

CH.	Sect.	Pg.	June 2005 Revision
CH 1	1.11	1-16 Correction	<p>NEWLY CERTIFIED NURSING HOMES FACILITIES</p> <p>Nursing homes facilities must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed <i>as if the beds were already certified</i>. Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.</p>
CH 1	1.11	1-16 Page change	<p>CHANGE IN OWNERSHIP</p> <p>schedule for existing residents continues, and the facility continues to use the existing provider number. For example, if the Admission assessment was done 10 days prior to the change in</p> <p>[This text moved to page 1-16]</p>
CH 1	1.11	1-17 Clarify Change of Ownership	<p>ADD: There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases, the beds are no longer certified. Also, there are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures debts, etc. Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See page 1-16 for information regarding newly certified facilities.</p>
CH 1	1.11	1-17 Clarify natural disaster	<p>Transfers of Residents</p> <p>DELETE: In instances where there has been a massive transfer of new residents to a nursing facility secondary to natural disasters (flood, earthquakes, fire), a new MDS must be completed by the admitting facility. The admitting facility should try to complete the MDS within 14 days of transfer if at all possible. If the admitting facility is having problems meeting the requirement they should contact their State agency to discuss the situation and receive guidance about any extensions in the 14-day time factor.</p>

			<p><u>ADD:</u> When there has been a transfer of residents secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Fiscal Intermediary for guidance.</p> <p>When 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. For questions related to this type of situation, providers should contact their State agency and their Regional Office.</p>
CH 1	1.18	1-27 Clarify electronic signature	<p><u>DELETE:</u> A hard copy of all MDS forms within the last 15 months, including the signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record. This applies to all nursing facilities.</p> <p>Until such time as CMS adopts an electronic signature standard that is compatible with pending Health Insurance Standards Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as CMS adopts an electronic signature standard, and the standard system is upgraded to enable compliance.</p> <p>There is no requirement to maintain two copies of the form in the resident's record (the hand written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed, and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the MDS record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the state. Please see Chapter 5 for detailed instructions on correcting MDS data.</p>

			<p>Facilities are required to maintain 15 months of assessment data in the resident's active clinical record according to CMS policy. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The exception is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.</p> <p>The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission.</p> <p>ADD: Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs.</p> <p>While use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically, the guidance language for Clinical Records found in <u>Appendix PP</u> [42 CFR 483.75(1)(1)] notes that facilities have the option for an individual's record to be maintained by computer rather than hard copy. In addition, proper security measures must be implemented via facility</p>
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			<p>policy to ensure the privacy and integrity of the record and to ensure that access to clinical records is made available to surveyors and others who are authorized by law.</p> <p>Long-term care facilities that are not capable of maintaining MDSs electronically must adhere to the current requirements that either a hand written copy or a computer-generated form must be maintained in the clinical record. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard. In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.</p> <p>Unless the provider has exercised the option to maintain electronic MDSs, facilities are required to maintain hard copies of 15 months of assessment data in the resident's active clinical record according to CMS policy. There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The exception is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.</p>
CH 1	1.18	1-28 Clarify electronic signature & move from page 1-27 to 1-28	<p>ADD: The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it</p>

			on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, including linking the prior electronic MDS to the new admission record, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission. In cases where the resident returns to the facility after a long break in care (e.g., 14 ½ months), staff may want to review the older record to familiarize them with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirement.
CH 3	AB2	3-14 Clarify definition	4. Nursing Home - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled or sick persons. Include admissions from hospital swing beds here.
CH 3	ADa	3-27 Clarify grammar	When the RN Assessment Coordinator worked on the <i>Background (Face Sheet) Information at Admission</i> , he or she must enter his or her signature on the date it is completed. Also, to the right of the name, enter the date the form was signed. If, for some technical reason, such as computer or printer breakdown, the <i>Background (Face Sheet) Information at Admission</i> cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record.
CH 3	A9	3-36 Correct labeling	1. a. Legal Guardian - Someone who has been appointed after a court hearing and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian.
CH 3	A9	3-37 Correct labeling	2. b. Other Legal Oversight - 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.
CH 3	A9	3-37 Correct labeling	3. c. Durable Power of Attorney/Health Care – 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 agent or proxy decision maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked

			by the resident at any time.	
CH 3	A9	3-37 Correct labeling	e.g. NONE OF ABOVE	
CH 3	G1A	3-77 Clarify definition	h. Eating - How the resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	
CH 3	G1A	3-83 Correct typo	Walk in Corridor	After receiving a new cane, Mr. X needed to be observed the first time he used it as he walked up and down the hall on his unit time to insure that he appropriately used the cane. He does not require any additional staff assistance. <i>Self Performance = 0 Support Provided = 0</i> <i>Coding rationale: Resident requires no set up to complete task independently.</i>
CH 3	G1A	3-84 Clarify rationale	Bed Mobility	Resident favors laying lying on right side. Since she has had a history of skin breakdown, staff must verbally remind her to reposition. <i>Self Performance = 1 Support Provided = 0</i> <i>Coding rationale: Resident requires staff supervision, cuing and reminders for safe ambulation-repositioning.</i>
CH 3	G1A	3-85 Clarify rationale	Walk in Room	Mr. K is able to walk in his room, but requires that a staff member place her arm around his waist when taking him to the bathroom due to his unsteady gait. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires staff supervision, cuing and reminders non-weight bearing assistance for safe ambulation.</i>
CH 3	G1A	3-85 Clarify rationale	Walk in Corridor	Mrs. Q requires continual verbal cuing and help with hand placement when walking down the unit hallway. Mrs. Q needs frequent reminders how to use her walker, where to place her hands and to pick up feet. She frequently needs to be physically guided to the day room. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires staff supervision, cuing and reminders non-weight bearing assistance for safe ambulation.</i>
CH 3	G4A	3-107	Definition: Functional limitation that interferes with daily	

		Clarify definition	functioning (particularly with activities of daily living), or places the resident at risk of injury.
CH 3	G4A	3-108 Clarify process	<p>DELETE: ●If the resident is unable to follow verbal directions demonstrate each movement (e.g., Ask the resident to do what you're doing). If a resident lacks all ability to perform ROM (range of motion) exercises on request due to impaired cognition, these items are coded based on the resident's ability to perform range of motion and voluntary movement. For Item G4a, a resident who is unable to follow your verbal instructions or a demonstration of movements can be actively assisted in range of motion exercises to assess for limitations. Move the resident's joints through slow, active assisted ROM by providing support and direction with each activity. In this section, you can also use observations, by the staff, of what the resident can do.</p> <p>●If resident is still unable to perform the activity after your demonstration, move the resident's joints through slow, active assisted range of motion to assess for limitations. In active/assistive range of motion exercises, the health professional provides support and direction with the resident performing some of the activity.</p> <p>ADD: ●Depending on the resident's cognitive level, use the direction most appropriate for assessing limitations in ROM such as:</p> <p>○Ask the resident to follow your verbal instructions for each movement</p> <p>○Demonstrate each movement (e.g., Ask the resident to do what you are doing).</p> <p>○Actively assist the resident with ROM exercises</p> <p>In active assisted exercises, the assessor will guide the resident's joints through the movements while providing support and direction with each activity. If resistance is met during the exercises stop immediately and use staff observations during the assessment period to determine the ability and/or limitations to ROM activity.</p> <p>●Staff observations of the ROM activity can be used to determine whether or not a resident can actually perform the activity, regardless of whether or not the movement was "on</p>

			command,” provided the movement fits the criteria specified for G1(B), ADL Support Provided below and occurred during the assessment period of observation.
CH 3	G4A	3-109 Clarify coding	<p>Coding: For each body part, code the appropriate response for the resident’s active (or assistive/passive active assisted) range of motion function during the past seven days.</p> <p>The process of determining the coding for G4(A) is a 2-step process. First, determine if there is a limitation in active or active assisted ROM. If “no,” code “0.” If “yes,” then go to the next question: Does the limitation in ROM interfere with function or place the resident at risk for injury? If “no,” code “0.” If “yes,” code either “1” or “2.” If the resident is unable to assist with ROM at all, consider that body part as limited. Enter the code in the column labeled (A). If the resident has an amputation on one side of the body, use Code “1”, Limitation on one side of the body. If there are bilateral amputations, use code “2”, Limitation on both sides of the body.</p> <p>If no assessment has been conducted and documented by a therapist within the last seven days, then a clinical professional (e.g., nurse) may assess this area following the guidance in this manual. In this Item, we are moving from performance issues to structural issues. We are not asking how an activity is carried out; we are determining the structural status of the joints.</p>
CH 3	G4B	3-111 Clarify Example	<p>Example of Functional Limitation</p> <p>Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her right legs flat on the bed. She has no feet. She has no other limitations.</p>

			<p>Coding</p> <table><tr><td></td><td>(A) Limitation in Range of Motion</td><td>(B) Loss of Voluntary Movement</td></tr><tr><td>a. Neck</td><td>2</td><td>0</td></tr><tr><td>b. Arm</td><td>1</td><td>1</td></tr><tr><td>c. Hand</td><td>1</td><td>1</td></tr><tr><td>d. Leg</td><td>1</td><td>1</td></tr><tr><td>e. Foot</td><td>2</td><td>2</td></tr><tr><td>f. Other</td><td>0</td><td>0</td></tr></table> <p>In this example, the resident is only able to turn her head slightly from side to side and tip her head towards each shoulder. Cervical ROM is an important component in every day activities. For example, cervical rotation is extremely important during walking. From a safety standpoint, a person can normally walk and move one’s head to look for potential obstacles, not only on the ground, but also to the side. If cervical ROM is not functional, then the person may be a potential fall risk. In this example, the resident has limited rotation and lateral flexion bilaterally.</p>		(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement	a. Neck	2	0	b. Arm	1	1	c. Hand	1	1	d. Leg	1	1	e. Foot	2	2	f. Other	0	0
	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement																						
a. Neck	2	0																						
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c. Hand	1	1																						
d. Leg	1	1																						
e. Foot	2	2																						
f. Other	0	0																						
CH 3	J1	3-138 Correct typo	<p>Definition: a. Weight Gain or Loss of 3 or More Pounds Within a 7-Day Period - This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weights, and for these residents you will be unable to determine if there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.</p>																					
CH 3	J1	3-138 Correct labeling & clarify signs	<p>c. Dehydrated; Output Exceeds Intake - Check this item if the resident has 2 or more of the following indicators:</p> <p>◆ 1. Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages and water in high fluid content foods such as gelatin and soups). Note: The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.</p> <p>◆ 2. Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset</p>																					

			<p>or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).</p> <p>• 3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).</p>
CH 3	K4	3-153 Clarify nutritional problem	<p>c. Leaves 25% or More of Food Uneaten at Most Meals. Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day. This assumes the resident is receiving the proper amount of food to meet their daily requirements and not excessive amounts above and beyond what they could be expected to consume.</p>
CH 3	K5	3-153 Clarify Parenteral/ IV	<p>K5. Nutritional Approaches (7-day look back)</p> <p><u>DELETE:</u> Definition: a. Parenteral/IV—Intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (Keep Vein Open), or via heparin locks. Do not code IV “push” medications here. Do not include the IV fluids in IV piggybacks. IV medications dissolved in a diluent, as well as IV push medications are captured as IV medications in Plac. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay. Do not include fluids administered solely as flushes.</p> <p><u>ADD:</u> Definition: a. Parenteral/Intravenous (IV) Include only fluids administered for nutrition or hydration, such as:</p> <ul style="list-style-type: none"> • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently • IV fluids running at KVO (Keep Vein Open) • IV fluids administered via heparin locks • IV fluids contained in IV Piggybacks • IV fluids used to reconstitute medications for IV administration <p>Do Not include:</p> <ul style="list-style-type: none"> • IV medications • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • Parental/IV fluids administered during chemotherapy or dialysis

			For coding IV medications, see page 3-182
CH 3	K5	3-153 Clarify mechanical Diet & page change	<p>c. Mechanically Altered Diet - A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below. Enteral feeding formulas are not coded here.</p> <p>[This text has moved to pg. 3-154]</p>
CH 3	K5	3-154 Clarify therapeutic diet	<p>e. Therapeutic Diet - A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals. Code enteral feeding formulas here when they meet this definition.</p>
CH 3	K6	3-154 Page change	<p>K6. Parenteral or Enteral Intake (7-day look back) <u>Skip to Section L on the MDS if neither Item K5a nor K5b is checked.</u></p> <p>[This text has moved to pg. 3-155]</p>
CH 3	M1	3-159 Clarify ulcers	<p>M1. Ulcers (7-day look back)</p> <p>Intent: To record the number of skin ulcers/open lesions, at each ulcer stage, on any part of the body.</p> <p>Definition: For coding in this section, a skin ulcer/open lesions can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are Skin ulcers that may develop because of circulatory problems, or pressure are coded in item M1 or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin, ulcers related to diseases such as syphilis and cancer, and surgical wounds are NOT coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.</p> <p>Process: Review the resident's record and consult with the</p>

			<p>nurse assistant about the presence of any skin ulcers an ulcer/open lesion. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, a skin ulcer an ulcer/open lesion can be missed.</p>
CH 3	M1	<p>3-160</p> <p>Clarify ulcers</p>	<p>Assessing a Stage 1 skin ulcers /open lesions requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers /open lesions in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the “orange-peel” look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.</p> <p>Coding: Record the number of skin ulcers /open lesions at each stage on the resident’s body, in the last 7 days. If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer /open lesions as Stage “4” until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no skin ulcers /open lesions at a particular stage, record “0” (zero) in the box provided. If there are more than 9 skin ulcers /open lesions at any one stage, enter a “9” in the appropriate box.</p> <p>Clarifications:</p> <ul style="list-style-type: none"> ◆ All problems and lesions present skin ulcers present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or skin ulcers lesions, as observed during the assessment period. ◆ Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The skin ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments). Do not code the debrided skin ulcer as a surgical wound.

			<ul style="list-style-type: none">◆ If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.																				
CH 3	M1	3-161 Clarify example	<p style="text-align: center;">Example</p> <p>Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 pressure ulcer over her sacrum and two Stage 1 pressure ulcers over her heels.</p> <p>Items M1, Ulcers (due to any cause)</p> <table><tr><td>Stage</td><td>Code</td></tr><tr><td>a. 1</td><td>2</td></tr><tr><td>b. 2</td><td>0</td></tr><tr><td>c. 3</td><td>1</td></tr><tr><td>d. 4</td><td>0</td></tr></table> <p>Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds do not meet the criteria provided in Item M1 (Ulcers) coding definitions: Four ulcers are consistent with Stage 2 ulcer staging and one ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers Code the resident's condition as follows:</p> <p>Items M1, Ulcers (due to any cause)</p> <table><tr><td>Stage</td><td>Code</td></tr><tr><td>a. 1</td><td>0</td></tr><tr><td>b. 2</td><td>40</td></tr><tr><td>c. 3</td><td>40</td></tr><tr><td>d. 4</td><td>0</td></tr></table>	Stage	Code	a. 1	2	b. 2	0	c. 3	1	d. 4	0	Stage	Code	a. 1	0	b. 2	40	c. 3	40	d. 4	0
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c. 3	40																						
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CH 3	M2	3-161 Clarify Ulcer types	<p>M2. Type of Ulcer (7-day look back)</p> <p>Intent: To record the highest stage for two types of skin ulcers, Pressure and Stasis, that was present in the last 7 days.</p> <p>Definition: a. Pressure Ulcer - Any lesion skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.</p>																				
CH 3	M2	3-162	<p>b. Stasis Ulcer – An open lesion A skin ulcer, usually in the</p>																				

		Clarify Ulcer types	lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).																										
CH 3		3-164 Clarify examples	<p style="text-align: center;">Example</p> <p>Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.</p> <table><tr><td>Items M1, Ulcers (due to any cause)</td><td>Code (# at stage)</td></tr><tr><td>a. Stage 1</td><td>3</td></tr><tr><td>b. Stage 2</td><td>1</td></tr><tr><td>c. Stage 3</td><td>0</td></tr><tr><td>d. Stage 4</td><td>0</td></tr></table> <table><tr><td>Items M2, Type of Ulcer</td><td>Code (highest stage)</td></tr><tr><td>a. Pressure Ulcer</td><td>2</td></tr><tr><td>b. Stasis Ulcer</td><td>0</td></tr></table> <p>Rationale for coding: Mr. C has 4 pressure ulcers, the Highest stage of which is Stage 2.</p> <p>Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.</p> <table><tr><td>Items M1, Ulcer (due to any cause)</td><td>Code (# at stage)</td></tr><tr><td>a. Stage 1</td><td>0</td></tr><tr><td>b. Stage 2</td><td>0</td></tr><tr><td>c. Stage 3</td><td>1</td></tr><tr><td>d. Stage 4</td><td>0</td></tr></table>	Items M1, Ulcers (due to any cause)	Code (# at stage)	a. Stage 1	3	b. Stage 2	1	c. Stage 3	0	d. Stage 4	0	Items M2, Type of Ulcer	Code (highest stage)	a. Pressure Ulcer	2	b. Stasis Ulcer	0	Items M1, Ulcer (due to any cause)	Code (# at stage)	a. Stage 1	0	b. Stage 2	0	c. Stage 3	1	d. Stage 4	0
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c. Stage 3	1																												
d. Stage 4	0																												

			<p>Items M2, Type of Ulcer</p> <p>a. Pressure ulcer 0</p> <p>b. Stasis ulcer 0</p> <p><i>Rationale for coding:</i> Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.</p>
CH 3	M3 & M4	3-165 Clarify skin ulcer & correct typo	<p>M3. History of Resolved/Cured Ulcers (90 days ago)</p> <p><i>Intent:</i> To determine if the resident previously had an ulcer a skin ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers. The definition of "skin ulcer" for this item is the same as the definition used for item M1.</p> <p>M4. Other Skin Problems or Lesions Present (7-day look back)</p> <p><i>Intent:</i> To document the presence of skin problems, ulcers, or lesions (other than pressure or stasis circulatory skin ulcers) and conditions that are risk factors for more serious problems.</p> <p>c. Open Lesions/Sores Other Than Pressure or Stasis Ulcers, Rashes, Cuts (e.g. cancer lesions) - Code in M4c any open skin lesions/sores that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here.</p> <p>d. Rashes (e.g., intertrigo, exzema eczema, drug rash, heat rash, herpes zoster) - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.</p>

CH 3	M5	3-167 Clarify devices & coding	<p>Definition: a. Pressure Relieving Device(s) for Chair Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.</p> <p>b. Pressure Relieving Device(s) for Bed - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.</p> <p>e. Ulcer Care - Includes any intervention for treating an ulcer at any ulcer stage skin problems coded in M1, M2 and M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.</p>
CH 3	M5	3-167 Page change	<p>g. Application of Dressings (With or Without Topical Medications) Other Than to Feet - Includes dry gauze dressings, dressings moistened with saline</p> <p>[This text has moved to pg. 3-168]</p>
CH 3	P1	3-182 Clarify intent	<p>P1. Special Treatments, Procedures, and Programs</p> <p>Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period. Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post procedure recovery period.</p>
CH 3	P1	3-185 Clarify trained nurse	<p>d. Respiratory Therapy – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining “trained nurse.”) A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice</p>

			act.
CH 3	P3	3-192 Clarify coding	<ul style="list-style-type: none"> This category does not include exercise groups with more than four residents per supervising helper or caregiver. <p>b. Range of Motion (Active) - Exercises performed by a resident, with cueing, or supervision, or physical assist by staff, that are planned, scheduled, and documented in the clinical record. Include active ROM and active assisted ROM. Any participation by the resident in the ROM activity should be coded here. When residents do most of the modality, but need some assistance with the final stretch, it is still considered active range of motion.</p>
CH 3	R2a & R2b	3-211 Clarify signature & date	<p>Intent: Federal regulations at 42 CFR 483.20 (i) (1) and (2) require each individual who completes a portion of the MDS assessment to sign and certify its accuracy in Item AA9. These regulations also require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.</p>
CH 3	R2a & R2b	3-212 Clarify signature & date	<p>Process: Each staff member who completes any portion of the MDS must sign and date (at AA9) the MDS and indicate beside the signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.</p> <p>Coding: All persons completing part of this assessment, including the RN Assessment Coordinator, must sign their names in the appropriate locations at Item AA9. To the right of the name, enter title and the letters that correspond to sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If for some technical reason such as computer or printer breakdown the MDS cannot be signed on the date it is completed, it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the</p>

			<p>discrepancy in the clinical record. Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.</p> <p>◆ The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment." Further, CFR 42 483.20(i)(2) states, "Each individual who completes a portion of the assessment must sign, date and certify the accuracy of that portion of the assessment in Item AA9."</p>
CH 3	T1c	<p>3-216 Clarify time period</p> <p>Clarify physician orders</p>	<p>c. ESTIMATE OF NUMBER OF DAYS (first 14 days †Through day 15)</p> <p>Clarifications:</p> <p>◆ Do not count the evaluation day in the estimate number of days unless treatment is rendered.</p> <p>◆ When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7.</p>
CH 3	T1d	<p>3-216 Clarify time period</p>	<p>d. ESTIMATE OF NUMBER OF MINUTES (first 14 days †Through day 15)</p>

- **Swing bed facilities.** Swing bed hospitals providing Part A skilled nursing facility-level services were phased into the skilled nursing facility prospective payment system (SNF PPS) starting July 1, 2002. Beginning on the first day of each hospital's cost reporting year on and after July 1, 2002, swing bed hospitals must complete a customized two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. A separate Swing Bed MDS Assessment Training Manual has been developed and can be found on the CMS website at:

<http://www.cms.hhs.gov/providers/snfpps/sbtraining.asp>.

Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

1.11 Facility Responsibilities for Completing Assessments

NEWLY CERTIFIED NURSING HOMES

Nursing homes must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed *as if the beds were already certified*. Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 (of the covered Part A stay) when establishing the Assessment Reference Date for the 5-Day Medicare assessments. For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Assuming a survey where the SNF has been determined to be in substantial compliance, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the survey as Day 1.

If the SNF is already certified and is adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

CHANGE IN OWNERSHIP

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment

schedule for existing residents continues, and the facility continues to use the existing provider number. For example, if the Admission assessment was done 10 days prior to the change in

ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the existing provider number.

There are situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases, the beds are no longer certified. Also, there are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Indicators, Quality Measures debts, etc. Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See page 1-16 for information regarding newly certified facilities.

TRANSFERS OF RESIDENTS

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

When there has been a transfer of residents secondary to disasters (flood, earthquake, fire) with an anticipated return to the facility, the evacuating facility should contact their Regional Office, State agency, and Fiscal Intermediary for guidance.

When 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. For questions related to this type of situation, providers should contact their State agency and their Regional Office.

1.12 Completion of the RAI

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations¹ require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical

¹ 42 CFR 483.20 (h)--(F 278)

1.18 Reproduction and Maintenance of the Assessments

Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to which the electronic signature belongs.

While use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically, the guidance language for Clinical Records found in Appendix PP [42 CFR 483.75(1)(1)] notes that facilities have the option for an individual's record to be maintained by computer rather than hard copy. In addition, proper security measures must be implemented via facility policy to ensure the privacy and integrity of the record and to ensure that access to clinical records is made available to surveyors and others who are authorized by law.

Long-term care facilities that are not capable of maintaining MDSs electronically must adhere to the current requirements that either a hand written copy or a computer-generated form must be maintained in the clinical record. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard. In the future, long-term care facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

Unless the provider has exercised the option to maintain electronic MDSs, facilities are required to maintain hard copies of 15 months of assessment data in the resident's active clinical record according to CMS policy. There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged. The information must be kept in a centralized location, accessible to all professional staff members (including consultants) who need to review the information in order to provide care to the resident.

The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is “readmitted,” the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, unless maintaining the MDSs electronically, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, including linking the prior electronic MDS to the new admission record, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission. In cases where the resident returns to the facility after a long break in care (e.g., 14 ½ months), staff may want to review the older record to familiarize them with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirement.

For additional information, refer to Resident Assessment Requirements for Long-Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

the admission was from an acute care hospital, an immediate review of current medications might be warranted since the resident could be at a higher risk for delirium or may be recovering from delirium associated with acute illness, medications or anesthesia. Or, if admission was from home, the resident could be grieving due to losses associated with giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

- Definition:**
1. **Private Home or Apartment** - Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.
 2. **Private Home/Apt. with Home Health Services** - Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.
 3. **Board and Care/Assisted Living/Group Home** - A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.
 4. **Nursing Home** - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled or sick persons. **Include admissions from hospital swing beds here.**
 5. **Acute Care Hospital** - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons.
 6. **Psychiatric Hospital, MR/DD Facility** - A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

x. *NONE OF ABOVE*

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

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

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

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

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

SECTION AD. FACE SHEET SIGNATURES

ADa. Signature of RN Assessment Coordinator

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

5. Medicare Readmission/Return Assessment**6. Other State-Required Assessment****7. Medicare 14-Day Assessment****8. Other Medicare Required Assessment**

Coding: Enter the number corresponding to the assessment code used for the Medicare Prospective Payment System. It is possible to select a code from both AA8a and AA8b (e.g., Item AA8a = coded “3” [Significant Change in Status assessment], and Item AA8b = coded “3” [60-Day assessment]). See Chapter 2, Section 2.6 for details on combining assessments.

If there are two Medicare Reasons for Assessment, i.e., an OMRA combined with a regularly scheduled Medicare assessment, code Item AA8b = 8.

When the Primary Reason for Assessment is “00”, and the Medicare Reason for Assessment is “6” or blank, the record is not edited or stored in the State MDS database. Facilities completing Medicare assessments on a standby basis should code AA8b as 1, 2, 3, 4, 5, or 7 to make sure that the assessments are properly edited and retained in the database.

A9. Responsibility/Legal Guardian

Intent: To record who has responsibility 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. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility’s legal counsel, as appropriate, for additional clarification.

Definition: **a. Legal Guardian** - Someone who has been appointed after a court hearing and is authorized to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, only another court hearing may revoke the decision-making authority of the guardian.

- b. Other Legal Oversight** - 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.
- c. Durable Power of Attorney/Health Care** - 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 agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.
- d. Durable Power of Attorney/Financial** - Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.
- e. Family Member Responsible** - Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.
- f. Resident Responsible for Self** - 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.
- g. NONE OF ABOVE**

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

Coding: Check all that apply.

A10. Advanced Directives

Intent: To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any

- e. **Locomotion On Unit** - How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a wheelchair, locomotion is defined as self-sufficiency once in the chair.
- f. **Locomotion Off Unit** - How the resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in a wheelchair, locomotion is defined as self-sufficiency once in chair.
- g. **Dressing** - How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas, and housedresses.
- h. **Eating** - How the resident eats and drinks, regardless of skill. **Do not include eating/drinking during medication pass.** Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

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

- i. **Toilet Use** - How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.
- j. **Personal Hygiene** - How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

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

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

Self-Performance - INDEPENDENT

ADLs - SELF-PERFORMANCE	INDEPENDENT
Bed Mobility	<p>Mrs. D can easily turn and position her in bed and is able to sit up and lie down without any staff assistance. She requires use of a single side rail that staff place in the up position when she is in bed.</p> <p><i>Self Performance = 0 Support Provided = 1</i></p> <p><i>Coding rationale: Resident is independent in set-up help only.</i></p>
Transfer	<p>When transferring to her chair, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk over to her reclining chair.</p> <p><i>Self Performance = 0 Support Provided = 0</i></p> <p><i>Coding rationale: Resident is independent.</i></p>
Eating	<p>After staff delivered a lunch tray to Mr. K, he is able to consume all food and fluids without any cueing or physical help from staff.</p> <p><i>Self Performance = 0 Support Provided = 0</i></p> <p><i>Coding rationale: Resident is independent.</i></p>
Toilet Use	<p>Mrs. L was able to transfer herself to the toilet, adjust her clothing, and perform the necessary personal hygiene after using the toilet without any staff assistance.</p> <p><i>Self Performance = 0 Support Provided = 0</i></p> <p><i>Coding rationale: Resident is independent.</i></p>
Walk in Room	<p>Mr. R is able to walk freely in his room (obtaining clothes from closet, turning on T.V.) without any cueing or physical assistance from staff.</p> <p><i>Self Performance = 0 Support Provided = 0</i></p> <p><i>Coding rationale: Resident is independent.</i></p>
Walk in Corridor	<p>After receiving a new cane, Mr. X needed to be observed the first time he used it as he walked up and down the hall on his unit to insure that he appropriately used the cane. He does not require any additional staff assistance.</p> <p><i>Self Performance = 0 Support Provided = 0</i></p> <p><i>Coding rationale: Resident requires no set up to complete task independently.</i></p>

Self-Performance – SUPERVISION

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

Self Performance - Limited Assistance

ADLs - SELF-PERFORMANCE	LIMITED ASSISTANCE
Bed Mobility	Resident favors laying on right side. Since she has had a history of skin breakdown, staff must sometimes help the resident place her hands on the side rail and encourage her to change her position when in bed. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires cuing and encouragement with set up or minor physical help.</i>
Transfer	Mrs. H is able to transfer from the bed to chair when she uses her walker. Staff places the walker near her bed and then help to steady the resident as she transfers. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires staff to set up her walker and provide help when she is ready to transfer.</i>
Eating	Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner, as he is tired and less interested in completing his meals. In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist in guiding his hand in order to get the utensil to his mouth. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: is unable to complete the meal without staff providing him non-weight-bearing assistance (3 or more times in the observation period).</i>
Toilet Use	Staff must assist Mr. P to zip pants, hand him a washcloth and remind him to wash his hands after using the toilet. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires staff to perform non-weight bearing activities to complete the task.</i>
Walk in Room	Mr. K is able to walk in his room, but requires that a staff member place her arm around his waist when taking him to the bathroom due to his unsteady gait. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires non-weight bearing assistance for safe ambulation.</i>
Walk in Corridor	Mrs. Q requires continual verbal cueing and help with hand placement when walking down the unit hallway. Mrs. Q needs frequent reminders how to use her walker, where to place her hands and to pick up feet. She frequently needs to be physically guided to the day room. <i>Self Performance = 2 Support Provided = 2</i> <i>Coding rationale: Resident requires non-weight bearing assistance for safe ambulation.</i>

This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

- 3. Not Able to Attempt Test Without Physical Help** - Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to “sit up in the chair without leaning on the chair back or arms for support.” You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

How to proceed: Tell Ms. Z, “You did an excellent job. That’s all we have to do.” STOP testing. The test is complete.

Coding: “0”, Maintained position as required in test.

G4. Limitation in Range of Motion (7-day look back)

(A) Limitation in Range of Motion (ROM).

Intent: **Limitation in the Range of Motion:** To record the presence of (A) limitation in range of joint motion or (B) loss of voluntary movement.

Definition: **Functional** limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

Process: **Assessing for Limitations:** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g., recent fracture or joint replacement).
- Perform each test on both sides of the resident's body.
- Depending on the resident's cognitive level, use the direction most appropriate for assessing limitations in ROM such as:
 - Ask the resident to follow your verbal instructions for each movement.
 - Demonstrate each movement (e.g., Ask the resident to do what you are doing).
 - Actively assist the resident with ROM exercises.

In active assisted exercises, the assessor will guide the resident's joints through the movements while providing support and direction with each activity. If resistance is met during the exercises stop immediately and use staff observations during the assessment period to determine the ability and/or limitations to ROM activity.

- Staff observations of the ROM activity can be used to determine whether or not a resident can actually perform the activity, regardless of whether or not the movement was "on command," provided the movement fits the criteria specified below and occurred during the assessment period of observation.
- STOP if a resident experiences pain.
- a. **Neck** - With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, and then left ear towards left shoulder.
- b. **Arm** - including shoulder or elbow - With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.
- c. **Hand** - including wrist or fingers - For each hand, instruct the resident to make a fist, and then open the hand (useful actions for grasping utensils, letting go).

- d. **Leg** - including hip or knee - While resident is lying supine in a flat bed instruct the resident to lift his or her leg (one at a time), bending it at the knee. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and extend it flat on the mattress.
- e. **Foot** - including ankle or toes - While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot.
- f. **Other Limitation or Loss** - Decreased mobility in spine, jaw, or other joints that are not listed.

Coding: For each body part, code the appropriate response for the resident's active (or active assisted) range of motion during the past seven days. The process of determining the coding for G4(A) is a 2-step process. First, determine if there is a limitation in active or active assisted ROM. If "no," code "0." If "yes," then go to the next question: Does the limitation in ROM interfere with function or place the resident at risk for injury? If "no," code "0." If "yes," code either "1" or "2." If the resident is unable to assist with ROM at all, consider that body part as limited. Enter the code in the column labeled (A). If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.

- 0. **No limitation** - Resident has full function range of motion on the right and left side.
- 1. **Limitation on One Side of the Body (Either Right or Left Side)** - that interferes with daily functioning or places the resident at risk of injury.
- 2. **Limitation on Both Sides of the Body** - that interferes with daily functioning or places the resident at risk of injury.

**Example of Coding for
(A) Limitation in Range of Motion**

Mr. O was admitted to the nursing facility for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

Coding (A)

Neck	0
Arm	0
Hand	0
Leg	1
Foot	0
Other	0

Example of Functional Limitation

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

Coding

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

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

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

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

- Definition:**
- a. **Cane/Walker/Crutch** - Also check this item in those instances where the resident walks by pushing a wheelchair for support, or uses an enclosed four-wheeled walker with/without a posterior seat and lap cushion.
 - b. **Wheeled Self** - Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.
 - c. **Other Person Wheeled** - Another person pushed the resident in a wheelchair.
 - d. **Wheelchair Primary Mode of Locomotion** - Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.
 - e. **NONE OF ABOVE** (is not used on the MPAF)

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

SECTION J. HEALTH CONDITIONS

J1. Problem Conditions (7-day look back)

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.

INDICATORS OF FLUID STATUS

- Definition:**
- a. **Weight Gain or Loss of 3 or More Pounds Within a 7-Day Period** - This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent **weights**, and for these residents you will be unable to determine if there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.
 - b. **Inability to Lie Flat Due to Shortness of Breath** - Resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air (orthopnea). This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check Item J11, "Shortness of breath." If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up), do not check Item J11.
 - c. **Dehydrated; Output Exceeds Intake** - Check this item if the resident has 2 or more of the following indicators.
 - 1. Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups). Note: The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.
 - 2. Resident has **one or more** clinical signs of dehydration, **including but not limited to** dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).
 - 3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

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

d. **NONE OF ABOVE**

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

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

K5. Nutritional Approaches (7-day look back)

Definition: a. Parenteral/Intravenous (IV) Include only fluids administered for **nutrition or hydration**, such as:

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids administered via heparin locks
- IV fluids contained in IV Piggybacks
- IV fluids used to reconstitute medications for IV administration

Do NOT include:

- IV medications
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- IV fluids administered solely as flushes
- Parenteral/IV fluids administered during chemotherapy or dialysis

For coding IV medications, see page 3-182

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

- c. **Mechanically Altered Diet** - A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below. **Enteral feeding formulas are not coded here.**
- d. **Syringe (Oral Feeding)** - Use of syringe to deliver liquid or pureed nourishment directly into the mouth. All efforts should be made to utilize other feeding methods (e.g., rubber tipped spoon) as this can result in lowered resident dignity.
- e. **Therapeutic Diet** - A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals. **Code enteral feeding formulas here when they meet this definition.**
- f. **Dietary Supplement Between Meals** - Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.
- g. **Plate Guard, Stabilized Built-Up Utensils, Etc.** - Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.
- h. **On Planned Weight Change Program** - Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).
- i. **NONE OF ABOVE** (*Not Used on the MPAF*)

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

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

K6. Parenteral or Enteral Intake (7-day look back) Skip to Section L on the MDS if neither Item K5a nor K5b is checked.

Intent: To record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last seven days.

a. PROPORTION OF TOTAL CALORIES

Definition: **Proportion of Total Calories Received** - The proportion of all calories ingested during the last seven days that the resident **actually received** (not ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the best response:

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

SECTION M.

SKIN CONDITION

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

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

M1. Ulcers (7-day look back)

Intent: To record the number of **skin** ulcers, at each ulcer stage, on any part of the body.

Definition: **For coding in this section,** a skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Skin ulcers that develop because of circulatory problems **or pressure** are coded in item M1. Rashes without open areas, burns, desensitized skin, **ulcers related to diseases such as syphilis and cancer,** and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.

- a. Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- b. Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater.
- c. Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- d. Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

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

Assessing a Stage 1 skin ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the “orange-peel” look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: Record the number of skin ulcers at each stage on the resident’s body, in the last 7 days. If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage “4” until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no skin ulcers at a particular stage, record “0” (zero) in the box provided. If there are more than 9 skin ulcers at any one stage, enter a “9” in the appropriate box.

- Clarifications:** ♦ All skin ulcers present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of skin ulcers, as observed during the assessment period.
- ♦ Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The skin ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments). Do not code the debrided skin ulcer as a surgical wound.
 - ♦ If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 pressure ulcer over her sacrum and two Stage 1 pressure ulcers over her heels.

Items M1, Ulcers

Stage	Code
a. 1	2
b. 2	0
c. 3	1
d. 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds **do not** meet the criteria provided in Item M1 (Ulcers) coding definitions. Code the resident's condition as follows:

Items M1, Ulcers

Stage	Code
a. 1	0
b. 2	0
c. 3	0
d. 4	0

Items M2, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4, Other Skin Problems or Lesions Present:

Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 and M6, (Foot Problems and Care) as appropriate.

M2. Type of Ulcer (7-day look back)

Intent: To record the highest stage for two types of **skin** ulcers, Pressure and Stasis, that was present in the last 7 days.

Definition: a. **Pressure Ulcer** - Any **skin ulcer** caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

- b. **Stasis Ulcer** - A skin ulcer, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1 may not necessarily be recorded in Item M2 (see last example below).

More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at:

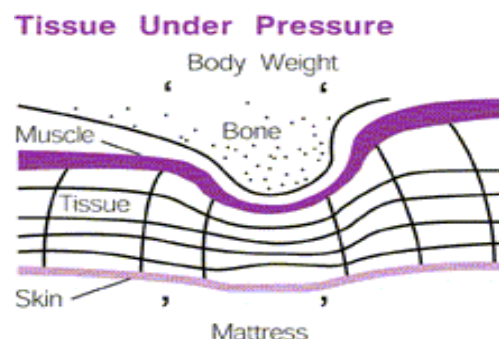
<http://www.ahrq.gov/consumer/bodysys/edbody6.htm>.

What are Pressure Ulcers?

A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



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

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1, Ulcers	Code (# at stage)
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure Ulcer	2
b. Stasis Ulcer	0

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

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

Items M1, Ulcer	Code (# at Stage)
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0
Items M2, Type of Ulcer	Code (highest stage)
a. Pressure ulcer	0
b. Stasis ulcer	0

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

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

Intent: To determine if the resident previously had a skin ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers. The definition of “skin ulcer” for this item is the same as the definition used for item M1.

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

Coding: Code “0” for No or “1” for Yes.

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

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

- Definition:**
- a. **Abrasions, Bruises** - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.
 - b. **Burns (Second or Third Degree)** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).
 - c. **Open Lesions/Sores (e.g., cancer lesions)** - Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here.
 - d. **Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)** - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.
 - e. **Skin Desensitized to Pain or Pressure** - The resident is unable to perceive sensations of pain or pressure.

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

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

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

M5. Skin Treatments (7-day look back)

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

- Definition:**
- a. **Pressure Relieving Device(s) for Chair** - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.
 - b. **Pressure Relieving Device(s) for Bed** - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.
 - c. **Turning/Repositioning Program** - Includes a continuous, consistent program for changing the resident's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored, and evaluated."
 - d. **Nutrition or Hydration Intervention to Manage Skin Problems** - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to manage a potential or active skin problem, should be coded here.
 - e. **Ulcer Care** - Includes any intervention for treating skin problems coded in M1, M2, and M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.
 - f. **Surgical Wound Care** - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

- g. Application of Dressings (With or Without Topical Medications) Other Than to Feet** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.
- h. Application of Ointments/Medications (Other Than to Feet)** - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).
- i. Other Preventative or Protective Skin Care (Other Than to Feet)** - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).
- j. NONE OF ABOVE**

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

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

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

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

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

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

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

SECTION P.

SPECIAL TREATMENTS AND PROCEDURES

P1. Special Treatments, Procedures, and Programs

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

a. SPECIAL CARE (14-day look back)

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

- Definition:**
- a. **Chemotherapy** - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The resident is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
 - b. **Dialysis** - Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).
 - c. **IV Medication** - Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy.

b. THERAPIES (7-day look back)

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

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

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

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

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

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

d. **Respiratory Therapy** – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident. (See clarification below defining “trained nurse.”) A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act.

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

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

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
 - Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
 - Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
 - These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
 - This category does not include groups with more than four residents per supervising helper or caregiver.
- a. **Range of Motion (Passive)** - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. A program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance. These exercises must be planned, scheduled, and documented in the clinical record. Helping a resident get dressed does not, in and of itself, constitute a range of motion exercise session.
- b. **Range of Motion (Active)** - Exercises performed by a resident, with cueing, supervision or physical assist by staff, that are planned, scheduled, and documented in the clinical record. Include active ROM and active assisted ROM. Any participation by the resident in the ROM activity should be coded here.
- c. **Splint or Brace Assistance** - Assistance can be of 2 types: 1) where staff provides verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff

Asking family members about their expectations of the nursing facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate nonverbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

Coding:

- a. **Resident** - Enter zero "0" for No or "1" for Yes to indicate whether or not the resident participated in the assessment. This item should be completed last.
- b. **Family** - Enter zero "0" for No or "1" for Yes to indicate whether or not the family participated; enter "2" for No family.
- c. **Significant Other** - Enter "0" for No or "1" for Yes to indicate whether or not a significant other participated; enter "2" for None if there is no significant other.

R2a. and b.

Signatures of Persons Coordinating the Assessment

Intent:

Federal regulations at 42 CFR 483.20 (i) (1) and (2) require the RN Assessment Coordinator to sign, date and certify that the assessment is complete in Items R2a and R2b.

Process: The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding: Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed, even if it is after the resident's date of discharge. If for some reason the MDS cannot be signed on the date it is completed it is appropriate to use the actual date that it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record. Backdating R2b on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.

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

- ♦ The text of the regulation CFR 42 483.20(i)(1)(ii) states, "Each assessment must be conducted or coordinated by a registered nurse who signs and certifies the completion of the assessment."

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

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

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

c. ESTIMATE OF NUMBER OF DAYS (Through day 15)

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

Clarifications: ♦ Do not count the evaluation day in the estimate number of days unless treatment is rendered.

♦ When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in T1c will be 7.

d. ESTIMATE OF NUMBER OF MINUTES (Through day 15)

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

Clarification: ♦ Do not include evaluation minutes in the estimate of number of minutes.