication in the LAST 7 DAYS?** 0. **No** 1. **Yes**

Item Rationale:

- To record whether the resident prepared and administered any of his/her medications in the last 7 days.
- For insulin, that would include prefilling the syringe and administering the insulin.

Coding Instructions

- **Code 0:** If the resident did not prepare and administer their medication during the lookback period.
- **Code 1:** If the resident prepared and administered their medication during the lookback period.

N0610 Medication Preparation and Administration – as Performed by the Resident

N0610. Medication Preparation and Administration – *as Performed by the Resident*	
Code one response that applies to the LAST 7 DAYS:	
Enter code ☐	0. Resident had no prescribed medications**.** 1. Resident prepared and administrated NONE of their own medications 2. Resident prepared and administrated SOME of their own medications. 3. Resident prepared and administrated ALL of their own medications

Item rationale:

- To record whether the resident prepared and administered any of his/her medications in the last 7 days.
- Documentation is required in the clinical record, monthly summary, or medication administration record to support the coding.

Coding Instructions:

- **Code 0:** If resident takes no medications
- **Code 1:** If no medications are prepared and administered by the resident.
- **Code 2:** If some medications are prepared and administered by the resident.
- **Code 3:** If all medications are prepared and administered by the resident.

N0700. Antipsychotic Medication Review

N0700. Antipsychotic Medication Review

Enter code ☐

A. **Did the resident receive antipsychotic medications since admission/entry or reentry or the prior assessment, whichever is more recent?**
0. **No** → Skip to N0800, Influenza vaccine
1. **Yes -** Antipsychotics were received on a routine basis only
2. **Yes -** Antipsychotics were received on a PRN basis only
3. **Yes -** Antipsychotics were received on a routine and PRN basis

Enter code ☐

B. **Has a gradual dose reduction** ***(GDR)*** **been attempted?**
0. **No** → Skip to N0800, Influenza vaccine
1. **Yes**

C. **Date of last attempted GDR:**
☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Enter code ☐

D. **Physician documented GDR as clinically contraindicated:**
0. **No**
1. **Yes**

E. **Date physician documented GDR as clinically contraindicated:**
☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Item Rationale:

- The use of unnecessary medications in long-term care settings can have a profound effect on the resident's quality of life.
- Antipsychotic medications are associated with increased risks for adverse outcomes that can affect health, safety, and quality of life.
- In addition to assuring that antipsychotic medications are being utilized to treat the resident's condition, it is also important to assess the need to reduce these medications whenever possible.
- Identify residents receiving antipsychotic medications to ensure that each resident is receiving the lowest possible dose to achieve the desired therapeutic effects.
- Monitor for appropriate clinical indications for continued use.
- Implement a system to ensure gradual dose reductions (GDR) are attempted at recommended intervals unless clinically contraindicated. GDRs are initiated by a physician or physician substitute, and the clinical record must contain documentation if the GDR is clinically contraindicated.

Definition:

- **Gradual dose reduction (GDR):** Stepwise tapering of a dose to determine whether a lower dose can manage symptoms, conditions, or risks or whether the dose or medication can be discontinued.

Steps for Assessment:

1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior assessment, whichever is more recent.
2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted.
3. If a gradual dose reduction was not attempted, review the medical record to determine if physician documentation indicates that the GDR is clinically contraindicated.

Coding Instructions for N0700A:

- **Code 0:** If antipsychotics were not received: Skip N0700B, N0700C, N0700D, and N0700E.
- **Code 1:** If antipsychotics were received on a routine basis only: Continue to N0700B, Has a GDR been attempted?
- **Code 2:** If antipsychotics were received on a PRN basis only: Continue to N0700B, Has a GDR been attempted?
- **Code 3:** If antipsychotics were received on a routine and PRN basis**:** Continue to N0700B, Has a GDR been attempted?

Coding Tips and Special Populations:

- Any medication with a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why it is being used.

Coding Instructions for N0700B:

- **Code 0:** If a GDR has not been attempted. Skip to N0700D, Physician documented GDR as clinically contraindicated.
- **Code 1:** If a GDR has been attempted. Continue to N0700C, Date of last attempted GDR.

Coding Instructions for N0700C:

- Enter the date of the last attempted Gradual Dose Reduction.

Coding Tips and Special Populations (N0700B and N0700C):

- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a Gradual Dose Reduction (GDR) in two separate quarters (with at least one month between the attempts) unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually unless clinically contraindicated.
- In N0700B and N0700C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication if the medication was started after the resident was admitted.
- If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0700B and N0700C.
- Before discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).
- Discontinuation of antipsychotic medication, even without a GDR process, should be coded in N0700B and N0700C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0700C is the first day the resident did not receive the discontinued antipsychotic medication.
- Do not count as a GDR an antipsychotic medication reduction performed to switch the resident from one antipsychotic medication to another.
- The start date of the last attempted GDR should be entered in N0700C, the Date of the last attempted GDR. The GDR start date is the first day the resident receives the reduced dose of the antipsychotic medication.
- In cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0700C.

- If multiple dose reductions have been attempted since admission OR since initiating the antipsychotic medication, record the date of the most recent reduction attempt in N0700C.

Coding Instructions for N0700D:

- **Code 0:** If a GDR has not been documented by a physician as clinically contraindicated. Skip N0700E Date physician documented GDR as clinically contraindicated.
- **Code 1:** If a GDR has been documented by a physician as clinically contraindicated. Continue to N0700E, Date physician documented GDR as clinically contraindicated.

Coding Instructions for N0700E:

- Enter the date the physician documented GDR attempts as clinically contraindicated.

Coding Tips and Special Populations (N0700D and N0700E):

- In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.
- In N0700D and N0700E, include physician documentation that a GDR attempt is clinically contraindicated since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, OR since the resident was started on the antipsychotic medication if the medication was started after the resident was admitted to the facility.
- Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering the medication would not achieve the desired therapeutic effects, and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

Extrapyramidal Side Effects:

- The symptoms can be acute (short-term) or chronic (long-term).
- They include movement dysfunction such as dystonia (continuous spasms and muscle contractions), akathisia (may manifest as motor restlessness), parkinsonism characteristic symptoms such as rigidity, bradykinesia (slowness of movement), tremor, and tardive dyskinesia (irregular, jerky movements).
    - https://en.wikipedia.org/wiki/Extrapyramidal_symptoms

- These signs and symptoms must be reported to a physician immediately as they could be related to psychotropic medication use.

AIMS Testing:

- The Abnormal Involuntary Movement Scale (AIMS) was originally published by the Psychopharmacology Research Branch of the National Institute of Mental Health in 1976.
- It was aimed at recording the occurrence of tardive dyskinesia (TD), detecting TD, and allowing the follow-up on the severity of a patient's TD over time in patients receiving neuroleptic medications.
- The AIMS consists of 12 clinician-rated items. The first 7 items assess the severity of dyskinesias in oro-facial, extremity, and trunk movements. Additional items assess the overall severity, incapacitation, and the patient's level of awareness of the movements and distress associated with them.
- The scale provides a total score (items 1 through 7), or item 8 can be used in isolation as an indication of the overall severity of symptoms.
- The following link includes an auto-calculating version of the 12-item AIMS testing, with printable results and a printable paper copy of the tool.
    - https://www.mdapp.co/abnormal-involuntary-movement-scale-aims-calculator-426/

AIMS Score Calculator:

Steps on how to print your input & results:

1. Fill in the calculator/tool with your values and/or your answer choices, and press Calculate.
2. Click on the Print button to open a PDF with the inputs and results in a separate window. You can save the PDF or print it to save a copy in the resident's clinical record.
3. Please note that once you have closed the PDF, you need to click on the Calculate button before you try opening it again; otherwise, the input and/or results may not appear in the PDF.

Instructions to accompany AIMS:

Before or after completing the Examination Procedure, observe the patient unobtrusively, at rest (e.g., in the waiting room). The chair used in this examination should be a hard, firm one without

arms.

Note: Part of the AIMS assessment includes observation of the patient under specific examination procedures. Because, in some cases, patients may suppress movements while concentrating intensely, the administration of the AIMS should be supplemented by requesting that the patient perform additional tasks during the assessment, where necessary.

1. Ask the patient whether there is anything in his/her mouth (e.g., gum, candy, etc.). and if there is, remove it.
2. Ask the patient about the current condition of his/her teeth. Do teeth bother the patient now?
3. Ask the patient whether he/she notices any movements in the mouth, face, hands, or feet. If yes, ask them to describe to what extent they currently bother the patient or interfere with his/her activities.
4. Have the patient sit in a chair with hands on knees, legs slightly apart, and feet flat on the floor. (Look at the entire body for movements while in this position).
5. Ask the patient to sit with hands hanging unsupported. If male, hang between legs;; if female and wearing a dress, hang over knees. (Observe hands or other body areas.)
6. Ask the patient to open their mouth. (Observe tongue at rest within the mouth). Do this twice.
7. Ask the patient to protrude the tongue. (Observe abnormalities of tongue movement). Do this twice.
8. Ask the patient to tap the thumb with each finger as rapidly as possible for 10 to 15 seconds, first with the right hand and then with the left hand. (Observe facial and leg movements.)
9. Flex and extend the patient's left and right arms (one at a time).
10. Ask the patient to stand up. (Observe in profile. Observe all body areas again, including the hips.)
11. Ask the patient to extend both arms outstretched in front with palms down. (Observe trunk, legs, and mouth).
12. Have the patient walk a few paces, turn, and walk back to the chair. (Observe hands and gait). Do this twice.

N0800. Influenza Vaccine

N0800. Influenza Vaccine	
Enter code ☐	A. **Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?** 0. **No** → Skip to N0800C, Reason influenza vaccine not received 1. **Yes**
	B. **Date of influenza vaccine** → Skip to N0900A, Pneumococcal vaccination ☐☐ - ☐☐ - ☐☐☐☐ M M D D Y Y Y Y

Item Rationale:

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results from pneumonia and subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.
- Influenza vaccines have been proven effective in preventing hospitalizations.
- Like any other medicine, a vaccine could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm or death is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.
    - **Mild problems** include soreness, redness, or swelling where the shot was given; hoarseness, sore, red, or itchy eyes; cough, fever, aches, headache, itching, and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1-2 days.
    - **Severe problems:** Life-threatening allergic reactions to vaccines are very rare. If they do occur, they usually occur within a few minutes to a few hours after the shot.

- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, there would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which vaccination can prevent.
- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine, while people with mild illness can usually get it.
- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.
- The safety of vaccines is always being monitored. For more information, visit the CDC's Vaccine Safety Monitoring and Vaccine Safety Activities.
    - http://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/index.html

Coding Instructions for N0800A:

- **Code 0:** If the resident did not receive the influenza vaccine in this facility during this year's influenza vaccination season. Proceed to N0800C if the influenza vaccine was not received; state the reason.
- **Code 1:** If the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to N0800B, Date influenza vaccine received.

Coding Instructions for N0800B:

- Enter the date that the influenza vaccine was received. Do not leave any boxes blank. If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014, should be entered as 01-17-2014.
- If the day only contains a single digit, fill the first box with "0." For example, October 6, 2013, should be entered as 10-06-2013. A full 8-character date is required.
- A full 8-character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

Coding Instructions for N0800C:

If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

- **Code 1:** If the resident was not in this facility during this year's influenza vaccination season.

- **Code 2:** If the resident received influenza vaccinations administered in any other setting (e.g., physician's office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.
- **Code 3:** If the influenza vaccine is not received due to medical contraindications, the resident is contraindicated from receiving it. Influenza vaccine is contraindicated for residents with severe reactions (e.g., respiratory distress) to a previous dose of influenza vaccine or a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and a history of Guillain-Barré Syndrome within six weeks after the previous influenza vaccination.
- **Code 4:** If the resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.
- **Code 5:** If the resident, responsible party/legal guardian did not offer the influenza vaccine.
- **Code 6:** If the vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
- **Code 9:** If none of the listed reasons, describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

Coding Tips and Special Populations:

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur anytime, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available.
- Access the CDC Seasonal Influenza (Flu) website for information about the current influenza season. This website provides information on influenza activity and has an interactive map showing the geographic spread of influenza.
    - http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm.
- Facilities can also contact their local health department website for local influenza surveillance information.

- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, if a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.
- A "high dose" inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident's primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.

Examples:

1. Resident J received the influenza vaccine in the facility on January 7, 2014, during this year's influenza vaccination season.
    a. **Coding:** N0800A would be coded 1, yes; N0800B would be coded 01-07-2014, and N0800C would be skipped.
    b. **Rationale:** Resident J received the vaccine in the facility on January 7, 2014, during this year's influenza vaccination season.
2. Resident R did not receive the influenza vaccine in the facility during this year's influenza vaccination season due to their known allergy to egg protein.
    a. **Coding:** N0800A would be coded 0, no; N0800B is skipped, and N0800C would be coded 3, not eligible-medical contraindication.
    b. **Rationale:** Allergies to egg protein are a medical contraindication to receiving the influenza vaccine. Therefore, Resident R did not receive the vaccine.
3. Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season. Their doctor provided documentation of receipt of the vaccine to the facility to place in Resident T's medical record. They also provided documentation that Resident T was explained the benefits and risks of the influenza vaccine before administration.
    a. **Coding:** N0800A would be coded 0, no; and N0800C would be coded 2, received outside this facility.
    b. **Rationale:** Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season.
4. Resident K wanted to receive the influenza vaccine if it arrived before their scheduled discharge on October 5th. However, Resident K was discharged before the facility

received its annual shipment of influenza vaccine, so Resident K did not receive the vaccine. Therefore, Resident K was encouraged to receive the influenza vaccine at their next scheduled physician visit.

a. **Coding:** N0800A would be coded 0, no; N0800B is skipped, and N0800C would be coded 9, none of the above.

b. **Rationale:** Resident K was unable to receive the influenza vaccine in the facility because the facility did not receive its shipment of influenza vaccine until after their discharge. None of the codes in N0800C, Influenza vaccine not received, state reason, are applicable.

N0900. Pneumococcal Vaccine

N0900. Pneumococcal Vaccine	
Enter code ☐	A. **Is the resident's pneumococcal vaccination up to date?** 0. **No** → Skip to N1000A, COVID-19 Vaccine 1. **Yes**
Enter code ☐	B. **If the pneumococcal vaccine was not received, state the reason:** 1. **Not eligible** (*medical contraindication)* 2. **Offered and declined** 3. **Not offered**

Item Rationale:

- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates.
- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.
- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Individuals living in long-term care facilities with an increased risk of invasive pneumococcal disease or its complications, i.e., those 65 years of age and older with certain medical conditions, should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include decreased immune function, damaged or absent spleen, sickle cell and other hemoglobinopathies, cerebrospinal fluid (CSF) leak, cochlear implants, and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking.

Coding Instructions N0900A, Is the Resident's Pneumococcal Vaccination Up to Date:

- **Code 0:** If the resident's pneumococcal vaccination status is not current or cannot be determined, proceed to item N0900B. If the Pneumococcal vaccine has not been received, state the reason.
- **Code 1:** If the resident's pneumococcal vaccination status is current.

Coding Instructions N0900B, If Pneumococcal Vaccine Not Received, State Reason:

If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- **Code 1:** If the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine, any vaccine component(s), or a physician order not to immunize.
- **Code 2:** If the resident, responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- **Code 3:** If the resident, responsible party/legal guardian did not offer the pneumococcal vaccine.

Coding Tips:

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/ (search for specific types of vaccines, as desired)
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at:
    - http://www.cdc.gov/vaccines/hcp/acip-recs/index.html
- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, N0900A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

Examples:

1. Resident L, who is 72 years old, received the PCV13 pneumococcal vaccine at their physician's office last year. They had previously been vaccinated with PPSV23 at age 66.
    a. **Coding:** N0900A would be coded 1, yes

b. **Rationale:** Resident L, who is over 65 years old, has received the recommended PCV13 and PPSV23 vaccines.

2. Resident B, who is 95 years old, has never received a pneumococcal vaccine. Their physician has an order stating that they are NOT to be immunized.
    a. **Coding:** N0900A would be coded 0, no; and N0900B would be coded 1, not eligible.
    b. **Rationale:** Resident B has never received the pneumococcal vaccine, so their vaccine is not current. Their physician has written an order for them not to receive one, so they are not eligible for the vaccine.
3. Resident T, who has a long history of smoking cigarettes, received the pneumococcal vaccine at age 62 when they were living in a congregate care community. They are now 64 years old and are being admitted to the facility after receiving chemotherapy and respite care. They have not been offered any additional pneumococcal vaccines.
    a. **Coding:** N0900A would be coded 0, no; and N0900B would be coded 3, Not offered.
    b. **Rationale:** Resident T received 1 dose of the PPSV23 vaccine before 65 years of age because they are a smoker. Because Resident T is now immunocompromised, they should receive PCV13 for this indication. They will also need 1 dose of PPSV23 8 weeks after PCV13 and at least 5 years after their last dose of PPSV23 (i.e., Resident T is eligible to receive PCV13 now and 1 dose of PPSV23 at age 67).

N1000. COVID-19 Vaccine

N1000. COVID-19 Vaccine	
Enter code ☐	A. **Is the resident's COVID-19 vaccination up to date?** 0. **No** 1. **Yes** → Skip to O0100A, Special care: Alcohol/drug treatment
Enter code ☐	B. **If the COVID-19 vaccine was not received, state the reason:** 1. **Not eligible** (*medical contraindication)* 2. **Offered and declined** 3. **Not offered**

Item Rationale:

- This item intends to report if a person is current with their COVID-19 vaccine status.

- Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81 percent of U.S. COVID-19-related deaths.
- Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, or ventilator support for breathing or may even die.
- A strong infection prevention and control program is vital to protect both residents and healthcare personnel.
- It is critical to remain current with all recommended COVID-19 vaccine doses to protect staff and residents from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection.
- COVID-19 vaccines currently approved or authorized by the U.S. Food & Drug Administration effectively reduce the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death.
- Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain an important strategy for preventing illnesses, hospitalizations, and deaths from COVID-19.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems caused by the COVID-19 vaccine are very rare.
- More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the CDC webpage "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States" https://www.cdc.gov/vaccines/covid-19/

Steps for Assessment:

1. Vaccination status may be determined based on information from any available source. Review the resident's medical record or documentation of COVID-19 vaccination and/or interview the resident, family, or other caregivers or healthcare providers to determine whether the resident is up to date with their COVID-19 vaccine.
2. If the resident is not up to date, ask the resident if they would like to receive the COVID-19 vaccine and make appropriate arrangements for the resident to receive the vaccination through their primary care provider.

Coding Instructions:

3. **Code 0:** If the resident does not meet the CDC's up-to-date definition. This includes residents who have not received one or more recommended COVID-19 vaccine doses for any reason, including medical, religious, or other qualified exemptions. This includes residents for whom vaccination status cannot be determined.
4. **Code 1:** If the resident meets the CDC's up-to-date definition. A dash is a valid response, indicating the item was not assessed. The State expects dash use to be a rare occurrence.

Coding Tip:

- Current COVID-19 vaccine recommendations are available on the Centers for Disease Control and Prevention's (CDC's) webpage "Stay Up to Date with COVID-19 Vaccines"
    - https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html

3.17. Section O: Special Treatments, Procedures, and Programs

Intent: The items in this section identify any special treatments, procedures, and programs the resident received or performed during the specified time periods.

Note: Facilities may code treatments, programs, and procedures that the resident performed themselves independently or after being set up by facility staff.

O0100. Special Care

O0100. Special Care	
Has the resident received any of the following in the LAST 14 DAYS? Check all that apply:	
☐	A. **Alcohol/drug treatment**
☐	B. **Chemotherapy**
☐	C. **Radiation**
☐	D. **Oxygen therapy**
☐	E. **BiPAP or CPAP**
☐	F. **IV access**
☐	G. **IV medications**
☐	H. **Transfusions**
☐	I. **Dialysis**
☐	J. **Hospice Care**
☐	K. **Isolation or quarantine for active infectious disease** *(does not include standard body/fluid precautions)*
☐	Z. **None of the above**

Item Rationale:

- The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can profoundly affect an individual's health status, self-image, dignity, and quality of life.
- Reevaluation of special treatments and procedures the resident received or performed or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- The facility should educate residents who perform any of the treatments, programs, and/or procedures below on the proper performance of these tasks, safety, and use of any equipment needed, and monitor them for appropriate use and continued ability to perform these tasks.

Coding Instructions:

- **Code A**: If the resident received any treatment or therapy by appropriate professionals in the facility or on an outpatient basis. This would include participation in 12-step meetings.
- **Code B:** If the resident receives any chemotherapy agent, administer it as an antineoplastic, which is given by any route.
    - Each medication should be evaluated before coding it here to determine its reason for use. Medications coded here are those used for cancer treatment.
    - For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain.
    - If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation.
- **Code C:** If the resident receives intermittent radiation therapy and/or radiation is administered via radiation implant.
- **Code D:** If continuous or intermittent oxygen administered via a mask or cannula is delivered to a resident to relieve hypoxia. This item may be coded if the resident places or removes their oxygen mask or cannula.
- **Code E:** If Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) is used by the resident, with or without oxygen,
- **Code G:** If the resident receives any drug or biological medication given by intravenous push, epidural pump, or drip through a central or peripheral port in this item.
    - Do not code flushes to keep an IV access port patent or IV fluids without medication here.
    - This item may be coded if administered by a home health RN or on an outpatient basis, as precautions would need to be taken to protect the IV administration site.
    - Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and involve continuous substance administration. Subcutaneous pumps are not coded in this item.

- **Code H:** If the resident received blood transfusions or any blood products (e.g., platelets, synthetic blood products) administered directly into the bloodstream.
    - Do not include transfusions administered during dialysis or chemotherapy.
    - Transfusions would have been received on an outpatient basis and can be coded here if it was administered during the look-back period.
- **Code I:** If the resident received peritoneal or renal dialysis, which occurs 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 medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items O0100G (IV medications) or O0100H (transfusions).
- **Code J:** If the resident is identified as being enrolled in a certified hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.
    - The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.
- **Code K:** If the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or has a positive test and is in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
    - This would be a rare occurrence in an assisted housing facility.
- **Code Z:** If the resident did not receive or perform any of the above treatments, procedures, or programs.

Coding Tips:

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

Coding tips for O0100K, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions):

- This would be a rare coding occurrence in assisted housing facilities
- Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff—no active symptoms). Do not code this item if the precautions are standard precautions because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance and glove use and may include masks, eye protection, and gowns.
- Code for "single room isolation" only when all the following conditions are met:
    - The resident has active infection with highly transmissible or epidemiologically significant pathogens acquired by physical contact or airborne or droplet transmission.
    - Precautions are over and above standard precautions. Transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
    - The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohort with a roommate, regardless of whether the roommate has a similar active infection that requires isolation.
    - The resident must remain in their room. This requires that all services be brought to the resident (e.g., activities, dining, etc.).
- The following resources are being provided to help the facility determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific infectious disease. The CDC guidelines outline isolation precautions and detail the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).
    - 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings https://www.cdc.gov/infectioncontrol/
    - As the CDC guideline notes, psychosocial risks are associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

- If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g., dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with an infectious disease, and may still code O0100K for single room isolation since it is still being maintained while the resident is in the facility.
- Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident's care plan will likely need to be completed.

O0200. Therapies

O0200. Therapies			
Record the number of days each of the following therapies were administered in the LAST 7 CALENDAR DAYS: *(for at least 15 minutes a day)*		1. **On-site:**	2. **Off-site:**
Enter number ☐	A. **Respiratory therapy**	☐	☐
Enter number ☐	B. **Psychological therapy** *(by any licensed mental health professional)*	☐	☐
Enter number ☐	C. **Speech-Language Pathology**	☐	☐
Enter number ☐	D. **Occupational Therapy**	☐	☐
Enter number ☐	E. **Physical Therapy**	☐	☐

Item Rationale:

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers/injuries, which contribute to diminished quality of life.
- Rehabilitation (i.e., via Speech-Language Pathology Services, Occupational and/or Physical Therapies) and respiratory, psychological, and recreational therapy can help

residents attain or maintain their highest level of well-being and improve their quality of life.

- Code only medically necessary therapies that occurred after admission/readmission to the facility that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur inside (by a home health agency) or outside the facility.

Coding Instructions:

- Record the number of days the resident received therapy (respiratory therapy, psychological therapy, speech/language pathology, occupational therapy, or physical therapy) for at least 15 minutes per day in the appropriate column for onsite or offsite services.
- If the resident received less than 15 minutes of therapy, it is not coded as a day of therapy.

Coding Tips:

- Only therapy time that requires the skills, knowledge, and judgment of a qualified therapist and all the requirements for skilled therapy are met, according to the payer source, shall be recorded on the MDS. Therapy includes speech/language pathology, occupational therapy, and physical therapy.
- Respiratory therapy—only minutes the respiratory therapist or qualified respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and treatment equipment setup and removal. Included are coughing, deep breathing, nebulizers, aerosol treatments, mechanical ventilation, etc., which must be provided by a qualified professional, such as a registered nurse or respiratory therapist. Count only the time that the qualified professional spends with the resident. The time that a resident self-administers a nebulizer treatment without the supervision of the respiratory therapist or

respiratory nurse is not included in the minutes recorded on the MDS. Do not include metered-dose and/or dry powder inhalers administration in respiratory minutes.

- Psychological therapy – Evaluation or clinical services by a licensed mental health specialist – An assessment of a mood, behavior disorder, or other mental health problem or treatment/services (e.g., individual psychotherapy; group therapy, regimen of medications) by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not check this item for routine visits by the facility social worker or case manager. Evaluation and treatment (clinical services) may occur at the home, private office, clinic, community mental health center, etc.
- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met: the physician orders the therapy; the physician's order includes a statement of frequency, duration, and scope of treatment; the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel.
    - For respiratory therapy, documentation of a change in a condition requiring RN/Respiratory therapist intervention, e.g., exacerbation of a chronic respiratory condition or onset of a new respiratory condition.

O0300. Rehabilitation/Restorative Care

O0300. Rehabilitation/Restorative Care	
Record the number of days each of the following programs was performed in the LAST 7 CALENDAR DAYS: *(for at least 15 minutes a day, enter 0 if none or less than 15 minutes daily)*	
Enter number ☐	A. **Range of motion** *(passive)*
Enter number ☐	B. **Range of motion** *(active)*
Enter number ☐	C. **Splint or brace assistance**
Enter number ☐	D. **Bed mobility**
Enter number ☐	E. **Transfer**
Enter number ☐	F. **Walking**
Enter number ☐	G. **Dressing and/or grooming**
Enter number ☐	H. **Eating and/or swallowing**
Enter number ☐	I. **Amputation/prostheses care**
Enter number ☐	J. **Communication**

Item Rationale:

- To record the number of days, in the last 7 days, for each technique that was provided for more than or equal to 15 minutes in a 24-hour period as a rehabilitative or restorative practice for the resident.
- Maintaining independence in daily living and mobility activities is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.
- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept focuses on achieving optimal physical, mental, and psychosocial functioning.

Definitions:

- **Restorative Programs**: Included are interventions that assist or promote the resident's ability to attain his or her maximum functional potential. Skill practice in these activities can improve or maintain function in physical abilities, ADLs, and IADLs. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P.1.b. Therapies.

Coding Instructions:

Record the number of days, 0-7, for items A through J when these techniques or training were provided.

- **Code A:** If the resident received provision of passive movements to maintain flexibility and useful motion in the joints of the body.
- **Code B:** If the resident performed active ROM and active-assisted ROM activities, with cueing, supervision, or physical assistance by staff.
- **Code C:** If the resident received (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint or (2) a scheduled program of applying and removing a splint or brace.
- **Code D:** If the resident engaged in activities provided to improve or maintain the resident’s self-performance in moving to and from a lying position, turning side to side, and positioning themself in bed.
- **Code E:** If the resident engaged in activities provided to improve or maintain the resident’s self-performance in moving between surfaces or planes, either with or without assistive devices.
- **Code F:** If the resident engaged in activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.
- **Code G:** If the resident received activities provided to improve or maintain the resident’s self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.
- **Code H:** If the resident engaged in activities provided to improve or maintain the resident’s self-performance in feeding oneself food and fluids or activities used to improve or maintain the resident’s ability to ingest nutrition and hydration by mouth.

- **Code I:** If the resident engaged in activities provided 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).
- **Code J:** If the resident engaged in activities provided to improve or maintain the resident's self-performance in functional communication skills or assist the resident in using residual communication skills and adaptive devices.

Coding Tips:

The following criteria for restorative nursing programs must be met to code O0400:

- Measurable objectives and interventions must be documented in the care plan and the medical record. If a restorative program is in place, the care/service plan must contain information about the program's goals and interventions. Each assessment is appropriate for assessing progress, goals, interventions, and duration/frequency as part of the care/service planning process.
- Evidence of periodic evaluation must be present in the resident's medical record.
- Direct care staff must be trained in the techniques that promote resident involvement in the activity.
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Dentures are not considered to be prostheses for coding O0400I.

O0400. Hospital Stay(s)

O0400. General Hospital Stay(s)	
Enter number ☐☐	**How many times was the resident admitted to an acute care hospital with an overnight stay in the LAST 6 MONTHS?**

Item Rationale:

- To record how many times the resident was admitted to an acute care/general hospital with an overnight stay in the last 6 months or since the last assessment if less than 6 months.

Coding Instructions:

- Enter the number of visits.
- If none, enter "0".

O0500. Emergency Department Visit(s)

O0500. Emergency Department Visit(s)	
Enter number ☐☐	**How many times did the resident visit an ED without an overnight stay in the LAST 6 MONTHS?**

Item Rationale:

- To record if, during the last 6 months, the resident visited a hospital emergency room/department (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time.

Coding Instructions:

- Enter the number of visits.
- If none, enter "0".

O0600. Physician Visits

O0600. Physician Visits	
Enter number ☐☐	**On how many days has a physician examined the resident in the LAST 14 DAYS?**

Item Rationale:

- To record the number of days during the last 14-day look-back period the physician has examined the resident (or since admission if less than 14 days ago).
- Examination can occur in the facility or the physician's office. It does not include daily visits by a physician when the resident is hospitalized.

Definitions:

- **Physician:** This includes an MD, DO (osteopath), or podiatrist who is the primary physician or consultant. It also includes authorized physician assistants or nurse practitioners collaborating with the physician.
- **Physical exam:** This may be a partial or full exam. This does NOT include exams conducted in an emergency room. If a physician examined the resident during an unscheduled emergency room visit, record the number of times this happened in Item 06, "Emergency Department" (Visits).

Coding Instructions:

- Enter the number of visits.
- If none, enter "0".

O0700. Physician Orders

O0700. Physician Orders	
Enter number ☐☐	**How many days has a physician changed the resident's orders in the LAST 14 DAYS?**

Item Rationale:

- To record the number of days, in the last 14 days, that the physician has changed the resident's orders.

Definitions:

- **Physician:** This includes an MD, DO (Osteopath), podiatrist, or dentist who is the primary physician or a consultant. It also includes authorized physician assistants, nurse practitioners, or clinical nurse specialists collaborating with the physician.
- **Physician Orders:** This includes written, telephone, fax, or consultation orders for new or altered treatment. It does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission due to an unexpected change/deterioration in condition or injury are considered new or altered treatment orders. They should be counted as a day with order changes.

Coding Instructions:

- Enter the number of days on which physician orders were changed.
- If none, enter “0”.

Coding Tips:

- Do not include order renewals without change, clarifications, and admission orders.
- Do not count visits or orders before the date of admission or reentry.
- 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. A PRN (as needed) order that has been in the clinical record and has been activated is not considered a new order.
- The following do not count as new orders:
    - Admission / re-admission orders
    - Renewal orders without changes
    - Clarifying orders without changes

- Orders written by a pharmacist
- Orders to transfer care from one physician to another
- Other orders written to increase the number of physician orders intentionally

O0800. Psychiatric Hospital Stay(s)

O0800. Psychiatric Hospital Stay(s)	
Enter number ☐☐	**How many times was the resident admitted to a psychiatric hospital with an overnight stay in the LAST 6 MONTHS?**

Item Rationale:

- To record the number of times the resident was admitted to a psychiatric unit or hospital with an overnight stay in the last 6 months (or since the last assessment if less than 6 months).

Coding Instructions:

- Enter the number of acute psychiatric hospital admissions in the last 6 months in the box.
- Enter "0" if there are no psychiatric hospital admissions.

O900. Outpatient Procedures

O0900. Outpatient Procedures	
Enter number ☐☐	**How many times has the resident had outpatient procedures in the LAST 6 MONTHS?**

Item Rationale:

- To record the number of times the resident had outpatient procedures in the last 6 months.
- This could include outpatient surgical or testing procedures, such as colonoscopies.

Coding Instructions:

- Enter the number of times the resident had outpatient procedures in the last 6 months.
- Enter "0" if there are no outpatient procedures.

O1000. Need for Ongoing Monitoring

O1000. Need for Ongoing Monitoring	
Enter code ☐	A. **Acute physical or psychiatric condition (not chronic)** 0. No monitoring is required 1. Facility nurse 2. Facility other staff 3. Home health nurse
Enter code ☐	B. **New treatment or medication** 0. No monitoring is required 1. Facility nurse 2. Facility other staff 3. Home health nurse

Steps for Assessment:

- The need for ongoing monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication must be documented by the physician or a Registered Nurse, including a description of what monitoring is required, how long the monitoring needs to occur, and what needs to be reported.
- Monitoring would not need to continue once a condition becomes stable for the resident.
- Review the resident's clinical record.
- Clinical records must contain documentation by the person coded as responsible for the monitoring to show that monitoring occurred during the look-back period.

Coding Tips for O0100:

- If more than one person is responsible, code for the highest level. If a licensed staff nurse and other facility staff are monitoring, code licensed staff nurse. If both a home health nurse and other staff are monitoring, code home health nurse.
- Suppose the resident has been placed on a new medication administered by any route that requires special monitoring for serious side effects or drug interactions. In that case, it may be coded in this area. An increase or decrease in the dosage of a medication is not a new medication.
- If the resident has a newly prescribed treatment that must be assessed for effectiveness, it could be coded in this area.

Intent O1000A:

- To record specific monitoring required by the resident, as determined by the physician or a registered nurse, for an acute condition.

Coding Instructions O1000A:

For any condition for which the need for monitoring applies for new treatment or medication, enter the numeric code for the person responsible for the monitoring.

- **Code 0:** If no monitoring is required.
- **Code 1:** If the resident requires monitoring by a facility nurse
- **Code 2:** If the resident requires monitoring by facility other staff (e.g., PSS or CRMA),
- **Code 3:** If the resident requires monitoring by a home health nurse.

Coding Tips for O0100A:

- The physician or Registered Nurse must determine the need for ongoing monitoring of an acute condition (unstable, fluctuating, medically complex) or new treatment/medication.
- This could include monitoring an acute condition (rapid onset, severe symptoms, and a short course) or a chronic condition that has exacerbated into an acute episode, e.g., diabetes with unstable glucose levels or angina requiring monitoring due to recurring episodes.
- Other examples of acute conditions are gall bladder attack (Cholecystitis), bronchial pneumonia, as well as decompensating psychiatric conditions, e.g., Schizophrenia or bipolar disorder.

Intent O1000B:

- To record specific monitoring required by the resident for possible serious, untoward side effects related to a new medication or the effectiveness of a newly prescribed treatment.
    - Serious or untoward side effects:
        - May result in death
        - May be life-threatening
        - May lead to hospital admission or evaluation
        - May require intervention to prevent disability or permanent damage
        - May be an allergic or other systemic reaction

Coding Instructions O1000B:

For any condition for which the need for monitoring applies for new treatment or medication, enter the numeric code for the person responsible for the monitoring.

- **Code 0:** If no monitoring is required.
- **Code 1:** If the resident requires monitoring by a facility nurse
- **Code 2:** If the resident requires monitoring by facility other staff (e.g., PSS or CRMA),
- **Code 3:** If the resident requires monitoring by a home health nurse.

3.18. Section P: Restraints and Alarms

P0100. Physical Restraints

P0100. Physical Restraints
Physical restraints are any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. **Coding:** 0. **Not used** 1. **Used less than daily** 2. **Used daily**
Used in Bed:
Enter code ☐ A. **Bedrail**
Enter code ☐ B. **Trunk restraint**
Enter code ☐ C. **Limb restraint**
Enter code ☐ D. **Other** *(specify)* _____
Used in Chair or Out of Bed:
Enter code ☐ E. **Trunk restraint**
Enter code ☐ F. **Limb restraint**
Enter code ☐ G. **Chair prevents rising**
Enter code ☐ H. **Other** *(specify)* _____

Item Rationale:

- Although the requirements describe the limited instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical restraints limit mobility and increase the risk for several adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers.
- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used be carefully considered and monitored. In many cases, the risk of using physical restraint may be greater than the risk of it not being used.

- The risk of restraint-related injury and death is significant when physical restraints are used.
- When physical restraints are considered, a thorough assessment of the problems to be addressed is necessary to determine reversible causes and contributing factors and identify alternative methods of treating non-reversible issues.
- When staff, in collaboration with the resident's primary care provider, determines that physical restraints are the appropriate course of action, and a signed physician order provides the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material, or equipment that will meet the resident's needs must be selected.
- Service/care planning must focus on preventing adverse effects of physical restraint use, appropriately timed restraint release, and resident monitoring.

Definitions:

- **Trunk restraints:** Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot easily remove, such as, but not limited to, vest or waist restraints or belts used in a wheelchair that restricts freedom of movement or access to their body.
- **Limb restraints:** Includes any manual method or physical or mechanical device, material, or equipment that the resident cannot easily remove and that restricts movement of any part of an upper extremity (e.g., hand, arm, wrist) or lower extremity (e.g., foot, leg) that either restricts freedom of movement or access to their own body. Hand mitts/mittens are included in this category.
    - **Note:** Trunk or limb restraints used in bed and chair should be marked in both sections.
- **Remove easily:** The manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish *their* objective (e.g., transfer to a chair, get to the bathroom in time).

- **Freedom of movement:** Any change in place or position for the body or any part of the body that the person is physically able to control or access.
- **Medical symptoms/diagnoses:** An indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the resident's subjective symptoms and medical diagnoses should be considered when determining the presence of medical symptom(s) that might support restraint use.

Steps for Assessment:

1. Review the resident's medical record (e.g., physician orders, nurses' notes, direct care staff documentation) to determine if physical restraints were used during the 7-day look-back period.
2. Consult the facility staff, medical record, or RN consultant to determine the resident's cognitive and physical status/limitations.
3. Considering the definition of physical restraint and the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use.
4. Evaluate whether the resident can easily and voluntarily remove any manual method, physical, mechanical device, material, or equipment attached or adjacent to their body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether the manual method, physical or mechanical device, material, or equipment restricts freedom of movement or restricts the resident's access to their own body.
5. Any manual method or physical or mechanical device, material, or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing every manual method or physical or mechanical device, material, or equipment (whether it is listed specifically on the MDS) attached or adjacent to the resident's body and its effect on the resident.
6. Determine if the manual method, physical or mechanical device, material, or equipment meets the definition of a physical restraint, as clarified below. Remember, the decision to code any manual method, physical or mechanical device, material, or equipment as a restraint depends on its effect on the resident.

7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of physical restraint must have physician documentation of a medical symptom that supports the use of the restraint, a physician's order for the type of restraint, and parameters of use and a service/care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate. Restraints must be periodically released, with skin areas and movement monitored, and the resident's overall well-being and condition must be monitored to ensure no harm from using the restraint device.

Coding Instructions:

Identify all physical restraints used at any time (day or night) during the 7-day look-back period. After determining whether an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:

- **Code 0:** If the item was not used during the 7-day *look-back period* **or** it was used but did not meet the definition of restraint.
- **Code 1:** If the item met the definition and was used less than daily *during the observation period*.
- **Code 2:** If the item met the definition and was used daily during the look-back period.

Coding Tips and Special Populations:

- Any manual method or physical or mechanical device, material, or equipment that does not fit into the listed categories but meets the definition of physical restraint and has not been excluded from this section should be coded in items P0100D or P0100H, "Other." These devices must also be assessed, service/care-planned, monitored, and evaluated.
- In classifying any manual method, physical or mechanical device, material, or equipment as a physical restraint, the assessor must consider its effect on the resident, not the purpose or intent of its use. It is possible that a manual method, physical or mechanical device, material, or equipment may improve a resident's mobility but also physically restrain them.
- This section excludes items typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).

- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building.
- Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems. Bed rails are used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of physical restraint, even though they may improve the resident's mobility in bed, the facility must code their use as a restraint at P0100A.
- Bed rails are used with immobile residents. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of physical restraint. For residents with no voluntary movement, the staff needs to determine if bed rails are used appropriately. Bed rails may create a visual barrier and deter physical contact with others. Some residents cannot carry out voluntary movements but exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.
- Chairs that prevent rising include any chair with a locked lap board that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibits the resident from rising, geriatric chairs, and enclosed frame wheeled walkers. For residents who can transfer from other chairs but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual and should be coded as P0100G–Chair Prevents Rising.
- For residents unable to transfer independently, the geriatric chair does not meet the definition of restraint and should not be coded at P0100G–Chair Prevents Rising.

- Geriatric chairs are used for immobile residents with no voluntary or involuntary movement. The geriatric chair does not meet the definition of a restraint. Enclosed frame-wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as physical restraint if the resident cannot exit the walker by opening a gate, bar, strap, latch, tray removal, etc. These walkers should be coded at P0100G–Chair Prevents Rising when deemed a physical restraint.
- Restraints are used in emergencies if the resident needs emergency care. Physical restraints may be used for brief periods to permit medical treatment to proceed unless the resident or legal representative has previously made a valid refusal of the treatment in question.

Additional Information:

- Restraints as a fall prevention approach. Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting physical restraints. There is no evidence that using physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may decrease the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- Request for restraints. While a resident, family member, legal representative, or surrogate may request the use of a physical restraint, the facility is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment but not to demand its use when it is not deemed medically necessary.
- The resident's subjective symptoms may not be used as the sole basis for restraint use. In addition, the resident's medical symptoms/diagnoses should not be viewed in isolation; instead, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the resident's condition, circumstances, and environment, and not a way to justify restraint use.

- The identification of medical symptoms should assist the facility in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The facility should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a physical restraint is employed to treat the medical symptom, protect the resident's safety, help the resident attain or maintain their highest level of physical or psychological well-being and support the resident's goals, wishes, independence, and self-direction.
- Physical restraints do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, they should not be used without seeking to identify and address the physical or psychological condition causing the medical symptom.
- If warranted, • Physical restraints may be used as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring themself or others and/or to prevent the resident from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist.
- Therefore, a clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom. After thorough evaluation and attempts at using alternative treatments and less restrictive methods, suppose it is determined that a physical restraint must still be employed. In that case, the medical symptoms supporting the restraint use must be documented in the resident's medical record, ongoing assessments, and service/care plans. A physician's order must also reflect the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint. The State will ultimately hold the facility accountable for the appropriateness of that determination.

P0200. Alarms

P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected. **Coding:** 0. **Not used** 1. **Used less than daily** 2. **Used daily**	
Enter code ☐	A. **Bed alarm**
Enter code ☐	B. **Chair alarm**
Enter code ☐	C. **Floor mat alarm**
Enter code ☐	D. **Motion sensor alarm**
Enter code ☐	E. **Wander/elopement alarm**
Enter code ☐	F. **Other** *(specify)* _____

Item Rationale:

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

- When the use of an alarm is considered an intervention in the resident's safety strategy, it must be based on the resident's assessment and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident.
- When an alarm is used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident.

Steps for Assessment:

1. Review the resident's medical record (e.g., physician orders, clinical notes, direct caregiver documentation) to determine if alarms were used during the 7-day look-back period.
2. Consult the facility staff, medical record, or RN consultant to determine the resident's cognitive and physical status/limitations.
3. Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning themself due to fear of setting off the alarm?

Coding Instructions:

Identify all alarms used at any time (day or night) during the 7-day look-back period. After determining whether an item listed in P0200 was used during the 7-day look-back period, code the frequency of use:

- **Code 0:** If the device was not used during the 7-day look-back period.
- **Code 1:** If the device was used less than daily.
- **Code 2:** If the device was used on a daily basis during the look-back period.

Coding Tips:

- Bed alarms include devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- Floor mat alarm includes devices such as a sensor pad placed on the floor beside the bed.

- Motion sensor alarm includes infrared beam motion detectors.
- Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
- Other alarms include devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
- Code any type of alarm, audible or inaudible, used during the look-back period in this section.
- If an alarm meets the criteria as a restraint, code the alarm uses in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in this section.
- Wandering is random or repetitive locomotion. This movement may be goal-directed (e.g., the resident appears to be searching for something, such as an exit), non-goal-directed, or aimless. Non-goal-directed wandering requires a response that addresses both safety issues and an evaluation to identify root causes to the degree possible.
- While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant to respond to them in a timely manner. Alarms do not replace necessary supervision.
- Bracelets or devices worn by or attached to the resident and/or their belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether the device activates a sound or alerts the staff.
- Do not code a universal building exit alarm applied to an exit door intended to alert staff when anyone (including visitors or staff members) exits the door.

3.19. Section Q: Participation in Discharge Planning and Goal Setting

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS-AH uses a person-centered approach to ensure that all individuals can learn about home- and community-based services and receive long-term care in the least restrictive setting possible. This is also a civil right for all residents.

Q0100. Participation in Discharge Planning and Goal Setting

Q0100. Participation in Discharge Planning and Goal Setting	
Identify all active participants in the assessment process Check all that apply:	
☐	A. **Resident**
☐	B. **Family**
☐	C. **Significant other**
☐	D. **Legal guardian**
☐	E. **Other legally authorized representative**
☐	Z. **None of the above**

Item Rationale:

- Residents who actively participate in the assessment process and the development of their care plan through interviews and conversations often experience improved quality of life and higher quality care based on their needs, goals, and priorities.
- Each care plan should be individualized and resident-driven. The resident should be actively involved whenever possible—except in unusual circumstances, such as if the individual cannot understand the proceedings or is comatose.
- During the care planning meetings, the residents should be made comfortable, and verbal communication should be direct with them.
- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate and if they desire to be involved in the assessment process.

Definitions:

- **Resident's Participation in Assessment**: The resident actively engages in interviews and conversations to meaningfully contribute to completing the MDS-AH. Facility staff

should engage the resident during the assessment to determine the resident's expectations and goals during the assessment.

- **Family Or Significant Other:** A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver, or close friend. Significant other does not include staff at the nursing home.
- **Guardian/Legally Authorized Representative:** A person authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Coding Instructions:

Record the participation of all those who participated in the assessment process. Check all that apply.

- **Code A:** If the resident actively participated in the assessment process.
- **Code B:** If a member of the resident's family actively participated in the assessment process.
- **Code C:** If a significant other of the resident actively participated in the assessment process.
- **Code D:** If a legal guardian actively participated in the assessment process.
- **Code E**: If another legally authorized representative actively participated in the assessment process.
- **Code Z**: If none of the above applies to the resident.

Coding Tips:

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the *resident's perspective* if they can express it, even if the opinion of a family member/significant other or guardian/legally authorized representative differs.
- Significant other does not include facility staff.

Q0200. Resident's Overall Goal

Q0200. Resident's Overall Goal	
Enter code ☐	A. **The resident's overall goal for discharge was established during the assessment process:** 1. **Discharge to the community** 2. **Remain in the facility** 3. **Discharge to another facility/institution** 9. **Unknown or uncertain**
Enter code ☐	B. **Indicate information source for Q0200A:** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Legal guardian** 5. **Other legally authorized representative** 9. **None of the above**

Item Rationale:

- This item identifies the resident's general expectations and goals for nursing home stay.
- The resident should be asked about their expectations regarding return to the community and goals for care.
- The resident may not be aware of the option of returning to the community and that services and supports may be available in the community to meet their individual long-term care needs.
- Additional assessment information may be needed to determine whether the resident requires additional community services and support.
- Unless the residents' goals for care are understood, their needs, goals, and priorities are not likely to be met.
- The resident's goals should be the basis for care planning.

Coding Instructions for Q0300A:

Record the residents' expectations as they express them. It is important to document their expectations.

- **Code 1:** If the resident indicates an expectation to return home, to assisted living, or another community setting.
- **Code 2:** If the resident indicates that they expect to remain in the nursing home.
- **Code 3:** If the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- **Code 9:** If the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and the family, significant other, guardian, or legally authorized representative does not exist or is not available to participate in the discussion.

Coding Instructions for Q0300B:

- **Code 1:** If the resident was the information source for Q0300A.
- **Code 2:** If the resident's family was the information source for Q0300A.
- **Code 3:** If the resident's significant other was the information source for Q0300A.
- **Code 4:** If the resident's legal guardian was the information source for Q0300A.
- **Code 5:** If the resident's other legally authorized representative was the information source for Q0300A.
- **Code 9:** If none of the above applies to the resident.

Coding Tips

- Some residents have very clear and directed expectations that will change little before discharge. Other residents may be unsure or experiencing an evolution in their thinking as their clinical condition changes or stabilizes. The resident's goals should be the basis for care planning.
- Encourage the involvement of family or significant others in the discussion if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about *their* goals, the response must reflect the resident's perspective if they can express it.
- In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. However, this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.
- The response to this item should be individualized and resident-driven rather than what the nursing home staff judged to be in the resident's best interest. This item focuses on exploring the resident's expectations, not whether or not the staff considers them realistic.
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive, e.g., "do not resuscitate" (DNR).
- The resident should be provided with options and access to information that allows them to make the decision and be supported in directing *their* care planning.

Q0300. Discharge Potential

Q0300. Discharge Potential	
Enter code ☐	**Does the resident have a support person who expresses a positive and supportive attitude towards discharge?** 0. **No** 1. **Yes**

Item Rationale:

- To identify residents who are potential candidates for discharge by monitoring their attitude and support person's attitude toward returning to the community and their overall progress at the facility over time. Some residents will meet the" "potential discharge" profile at admission; others will move into this status as they continue to improve during residency.

Definitions:

- **Discharge:** This can be at a home, community, care facility, or residential setting.
- **Support person:** A spouse, family member, significant other, or another person.

Coding Instructions:

- **Code 0**: No, if a support person has not been identified who has expressed a positive and supportive attitude towards the resident returning to the community.
- **Code 1:** Yes, if a support person has been identified who has expressed a positive and supportive attitude towards the resident returning to the community.

Q0400. Return to Community

Q0400. Return to Community	
Enter code ☐	A. **Does the resident wish to talk to someone about leaving this facility to live and receive services in the community?** 0. **No** 1. **Yes**
Enter code ☐	B. **Indicate information source for Q0400A:** 1. **Resident** 2. **Family** 3. **Significant other** 4. **Facility staff** 5. **Legal guardian** 6. **Other legally authorized representative** 9. **None of the above**

Item Rationale:

- The goal of follow-up action is to initiate and maintain collaboration between the facility and the Local Contact Agency (LCA) to support the resident's expressed interest in talking to someone about the possibility of leaving the facility and returning to live and receive services in the community.

- The underlying intention of the return to the community item is to ensure that all individuals have the opportunity to learn about home and community-based services and have an opportunity to receive long-term services and support in the least restrictive setting appropriate for their needs.
- CMS has found that in many cases, individuals requiring long-term services and/or their families are unaware of community-based services and supports that could adequately support individuals in community living situations.
- LCAs are experts in available home and community-based services (HCBS) and can provide valuable information to residents and the facility.
- The Local Contact Agency (LCA) is the Long-Term Care Ombudsman Program in the State of Maine. They can be reached at (207) 621-1079 or toll-free at (800) 499-2299. A referral to the LCA is not a guarantee of discharge; it is a request for information about the availability of resources in the resident's preferred community.

Coding Instructions for Q0400A:

- **Code 0:** If the resident (or family or significant other, guardian, or legally authorized representative) states that they do not want to talk to someone about the possibility of returning to live and receive services in the community.
- **Code 1:** If the resident (or family or significant other, guardian, or legally authorized representative) states that they want to talk to someone about the possibility of returning to live and receive services in the community.

Coding Instructions for Q0400B:

- **Code 1:** If the resident was the information source for Q0400A.
- **Code 2:** If the resident's family was the information source for Q0400A.
- **Code 3:** If the resident's significant other was the information source for Q0400A.
- **Code 4:** If the resident's legal guardian was the information source for Q0400A.
- **Code 5:** If the resident's other legally authorized representative was the information source for Q0400A.
- **Code 9:** If none of the above applies to the resident.

Q0500. Referral

Q0500. Referral	
Enter code ☐	**Has a referral been made to the Local Contact Agency (LCA) within the last calendar year?** 0. **No** 1. **Yes**

Item Rationale:

- Returning home or transitioning to a non-institutional setting can be very important to the resident's health and quality of life.
- Some residents may be able to return to the community if they are provided assistance and referral to appropriate community resources to facilitate care in a noninstitutional setting.

Definitions:

- **Local Contact Agency:** Each state has community contact agencies that can provide individuals with information about community living options and available community-based supports and services. These local contact agencies may be a single-entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other State-designated entities.

Coding Instructions:

- **Code 0:** If a referral has not been made to the LCA within the last calendar year.
- **Code 1:** If a referral has been made to the LCA within the last calendar year.

3.20. Section X

Intent: This Section is used to locate the erroneous assessment or tracking form record in the state database.

X0100. Type of Provider (A0300 on existing record to be modified/inactivated)

X0100. Type of Provider *(A0300 on existing record to be modified/inactivated)*	
Enter code ☐	**Type of provider:** 1. **Residential Care Level IV PNMI** *(RCF)* 2. **Adult Family Care Home** *(AFCH)*

Coding Instructions:

- Enter the code exactly as submitted in the prior erroneous MDS-AH item A0300.

X0200. Type of Assessment (A0400 on existing record to be modified/inactivated)

X0200. Type of Assessment *(A0400 on existing record to be modified/inactivated)*	
Enter code ☐☐	A. **Reason for assessment:** *(A0400A on existing record to be modified/inactivated)* 01. **Admission assessment** *(REQUIRED BY DAY 14)* 02. **Semi-annual assessment** 03. **Significant change in status assessment** 04. **Significant correction to prior comprehensive assessment** 99. **None of the above**
Enter code ☐☐	B. **Entry/discharge reporting:** *(A0400B on existing record to be modified/inactivated)* 01. **Entry tracking record** 02. **Discharge assessment -** Return not anticipated 03. **Discharge assessment -** Return anticipated 04. **Death in facility -** Tracking record 05. **Discharge prior to completion of assessment** 99. **None of the above**

Coding Instructions for X0200A:

- Enter the code exactly as submitted in the prior erroneous MDS-AH item A0400A.

Coding Instructions for X0200B:

- Enter the code exactly as submitted in the prior erroneous MDS-AH item A0400B.

X0300. Legal Name of Resident (A0500 on existing record to be modified/inactivated)

X0300. Legal Name of Resident *(A0500 on existing record to be modified/inactivated)*	
A. **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	B. **Middle Initial:** ☐
C. **Last Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐	D. **Suffix:** ☐☐☐

Coding Instructions:

- Enter in the following order - a.) First name, b.) Middle initial, c.) Last name, d.) Jr. /Sr. exactly as submitted in the prior erroneous MDS-AH item A0500.

X0400. Social Security Number (A0600 on existing record to be modified/inactivated)

X0400. Social Security Number *(A0600 on existing record to be modified/inactivated)*

☐☐☐ - ☐☐ - ☐☐☐☐

Coding Instructions:

- Enter one number per box, starting with the left-most box with the SSN, exactly as submitted in the prior erroneous MDS-AH item A0600.
- Recheck the number to be sure you have written the digits correctly.

X0500. Gender (A0700 on existing record to be modified/inactivated)

X0500. Gender *(A0700 on existing record to be modified/inactivated)*

Enter code ☐

1. **Male**
2. **Female**
3. **Non-binary**

Coding Instructions:

- Enter the code exactly as submitted in the prior erroneous MDS-AH item A0700.

X0600. Birth Date (A0800 on existing record to be modified/inactivated)

X0600. Birth Date *(A0800 on existing record to be modified/inactivated)*

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Coding Instructions:

- Enter one number per box, starting with the left-most box with the date, exactly as submitted in the prior erroneous MDS-AH item A0800.
- For a one-digit month or day, place a zero in the first box. For example, February 3, 2024, should be entered as 02-03-2024.

X0700. Assessment Reference Date (A0900 on existing record to be modified/inactivated)

X0700. Assessment Reference Date *(A0900 on existing record to be modified/inactivated)*

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Coding Instructions:

- Enter one number per box, starting with the left-most box with the date, exactly as submitted in the prior erroneous MDS-AH item A0900.
- For a one-digit month or day, place a zero in the first box. For example, February 3, 2024, should be entered as 02-03-2024.

X0800. Date of Death or Discharge (A1800 on existing record to be modified/inactivated)

X0800. Date of Death or Discharge *(A1800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

Coding Instructions:

- Enter one number per box, starting with the left-most box with the date, exactly as submitted in the prior erroneous MDS-AH item A1800.
- For a one-digit month or day, place a zero in the first box. For example, February 3, 2024, should be entered as 02-03-2024.

X0900. Date of Entry/Reentry (A1200 on existing record to be modified/inactivated)

X0900. Date of Entry/Reentry *(A1200 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

Coding Instructions:

- Enter one number per box, starting with the left-most box with the date, exactly as submitted in the prior erroneous MDS-AH item A1200.
- For a one-digit month or day, place a zero in the first box. For example, February 3, 2024, should be entered as 02-03-2024.

X1000. Correction Number

X1000. Correction Number

Enter number

Enter the number of requests to modify/inactivate the existing record, including the present one.

Coding Instructions:

- For the first correction request for an MDS-AH record, code a value of "01", regardless of the number of items being corrected in the assessment.
- For the second correction request for the same MDS-AH record, code a value of "02," etc. With each subsequent request, X1000 is incremented by one.
- For values from one through nine, a leading zero "0" should be coded in the first box.

X1100. Reasons for Modification

X1100. Reasons for Modification - Complete only if the Type of Record is to modify in error *(A0100 = 2)*	
Check all that apply:	
☐	A. **Transcription error**
☐	B. **Data entry error**
☐	C. **Software product error**
☐	D. **Item coding error**
☐	E. **Other errors requiring modification**

Item Rationale:

- To identify the reason(s) for the error(s) that require modification or the prior, erroneous assessment or discharge record that has previously been accepted into the State database.

Definitions:

- **Transcription error:** Includes errors made while encoding MDS-AH assessment or discharge information from other sources. An example is transposing the digits from the patient's weight (e.g., recording "191" rather than the correct weight of "119").
- **Data entry error:** Includes errors made while encoding MDS-AH assessment or discharge tracking form information in the facility's computer system. An example is a "keypunching" error in which the response to physician visits (P9) is incorrectly coded "90" rather than the correct number of "09" visits on the MDS form.
- **Software Product error:** Includes any error created by the encoding software, such as "storing" an item with the wrong format (e.g., misplacing the decimal point in an ICD-9 code in item I3) or "storing" an item in the wrong position in an electronic MDS-AH record.
- **Item coding error:** This includes any error made while coding an MDS-AH item. An example is choosing an incorrect code for a self-performance item in Section G (e.g., choosing a code of "A" in G0500 for a resident who rode to a destination with staff and required support to attend a medical appointment, which should be coded as "C"). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the coding instructions.
- **Other error:** Includes any other reason for error that causes prior assessment or tracking form record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to the final completion of editing and review. Facility staff should describe the "other error" in the space provided on the form.

Proper Error Correction Procedure:

1. When an error is made in a medical record entry, proper error correction procedures must be followed. Draw a line through the entry (thin pen line).
2. Make sure that the inaccurate information is still legible.
3. Initial and date the entry.
4. State the reason for the error (i.e., in the margin or above the note if room).
5. Document the correct information.
6. If the error is in a narrative note, entering the correct information on the next available line/space may be necessary. Document the current date and time, and refer to the incorrect entry.
7. Do not obliterate or otherwise alter the original entry by blocking it out with a marker, using white, or writing over an entry.

Coding Instructions:

- If the action request is a modification (A0100 = "2"), check all that apply.
- Leave all blank if the action requested is an inactivation (A0100 = "3").

X1200. Reasons for Inactivation

X1200. Reasons for Inactivation	
Check all that apply:	
☐	A. **The event did not occur**
☐	B. **Test record submitted as production record**
☐	C. **Inadvertent submission of non-required record**
☐	D. **Other errors requiring inactivation**

Item Rationale:

- To identify the reason(s) for the required inactivation of an invalid assessment or discharge form record that has previously been accepted into the State database.

Definitions:

- **Test record submitted as a production record:** An example is a fictitious assessment or discharge form record, which was fabricated to test a software product and then inadvertently submitted to the state as a production record.
- **Event did not occur:** Includes submission of an assessment or discharge form record describing an event that did not occur. The event did not occur if any of the following apply:

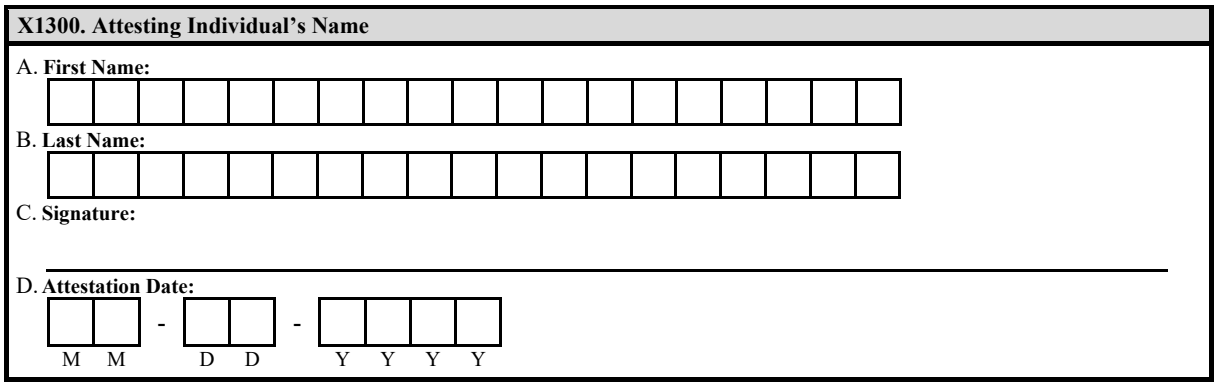
- The record submitted does not correspond to an actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was no event.
- The record submitted identifies the wrong resident. For example, a discharge form was completed and submitted to the wrong person.
- The record submitted identifies the wrong reason for assessment. For example, an admission assessment was submitted when the annual was due.

- **Inadvertent submission of inappropriate records:** An example would be submitting a non-required assessment for the facility's "in-house" training program.
- **Other reason requiring inactivation:** Includes any other reason for error that causes a prior assessment or discharge form record to require inactivation under the Correction Policy. Facility staff should describe the "other error" in the space provided on the form.

Coding Instructions:

- If the action requested is an inactivation (A0100 = "3"), check all that apply.
- Leave all blank if the action requested is a modification (A0100 = "2").

X1300. Attesting Individual's Name



Item Rationale:

- To identify the facility staff completing the Correction Request form and ensure the accuracy of the information.

Coding Instructions:

- Staff who completed the MDS-AH Correction Request form must enter their first and last name, signature, and date.
- The entire form should be signed and completed within 14 days of detecting an error in an MDS-AH record that resides in the State database.

- If the facility does not have an electronic signature policy, a hard copy of this form, including the signature of the responsible staff, must be attached to the modified or inactivated MDS-AH record and retained in the resident's record.

Correcting Errors in MDS Records That Have Been Accepted Into the Submission Management System (SMS)

Facilities should correct any errors necessary to ensure that the information in the State database accurately reflects the resident's identification, location, overall clinical status, or payment status.

- Errors identified in MDS-AH records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software errors, item coding errors, or other errors.

- The following two processes have been established to correct MDS records (assessments, Entry tracking records, and discharge tracking records that have been accepted into the State database:
    - Modification
    - Inactivation
- A Modification request moves the inaccurate record into history in the database and replaces it with the corrected record as the new active record.
- An Inactivation request also moves the inaccurate record into history in the database but does not replace it with a new record.
- Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS-AH.
- The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable the location of the erroneous MDS record previously submitted and accepted into SMS. Section X items are defined in the MDS-AH Training Manual.
- When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical record. In addition, the facility

would keep a hard copy of the Correction Request items (Section X) with an inactivated record.

Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record, or Death in Facility tracking record) has been accepted in SMS, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include:

- **Target Date:** Admission Date (Item A1400) on an Entry tracking record (Item A0400B = 1) or Discharge Date (Item A1800) on a Discharge/Death in Facility record (Item A0400B = 02, 03, or 04), or Assessment Reference Date (Item A0900). The ARD (Item A0900) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look-back period and alters the actual assessment timeframe. Consider the following examples:
    - When entering the assessment into the facility's software, the ARD, intended to be 02/12/2021, was inadvertently entered as 02/02/2021.
    - The MDS Coordinator completed the assessment based on the ARD of 02/12/2021 (the seven-day look-back period was 02/06/2021 through 02/12/2021).
    - This would be an acceptable use of the modification process to modify the ARD (A0900) to reflect 02/12/2021.
- Type of Assessment (Item A0400A)
- Clinical Items (Items B0100-Q0500)
- To correct an error in the Type of Provider (Item A0300), the existing record must be inactivated and then a new corrected record must be submitted. In this situation, the modification process would not be used.

When an error is discovered in an MDS-AH Entry tracking record, Death in Facility tracking record, Discharge assessment, or an assessment in which (where Item A0400A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with *all* items included, not just the items in error.

2. Complete the required Correction Request Section X items and include them with the corrected record. Item A0100 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in an assessment (Item A0400A = 01 through 04), then the facility must determine if there are any significant errors. If the only errors are minor errors, the facility must take the following actions to correct the assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include them with the corrected record. Item A0100 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any significant error is discovered in an assessment that has been accepted into SMS, the facility must take the following actions to correct the assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include them with the corrected record. Item A0100 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if the MDS item(s) correction revealed that the resident met the criteria for a Significant Change in Status Assessment.

- If the criteria for Significant Change in Status Assessment were not met, as shown in the example above, then a Significant Correction to the Prior Assessment is required.
- The facility determined that information on an assessment that had already been submitted was not correct. A new assessment reference date (A900) is set, and a new assessment is completed.
- A facility cannot add or change the coding to a modification if that same coding was not present during the look-back period on the original assessment. When errors in an assessment accepted in SMS have been corrected in a more current assessment (Item A0400A = 01 through 04), the facility is not required to perform a new additional assessment.

- The facility has already updated the resident's status and care plan. However, the facility must use the Modification process to ensure that the erroneous assessment residing in SMS is corrected.

Inactivation Requests

An Inactivation should be used when a record has been accepted into SMS, but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident, but there was no actual discharge. An Inactivation (Item A0100 = 3) must be completed when any of the following items are inaccurate:

- Type of Provider (Item A0300)
- Discharge Date (Item A1800) on a Discharge assessment record (Item A0400B = 02, 03, or 04) when the look-back period would change if the MDS was modified.
- Assessment Reference Date (Item A0900) on an assessment when the look-back period would change if the MDS was modified.
- When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This is an MDS record, but only the Section X items and item A0100 are completed. This is sufficient information to locate the record in SMS, inactivate it, and document the reason for inactivation.
- For instance, when the provider determines that the type of provider is incorrect, the provider must deactivate the record in SMS and then complete and submit a new MDS-AH record with the correct type of provider, ensuring that the clinical information is accurate.
- Inactivation should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.
- In such instances, a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS-AH record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS-AH assessment completion requirements.

3.21. Section Z: Assessment Administration

Z0100. Assessment Information

Z0100. Assessment Information
MaineCare Billing Group: *(calculated by software)*

Item Rationale

- Used to capture an alternate payment group in states that employ the MDS-AH for Medicaid case-mix reimbursement for Private Non-Medical Institutions, Appendix C (PNMI-C) and Adult Family Care Hom (AFCH).

Coding Instructions:

- Enter the MaineCare billing group number.

Z0200. Signatures

Z0200. Signatures

I certify that the accompanying information accurately reflects assessment information for this resident and that I collected or coordinated the collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable MaineCare requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care and as a basis for payment from state and federal funds. I further understand that payment of such state and federal funds and continued participation in government-funded health care programs is conditioned on the accuracy and truthfulness of this information. I may be held personally accountable for or may subject my organization to criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information for this facility and on its behalf.

A. **Signature(s) of the person(s) completing this form:**
(write "ALL" for sections completed if the person signing completed sections A - Z)

1. _____
Signature Title Section(s) Completed Date

2. _____
Signature Title Section(s) Completed Date

3. _____
Signature Title Section(s) Completed Date

4. _____
Signature Title Section(s) Completed Date

B. **Coordinator signature:**

1. _____
Signature Title Date

Item Rationale:

- To obtain the signatures of all persons who completed any part of the MDS-AH. Legally, it is an attestation of accuracy, with the primary responsibility for its accuracy being the person selecting the MDS-AH item response.
- Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.
- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
    - the development of an individualized service/care plan
    - Medicaid reimbursement programs
    - quality monitoring activities, such as the quality measure reports
    - the data-driven survey and certification process
    - the quality measures used for public reporting
    - research and policy development.

Steps for Assessment:

1. Verify that all items on this assessment are accurate and complete.
2. Verify that Item Z0200A (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Z0200A Coding Instructions:

- All staff who completed any part of the MDS must enter their signatures, titles, sections, or portion(s) of the section(s) they completed and the date completed. This is a legal document. The date entered accurately must reflect the date the assessment is being signed as complete.
- If a staff member cannot sign Z0200A on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Z0200A Coding Tips and Special Populations:

- Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0200A, any staff member who has completed a sub-set of items within a section should identify which item(s) they completed within that section.
- Facilities may use electronic signatures for medical record documentation, including the MDS-AH, when permitted to do so by state and local law and when authorized by the facility's policy.
- Facilities must have written policies that meet all state and federal privacy and security requirements. These policies must ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- If a facility does not have an electronic signature policy, print the signature sections, sign, and place the signed copy in the clinical record.
- Although the use of electronic signatures for the MDS-AH does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.

Z0200B Coding Instructions:

- For Z0200B, use the actual date that the RN assessment coordinator completed, reviewed, and signed the MDS-AH as complete.
- This date must be equal to the latest date at Z0200A or later than the date(s) at Z0200A, which documents when assessment team members completed portions of the assessment information.
- If the assessment coordinator cannot sign the MDS on the date it is completed, he or she should use the actual date that it is signed.

Appendix A: AHA Function Score Using AFCH RUG Model

AH Grouper Using the AFCH RUG Model

- This calculation worksheet describes the AFCH RUG model using the fields from the MDS-AH assessment tool.
- This model has eight RUG groups. The groups are determined by the Assisted Living Score (ALS score), the Instrumental Activities of Daily Living (IADL) score, and the AH function score. The assessment is placed into the group with the highest case mix index (CMI) among the groups for which the resident is eligible.
- If any assessment item used to calculate the group is not provided or is coded with an invalid code, the RUG group will automatically be calculated as "BC1" not classified and will receive the lowest CMI.

Calculate Function Score

Calculate the resident's Function Score. Use the following table to determine the Function Score Eating (G0100A1), Upper body dressing (G0100E1), Lower body dressing (G0100F1), Putting on/taking off footwear (G0100G1), Personal hygiene (G0100H1), Roll left and right (G0200A1), Sit to lying (G0200B1), Lying to sitting on the side of the bed (G0200C1), Chair/bed-to-chair transfer (G0200E1), Toilet transfer (G0200F1), Locomotion 10 feet in room (G0200H1), Locomotion 50 feet with two turns (G0200I1), Locomotion 150 feet (G0200J1).

Safety & Quality of Performance	Function Score
05, 06	4
04	3
03	2
02	1
01, 07, 08, 09, 99	0

Enter the Function Score for each item

Category	Field Description	Field	Function Score
Eating	Eating	G0100A1	
Personal Hygiene	Personal hygiene	G0100H1	
Transfer	Chair/bed-to-chair transfer	G0200E1	
Toilet Use	Toileting hygiene	G0200F1	

Next, calculate the average score for the three bed mobility items, three locomotion items, and the three dressing items. Enter the averages in the Average column below.

Category	Field Description	Field	Function Score	Average
Dressing[1]	Upper body dressing	G0100E1		
	Lower body dressing	G0100F1		
	Putting on/taking off footwear	G0100G1		
Bed Mobility[2]	Roll left and right	G0200A1		
	Sit to lying	G0200B1		
	Lying to sitting on the side of the bed	G0200C1		
Locomotion[3]	Locomotion 10 feet in room	G0200H1		
	Locomotion 50 feet with two turns	G0200I1		
	Locomotion 150 feet	G0200J1		

Calculate the sum of the function scores for Eating, Personal Hygiene, Transfer, Toilet Use, with the averages for Dressing, Bed Mobility, and Locomotion. Round this sum to the nearest integer. This is the AH Function Score. The Function Score ranges from 0 to 28.

AH Function Score: _____

Calculate the ALS Score

There are seven items included in the ALS Score:

1. Modified Cognitive Skills
2. Depression
3. Assistance with phoning or arranging transportation
4. Use of incontinence supplies
5. Administration of PRN medications
6. Medication administration
7. Physician order changes

Modified Cognitive Skills

- C0400 Cognitive Skills for Daily Decision-Making _____

If C0400 > 0, the score is 1. Otherwise, the score is 0.

Modified Cognitive Skills Score _____

[1] Calculate the sum of the function scores for upper body dressing, lower body dressing, and putting on/taking off footwear. Divide this sum by 3. This is the Dressing function score.
[2] Calculate the sum of the function scores for roll left and right, sit to lying, and lying to sitting on the side of the bed. Divide this sum by 3. This is the Bed Mobility function score.
[3] Calculate the sum of the function scores for locomotion 10 feet in room, locomotion 50 feet with two turns, and locomotion 150 feet. Divide this sum by 3. This is the Locomotion function score.

Depression

- Count the number of items D0100Aa-D0100Ah and D0200Aa-D0200Al where the item is coded > 0 _____

If the count of items is more than 2, the score is 1. Otherwise, the score is 0.

Depression Score _____

Assistance with phone or arranging transportation

- G0400A Resident arranged for suitable transportation _____
- G0400D Resident used phone _____

If either G0400A or G0400D is 1 or 2, the score is 1. Otherwise, the score is 0.

Assistance with phone or arranging transportation Score _____

Use of incontinence supplies

- H0400 Use and Management of Incontinence Supplies _____

Value	Description	Score
0	Incontinence supplies not used	0
1	Resident incontinent and manages supplies	1
2	Resident incontinent and requires assistance with supplies	2
3	Resident incontinent and unable to manage supplies	0

Use of incontinence supplies Score _____

Administration of PRN medications

- N0500C Self-Administered Medications: Over-the-counter _____

If N0500C is checked, the score is 1. Otherwise, the score is 0.

Administration of PRN medications Score _____

Medication administration

- N0600 Medication Preparation Administration _____

If N0600 is 0, the score is 0. Otherwise, the score is 1.

Medication administration Score _____

Physician order changes

- O0700 Physician Orders _____

If O0700 > 0, the score is 1. Otherwise, the score is 0.

Physician order changes Score _____

ALS Score

Add the score for all seven items to get the total ALS Score

ALS Score _____

Appendix A: AHA Function Score Using AFCH RUG Model

Calculate IADL with Bathing Score (IADLB)

Safety & Quality of Performance	Function Score
05, 06	4
04	3
03	2
02	1
01, 07, 08, 09, 99	0

- G0200G1 Bathing (code using table above) _____

IADL Self-Performance Code	Description	Score
0	Independent	0
1	Done with help	1
2	Done by others	2
9	None of the above	0

- G0400B Resident managed finances (value 9, code 0) _____
- G0400C Manage cash and personal needs allowance (value 9, code 0) _____
- **** Missing equivalent fields for G5aa, G5ab, G5af, G5ah, G5ai

Add IADL scores plus the bathing score for the IADLB score.

IADLB Score _____

Use the following table to calculate the ALS group.

Group	ALS Score	AH Function Score	IADLB Score	Weight
AV2	7-9	7-28	-	1.657
AV1	7-9	0-6	-	1.21
AH2	5-6	7-28	-	1.36
AH1	5-6	0-6	-	1.027
AM2	2-4	-	12-18	0.924
AM1	2-4	-	10-11	0.804
AL1	2-4	-	0-9	0.551
BC1	Unclassified			0.551

Appendix B: AHA Function Score

Calculate AHA Function Score

Calculate the resident's Function Score. Use the following table to determine the Function Score Eating (G0100A1), Upper body dressing (G0100E1), Lower body dressing (G0100F1), Putting on/taking off footwear (G0100G1), Personal hygiene (G0100H1), Roll left and right (G0200A1), Sit to lying (G0200B1), Lying to sitting on the side of the bed (G0200C1), Chair/bed-to-chair transfer (G0200E1), Toilet transfer (G0200F1), Locomotion 10 feet in room (G0200H1), Locomotion 50 feet with two turns (G0200I1), Locomotion 150 feet (G0200J1).

Safety & Quality of Performance	Function Score
05, 06	4
04	3
03	2
02	1
01, 07, 08, 09, 99	0

Enter the Function Score for each item

Category	Field Description	Field	Function Score
Eating	Eating	G0100A1	
Personal Hygiene	Personal hygiene	G0100H1	
Transfer	Chair/bed-to-chair transfer	G0200E1	
Toilet Use	Toileting hygiene	G0200F1	

Next, calculate the average score for the three bed mobility items, three locomotion items, and the three dressing items. Enter the averages in the Average column below.

Category	Field Description	Field	Function Score	Average
Dressing[4]	Upper body dressing	G0100E1		
	Lower body dressing	G0100F1		
	Putting on/taking off footwear	G0100G1		
Bed Mobility[5]	Roll left and right	G0200A1		
	Sit to lying	G0200B1		
	Lying to sitting on the side of the bed	G0200C1		
Locomotion[6]	Locomotion 10 feet in room	G0200H1		
	Locomotion 50 feet with two turns	G0200I1		
	Locomotion 150 feet	G0200J1		

[4] Calculate the sum of the function scores for upper body dressing, lower body dressing, and putting on/taking off footwear. Divide this sum by 3. This is the Dressing function score.
[5] Calculate the sum of the function scores for roll left and right, sit to lying, and lying to sitting on the side of the bed. Divide this sum by 3. This is the Bed Mobility function score.
[6] Calculate the sum of the function scores for locomotion 10 feet in room, locomotion 50 feet with two turns, and locomotion 150 feet. Divide this sum by 3. This is the Locomotion function score.

Appendix B: AHA Function Score

Calculate the sum of the function scores for Eating, Personal Hygiene, Transfer, Toilet Use, with the averages for Dressing, Bed Mobility, and Locomotion. Round this sum to the nearest integer. This is the AH Function Score. The Function Score ranges from 0 through 28.

AH Function Score: _____