



**Minimum Data Set (MDS) 3.0
Instructor Guide**

Section J Health Conditions

Objectives

- State the intent of Section J.
- Identify health conditions assessed in Section J that affect a resident's functional status and quality of life.
- Describe how to conduct the Pain Assessment interview.
- Describe how to conduct the assessment for other health conditions including history of falls, shortness of breath, and tobacco use.
- Code Section J correctly and accurately.

Methodology

This lesson uses lecture, scenario-based examples and practice problems, and a video-based activity.

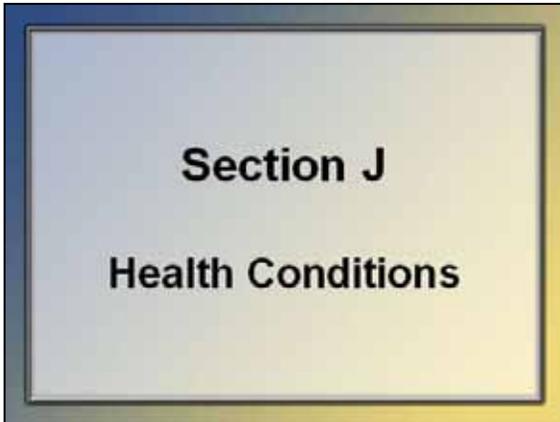
Training Resources

- Instructor Guide
- Slides 1 – 162
- Video: Pain Assessment Interview

Instructor Preparation

- Review the Instructor Guide.
- Review learning objectives for the lesson.
- Rehearse with slide presentation.

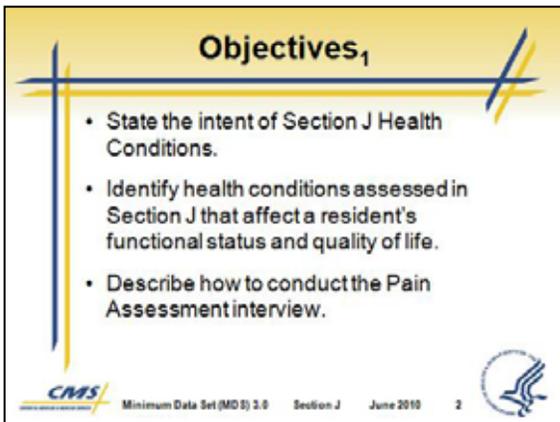
SLIDES	INSTRUCTIONAL GUIDANCE
<p style="text-align: center;">Instructor Notes</p> <p>Direct participants to turn to Section J in the MDS 3.0 instrument.</p> <p style="text-align: center;">Instructor Notes</p>	



Slide 1

I. Introduction/ Objectives

- A. Section J addresses various conditions that impact a resident’s quality of life.
- B. A key component of this section is an interview-based assessment for pain.



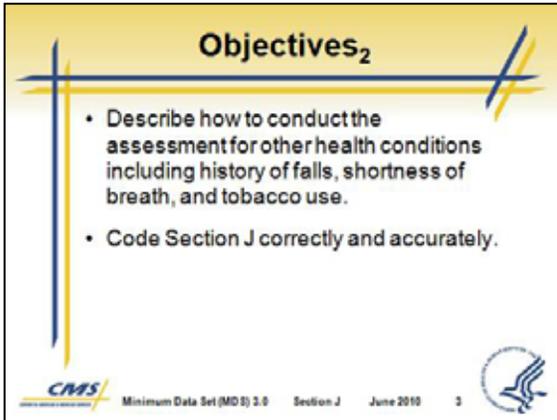
Slide 2

C. Objectives

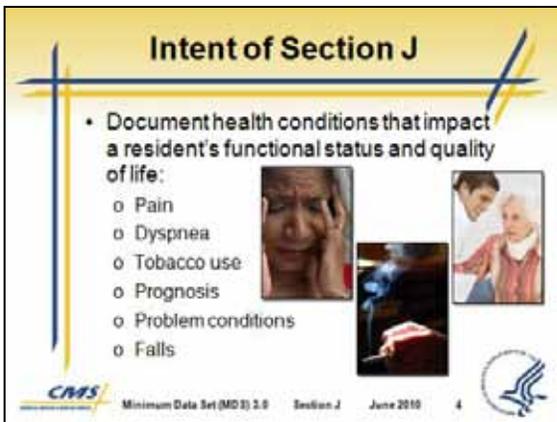
- State the intent of Section J.
- Identify health conditions assessed in Section J that affect a resident’s functional status and quality of life.
- Describe how to conduct the Pain Assessment interview.

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Slide 3



Slide 4



Slide 5

- Describe how to conduct the assessment for other health conditions including history of falls, shortness of breath, and tobacco use.
- Code Section J correctly and accurately.

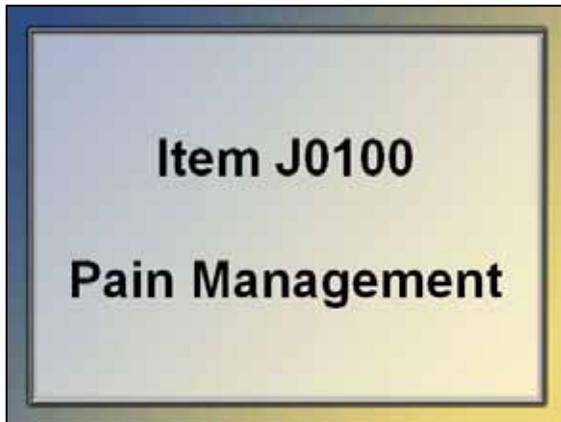
D. Intent of Section J

1. Document health conditions that impact a resident's functional status and quality of life:
 - a. Pain
 - b. Dyspnea
 - c. Tobacco use
 - d. Prognosis
 - e. Problem conditions
 - f. Falls

E. Pain Assessment

1. The pain assessment now consists of an interview with resident.
2. Conduct a staff assessment only if resident is unable to participate in the interview.
3. Pain items assess:
 - a. Presence of pain
 - b. Frequency of pain
 - c. Effect on function
 - d. Intensity
 - e. Management
 - f. Control

SLIDES



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INSTRUCTIONAL GUIDANCE

II. Item J0100 Pain Management

- A. Section J begins with a determination of any pain management regimen a resident may be receiving.
1. J0100 consists of three items that document what type of pain interventions provided to the resident during the look-back period.
 2. J0100 is required for all residents regardless of his or her current pain level.

Instructor Notes

Pain Medication Regimen

Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections, or intraspinal delivery.

This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

Instructor Notes



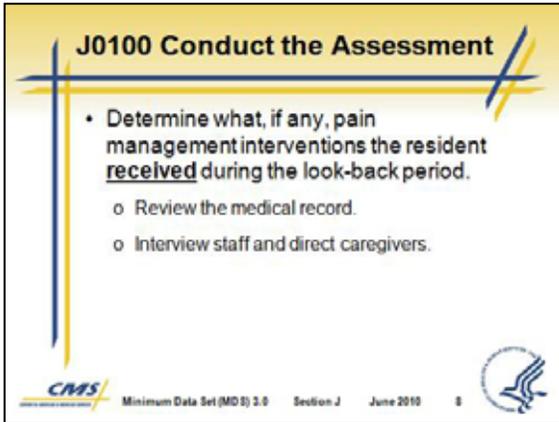
Slide 7

B. J0100 Importance

1. Pain can cause suffering and is associated with:
 - Inactivity
 - Social withdrawal
 - Depressed mood
 - Functional decline
2. Pain can interfere with participation in rehabilitation.
3. Effective pain management interventions can help to avoid these adverse outcomes.

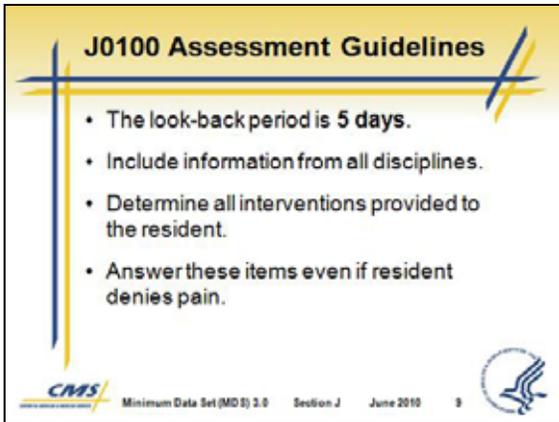
SLIDES

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- C. J0100 Conduct the Assessment
1. Determine what, if any, pain management interventions the resident **received** during the look-back period.
 - a. Review the medical record.
 - b. Interview staff and direct caregivers.



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- D. J0100 Assessment Guidelines
1. Determine what, if any, pain management interventions the resident **received** during the look-back period.
 - a. Review the medical record.
 - b. Interview staff and direct caregivers.
 2. The look-back period is **5 days**.
 3. Include information from all disciplines.
 4. Determine all interventions for pain provided to the resident during the look-back period.
 5. Answer these items even if the resident currently denies pain.



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- E. J0100A Scheduled Pain Medication Regimen Coding Instructions
- **Code 0. No.**
 If the medical record does not contain documentation that a scheduled pain medication was received
 - **Code 1. Yes.**
 If medical record contains documentation that a scheduled pain medication was received

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Instructor Notes

Notes

Scheduled Pain Medication Regimen

Pain medication order that defines dose and specific time interval for pain medication administration. For example, “once a day” or “every 12 hours.”

Notes

Instructor Notes



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F. J0100B Received PRN Pain Medications Coding Instructions

1. Code 0. No.

If record does not contain documentation that a PRN medication was received or offered

2. Code 1. Yes.

If record contains documentation that a PRN medication was either received OR offered but was declined

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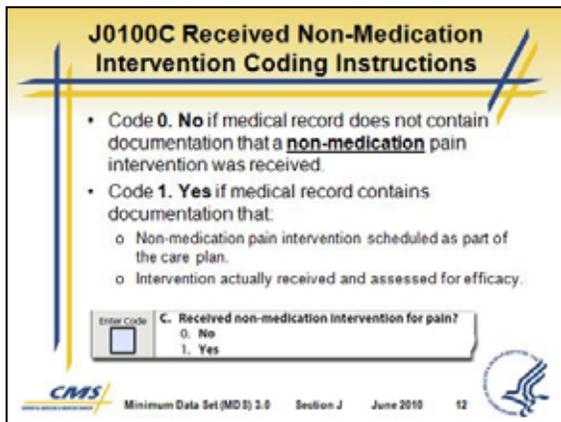
Notes

PRN Pain Medications

Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as “every 4 hours as needed for pain” or “every 6 hours as needed for pain.”

Notes

Instructor Notes



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G. J0100C Received Non-Medications Intervention Coding Instructions

Code 0. No.

If the medical record does not contain documentation that a non-medication pain intervention was received

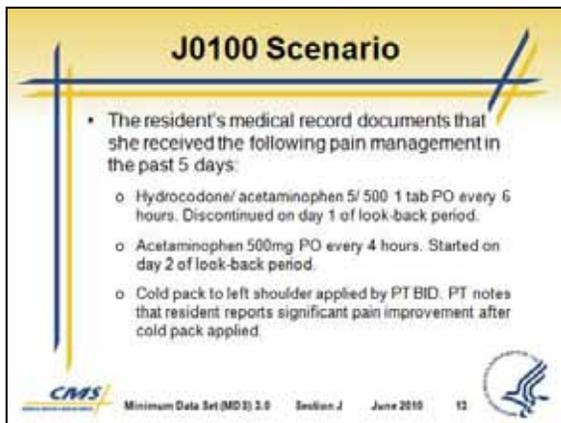
Code 1. Yes.

If medical record contains documentation that:

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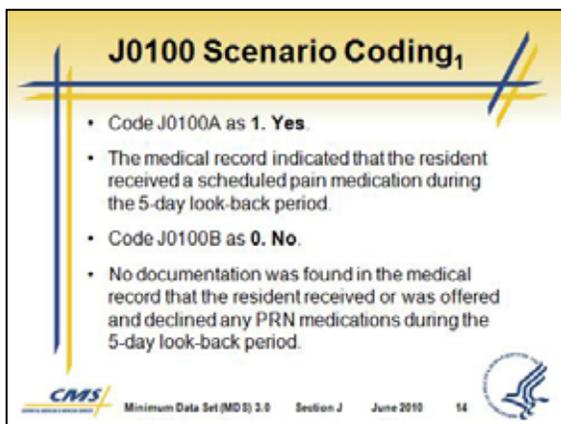
- a. Non-medication pain intervention was scheduled as part of the care plan.
- b. It is documented that the intervention was actually received and assessed for efficacy.



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H. J0100 Scenario

1. The resident's medical record documents that she received the following pain management in the past 5 days:
 - a. Hydrocodone/ acetaminophen 5/ 500 1 tab PO every 6 hours. Discontinued on day 1 of look-back period.
 - b. Acetaminophen 500mg PO every 4 hours. Started on day 2 of look-back period.



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I. J0100 Scenario Coding

1. Code J0100A as **1. Yes**.
2. The medical record indicated that the resident received a scheduled pain medication during the 5-day look-back period.
3. Code J0100B as **0. No**.
4. No documentation was found in the medical record that the resident received or was offered and declined any PRN medications during the 5-day look-back period.

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J0100 Scenario Coding₂

- Code J0100C as **1. Yes.**
- The medical record indicates that the resident received scheduled non-medication pain intervention (cold pack to the left shoulder) during the 5-day look-back period.

J0100, Pain Management - Complete for all residents, regardless of current pain level.
At any time in the last 5 days, has the resident:

Enter Code: 1
Enter Code: 0
Enter Code: 1

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J0100 Pain Management Practice

- The resident's medical record includes the following pain management documentation:
 - MS-Contin (morphine sulfate controlled-release) 15 mg PO Q 12 hours.
- Resident refused every dose of medication during the 5-day look-back period.
- No other pain management interventions were documented.

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How should J0100A be coded?

A. Code 0. No.
B. Code 1. Yes.

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5. Code J0100C as **1. Yes.**
6. The medical record indicates that the resident received scheduled non-medication pain intervention (cold pack to the left shoulder) during the 5-day look-back period.

Point out coding for this scenario in the graphic.

J. J0100 Pain Management Practice

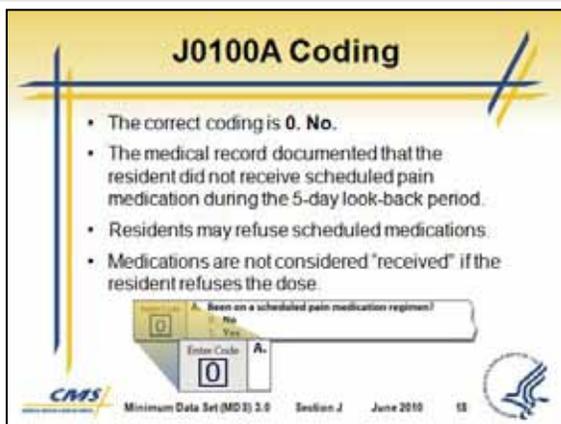
1. The resident's medical record includes the following pain management documentation:
 - a. Morphine sulfate controlled-release 15 mg PO Q 12 hours.
2. Resident refused every dose of medication during the 5-day look-back period.
3. No other pain management interventions were documented.

Refer students to the MDS instrument provided to code each item.

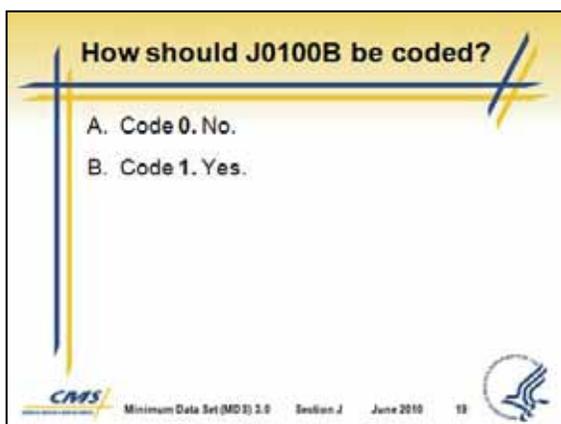
4. How should J0100A be coded?
 - a. Correct answer is A. **Code 0. No.**

SLIDES

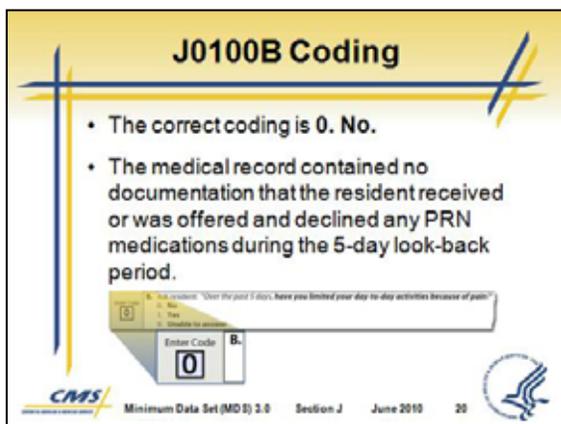
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5. J0100A Coding
 - a. The correct coding is **0. No.**
 - b. The medical record documented that the resident did not receive scheduled pain medication during the 5-day look-back period.
 - c. Residents may refuse scheduled medications.
 - d. Medications are not considered “received” if the resident refuses the dose.

6. How should J0100B be coded?
 - a. Correct answer is A. Code **0. No.**

7. J0100B Coding
 - a. The correct coding is **0. No.**
 - b. The medical record contained no documentation that the resident received or was offered and declined any PRN medications during the 5-day look-back period.

SLIDES

How should J0100C be coded?

- A. Code 0. No.
- B. Code 1. Yes.

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J0100C Coding

- The correct coding is 0. No.
- The medical record contains no documentation that the resident received non-medication pain intervention during the 5-day look-back period.

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Item J0200

Should Pain Assessment Interview Be Conducted?

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8. How should J0100C be coded?
 - a. Correct answer is A. Code **0. No.**

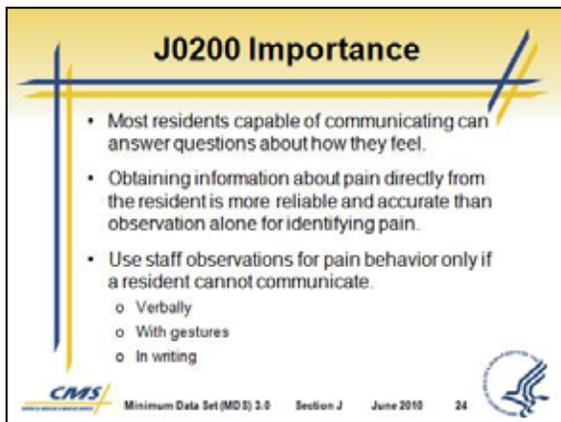
9. J0100C Coding
 - a. Correct answer is A. Code **0. No.**
 - b. The medical record contains no documentation that the resident received non-medication pain intervention during the 5-day look-back period.

III. J0200 Should Pain Assessment Interview Be Conducted?

- A. This item documents whether the pain assessment interview should be conducted.

SLIDES

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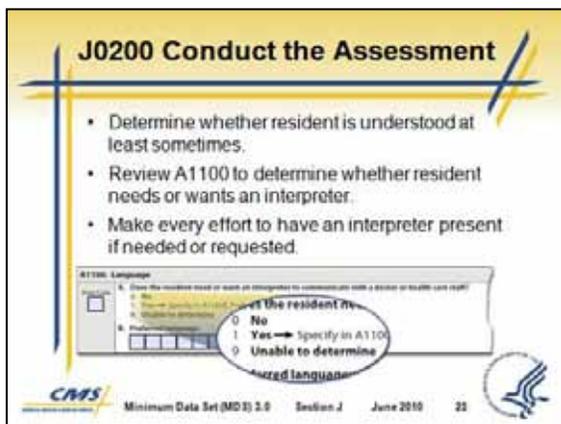


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B. J0200 Importance

1. Most residents capable of communicating can answer questions about how they feel.
 - a. Obtaining information about pain directly from the resident is more reliable and accurate than observation alone for identifying pain.
 - b. Use staff observations for pain behavior only if a resident cannot communicate.
 - Verbally
 - With gestures
 - In writing

Emphasize not to rely on verbal communication only.



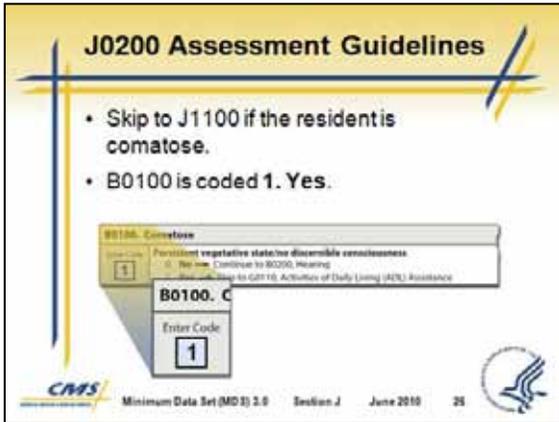
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C. J0200 Conduct the Assessment

1. Most residents can complete the interview.
2. Determine whether the resident is understood at least sometimes.
3. Review the Language item (A1100) to determine whether the resident needs or wants an interpreter.
4. If an interpreter is needed or requested, every effort should be made to have an interpreter present for the MDS clinical interview.

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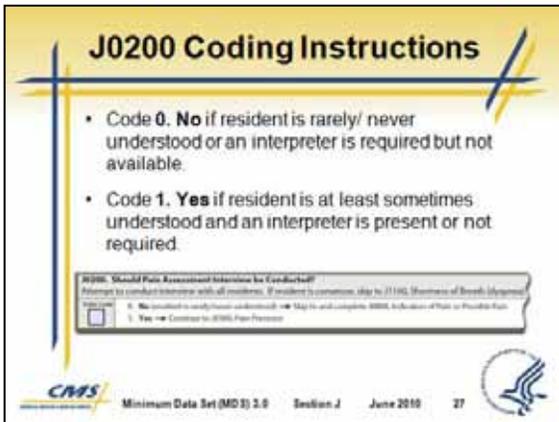
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D. J0200 Assessment Guidelines

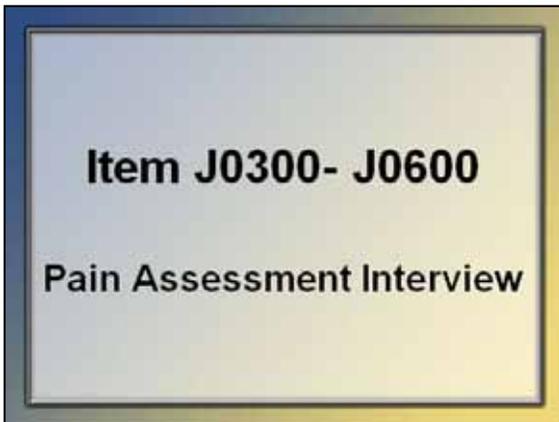
1. Skip to J1100 if the resident is comatose.
2. B0100 is coded **1. Yes.**



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E. J0200 Coding Instructions

- **Code 0. No.**
If resident is rarely/ never understood or an interpreter is required but not available
Skip to Indicators of Pain or Possible Pain item (J0800).
- **Code 1. Yes.**
If resident is at least sometimes understood and an interpreter is present or not required
Continue to Pain Presence item (J0300).



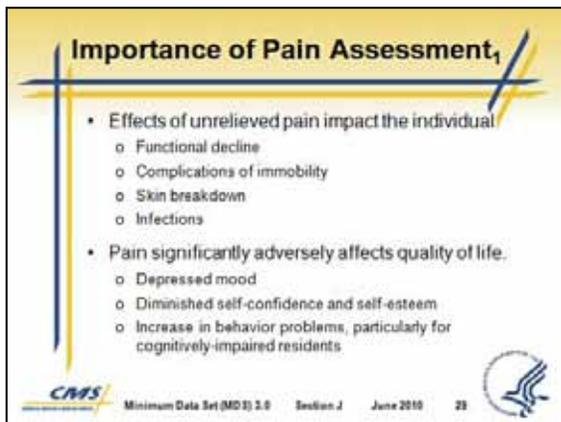
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IV. J0300 – J0600 Pain Assessment Interview

- A. The pain assessment interview consists of four items that address multiple aspects of the effect of pain.

SLIDES

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- B. Importance of Pain Assessment**
1. Effects of unrelieved pain impact the individual.
 - a. Functional decline
 - b. Complications of immobility
 - c. Skin breakdown
 - d. Infections
 2. Pain significantly adversely affects quality of life.
 - a. Depressed mood
 - b. Diminished self-confidence and self-esteem
 - c. Increase in behavior problems, particularly for cognitively-impaired residents
 3. Some older adults limit their activities in order to avoid having pain.
 4. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.



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Instructor Notes

Pain

Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.

Instructor Notes

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Pain Assessment Interview

- Interview any resident not screened out by J0200.
- The interview consists of 4 questions.
- Begins with the primary question.
 - J0300 Pain Presence
- Includes 3 follow-up items.
 - J0400 Pain Frequency
 - J0500 Pain Effect on Function
 - J0600 Pain Intensity

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C. Pain Assessment Interview

1. Interview any resident not screened out by J0200.
2. The interview consists of 4 items.
3. The interview begins with the primary question asked of all residents completing the interview.
 - a. J0300 Pain Presence
4. The interview then includes 3 follow-up items for any resident reporting pain.
 - a. J0400 Pain Frequency
 - b. J0500 Pain Effect on Function
 - c. J0600 Pain Intensity

D. Pain Assessment Interview Guidelines

1. The look-back period for all pain interview items is **5 days**.
2. Conduct the interview close to the end of the look-back period.
 - a. This should more accurately capture pain episodes that occur during the 5-day look-back period
3. Ask each question in order and as written in the item set.
4. Code **9** if the resident refuses to answer a question and move on to the next question.
5. The interview is complete if the resident answers “No” to J0300 Pain Presence, indicating the resident has not experienced pain or hurting during the look-back period.

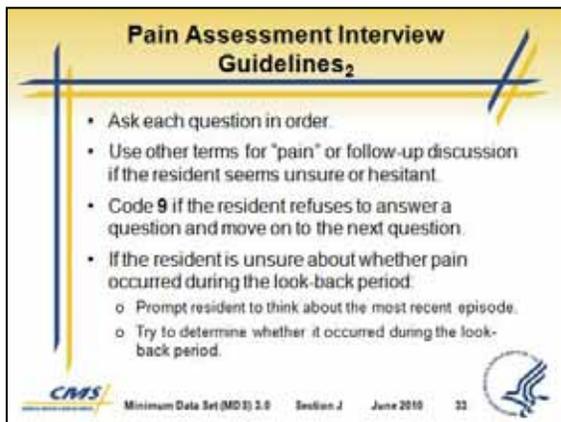
Pain Assessment Interview Guidelines₁

- The look-back period for all pain interview items is **5 days**.
- Conduct the interview close to the end of the 5-day look-back period.
- Skip to the Staff Assessment if the resident is unable to answer J0300 Pain Presence.
- Stop the interview and skip to the Staff Assessment if the resident is unable to answer J0400 Pain Frequency.

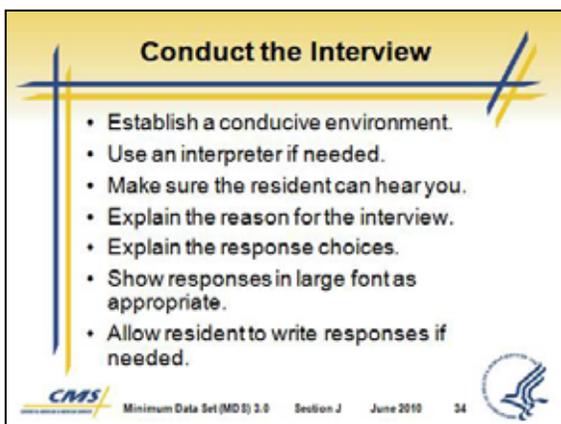
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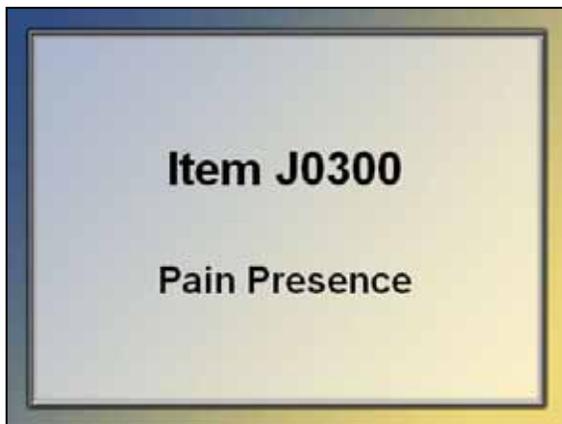
6. If the resident is unsure about whether pain occurred during the look-back period:
 - a. Prompt resident to think about the most recent episode.
 - b. Try to determine whether it occurred during the look-back period.
7. Use other terms for “pain” or follow-up discussion if the resident seems unsure or hesitant.
8. Skip to the Staff Assessment if the resident is unable to answer or does not respond to J0300 Pain Presence.

E. Conduct the Interview

1. Conduct this interview similar to other interviews.
2. Establish an environment conducive for an interview.
 - a. Private setting
 - b. Positioning (make sure the resident can see your face)
 - c. Minimize glare from light sources
3. Determine if interpretive language services are needed,
 - a. If so, provide per facility policy.
4. Make sure the resident can hear you.
 - a. Residents with hearing impairment should be interviewed using their usual communication devices/ techniques, as applicable.

SLIDES	INSTRUCTIONAL GUIDANCE
	<ul style="list-style-type: none"> b. Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability. c. Minimize background noise. <ol style="list-style-type: none"> 5. Give an introduction to start the interview. 6. Explain the response choices for each item in the pain interview. 7. Show responses in large font (such as cue cards) as appropriate. 8. Allow resident to write responses if needed.

Instructor Notes	
Notes	<p>Suggested Language to Introduce the Interview</p> <p>“I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.”</p>
Instructor Notes	



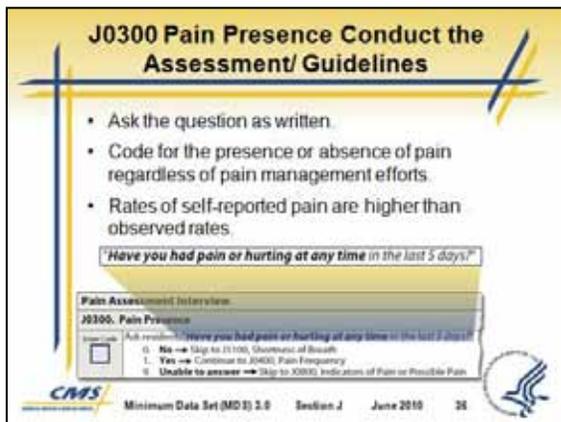
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V. J0300 Pain Presence

- A. The pain assessment interview begins with a determination of whether pain is present.

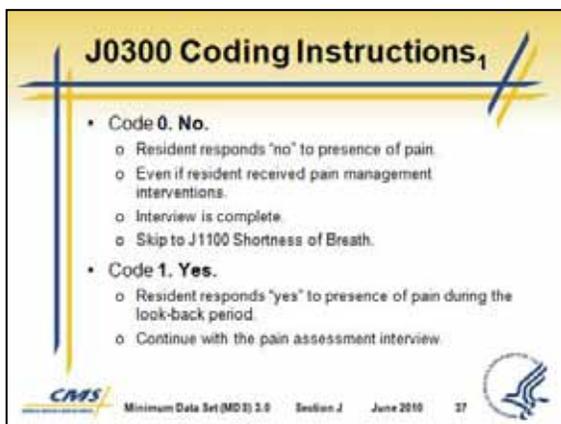
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- B. J0300 Pain Presence Conduct the Assessment and Assessment Guidelines
1. Code for the presence or absence of pain regardless of pain management efforts during the 5-day look-back period.
 2. Code “No” for the presence of pain even if the reason for no pain is that the resident received pain management interventions.
 3. Rates of self-reported pain are higher than observed rates.
 4. Although some observers have expressed concern that residents may not complain and may deny pain, the regular and objective use of self-report pain scales enhances residents’ willingness to report.



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- C. J0300 Coding Instructions
- **Code 0. No.**
If the resident responds “no” to any pain in the 5-day look-back period
Code 0. No even if the reason for no pain is that the resident received pain management interventions.
If coded **0**, the pain interview is complete.
Skip to Shortness of Breath item (J1100).

Emphasize skip pattern here.

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J0300 Coding Instructions₂

- **Code 9. Unable to answer.**
 - Is unable to answer.
 - Does not respond.
 - Gives a nonsensical response.
- Skip to the Staff Assessment for Pain (J0800).

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J0300 Scenario

- When asked about pain, Mrs. S. responds, "No. I have been taking the pain medication regularly, so fortunately I have had no pain."

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- **Code 1.Yes.**

If the resident responds "yes" to pain at any time during the look-back period

If coded **1**, proceed to items J0400, J0500, J0600, and J0700.

- **Code 9 Unable to answer.**

If the resident is unable to answer, does not respond, or gives a nonsensical response

Skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).

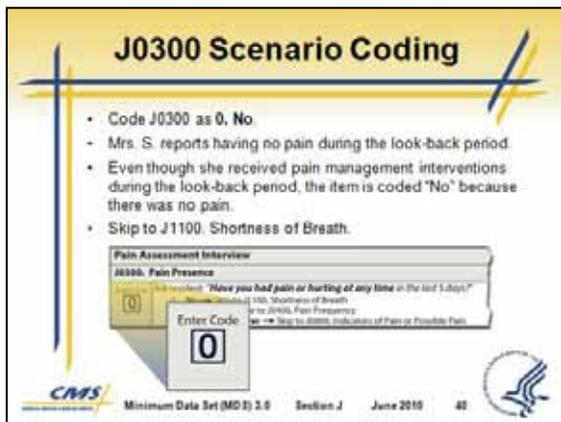
Emphasize skip pattern here.

D. J0300 Scenario

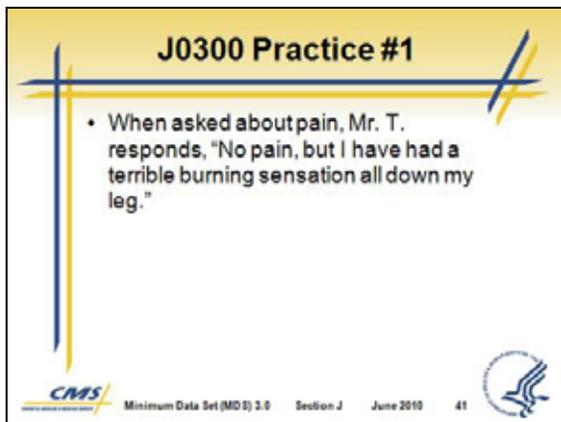
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SLIDES

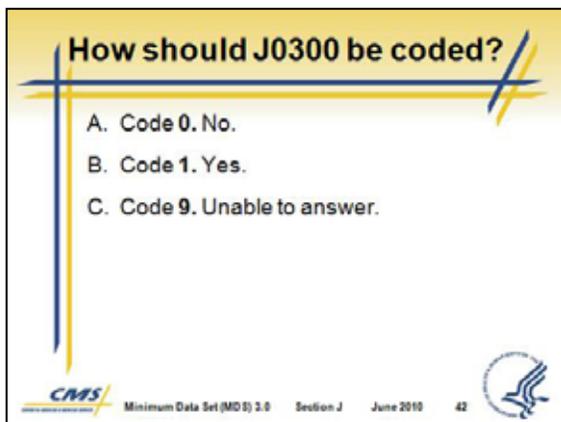
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2. J0300 Scenario Coding
 - a. Code J0300 as **0. No.**
 - b. Mrs. S. reports having no pain during the look-back period.
 - c. Even though she received pain management interventions during the look-back period, the item is coded **No** because there was no pain.
 - d. Skip to J1100 Shortness of Breath.

- E. J0300 Practice #1
 1. When asked about pain, Mr. T. responds, "No pain, but I have had a terrible burning sensation all down my leg."

2. How should J0300 be coded?
 - a. Correct answer is B. Code **1. Yes.**

SLIDES

J0300 Practice #1 Coding

- The correct coding is **1. Yes.**
- Although Mr. T.'s initial response is "no," the comments indicate that he has experienced pain (burning sensation) during the look-back period.

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Item J0400

Pain Frequency

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J0400 Pain Frequency
Conduct the Assessment

- Ask the question exactly as written.
- May use cue cards to present response options.

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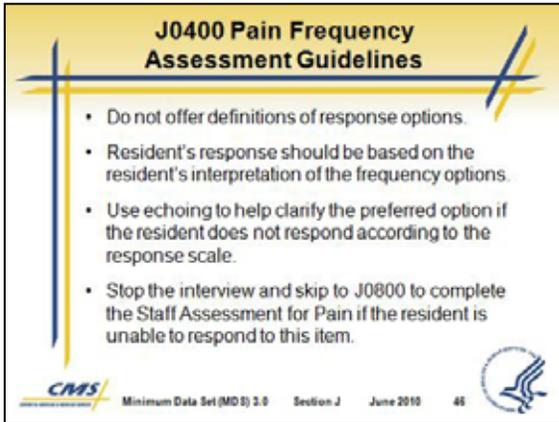
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3. J0300 Practice #1 Coding
 - a. The correct coding is **1. Yes.**
 - b. Although Mr. T.'s initial response is "no," the comments indicate that he has experienced pain (burning sensation) during the look-back period.

VI. J0400 Pain Frequency

- A. If the resident reports experiencing pain, continue with the pain assessment interview.
- B. The first item to address is the frequency of pain.
- C. J0400 Pain Frequency Conduct the Assessment
 1. Ask the question exactly as written.
 - a. "How much of the time have you experienced pain or hurting over the last 5 days?"
 2. Staff may present response options on a written sheet or cue card.
 - a. This can help the resident respond to the items

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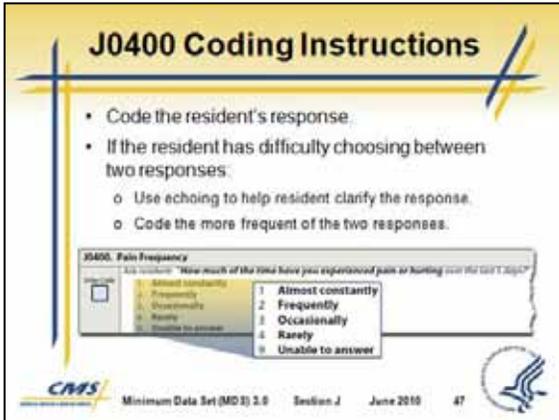
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D. J0400 Pain Frequency Assessment Guidelines

1. Do not offer definitions of the response options.
2. A resident's response should be based on the resident's interpretation of the frequency options.
3. If the resident provides a related response but does not use the provided response scale, help clarify the best response by echoing (repeating) the resident's own comment and providing related response options.
 - a. This interview approach frequently helps the resident clarify which response option he or she prefers.

E. J0400 Coding Instructions

1. Code the resident's response.
2. If the resident has difficulty choosing between two responses:
 - a. Use echoing to help resident clarify the response.
 - b. If the resident continues to have difficulty selecting between two of the provided responses, then code the more frequent of the two.



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J0400 Scenario

- When asked about pain, Ms. M. responds, "I would say rarely."
- Since I started using the patch, I don't have much pain at all, but four days ago the pain came back.
- I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day."

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J0400 Scenario Coding

- Code J0400 as **4. Rarely.**
- Ms. M. selected the "rarely" response option.

J0400. Pain Frequency
How much of the time have you experienced pain or feeling over the last 7 days?
Select one
1. Never
2. Rarely
3. Occasionally
4. Frequently
5. Always
Enter Code
4

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J0400 Practice #1

- When asked about pain, Miss K. responds:
 - "I can't remember. I think I had a headache a few times in the past couple of days, but they gave me Tylenol and the headaches went away."
- Interviewer clarifies by echoing what Miss K. said:
 - "You've had a headache a few times in the past couple of days and the headaches went away when you were given Tylenol."
 - "If you had to choose from the answers, would you say you had pain occasionally or rarely?"
- Miss K. replies "Occasionally."

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INSTRUCTIONAL GUIDANCE

F. J0400 Scenario

1. When asked about pain, Ms. M. responds, "I would say rarely."
2. Since I started using the patch, I don't have much pain at all, but four days ago the pain came back.
3. I think they were a bit overdue in putting on the new patch, so I had some pain for a little while that day."

4. J0400 Scenario Coding

- a. Code J0400 as **4. Rarely.**
- b. Ms. M. selected the "rarely" response option.

G. J0400 Practice #1

1. When asked about pain, Miss K. responds:
 - a. "I can't remember. I think I had a headache a few times in the past couple of days, but they gave me acetaminophen and the headaches went away."
2. Interviewer clarifies by echoing what Miss K. said:
 - a. "You've had a headache a few times in the past couple of days and the headaches went away when you were given acetaminophen."

SLIDES

INSTRUCTIONAL GUIDANCE

How should J0400 be coded?

- A. Code 1. Almost constantly
- B. Code 2. Frequently
- C. Code 3. Occasionally
- D. Code 4. Rarely
- E. Code 9. Unable to answer

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J0400 Practice #1 Coding

- The correct coding is 3. Occasionally.
- After the interviewer clarified the resident's choice using echoing, the resident selected a response option.

J0400, Pain Frequency
"How much of the time have you experienced pain or hurting over the last 7 days?"
Almost constantly
Frequently
Occasionally
Rarely
Unable to answer

Enter Code
3

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J0400 Practice #2

- When asked about pain, Mr. J. responds:
 - o "I don't know if it is frequent or occasional."
 - o "My knee starts throbbing every time they move me from the bed or the wheelchair."
- The interviewer says:
 - o "Your knee throbs every time they move you."
 - o "If you had to choose an answer, would you say that you have pain frequently or occasionally?"
- Mr. J. is still unable to choose between frequently and occasionally.

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3. If you had to choose from the answers, would you say you had pain occasionally or rarely?"
4. Miss K. replies "Occasionally."
5. How should J0400 be coded?
 - a. Correct answer is C. Code **3**. Occasionally.

6. J0400 Practice #1 Coding
 - a. The correct coding is **3**. Occasionally.
 - b. After the interviewer clarified the resident's choice using echoing, the resident selected a response option.

- H. J0400 Practice #2
1. When asked about pain, Mr. J. responds:
 - a. "I don't know if it is frequent or occasional."
 - b. "My knee starts throbbing every time they move me from the bed or the wheelchair."

SLIDES

INSTRUCTIONAL GUIDANCE

How should J0400 be coded?

- A. Code 1. Almost constantly
- B. Code 2. Frequently
- C. Code 3. Occasionally
- D. Code 4. Rarely
- E. Code 9. Unable to answer

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J0400 Practice #2 Coding

- The correct coding is **2. Frequently**.
- The interviewer appropriately echoed Mr. J.'s comment and provided related response options to help him clarify which response he preferred.
- Mr. J. remained unable to decide between frequently and occasionally.
- The interviewer, therefore, coded for the higher frequency of pain.

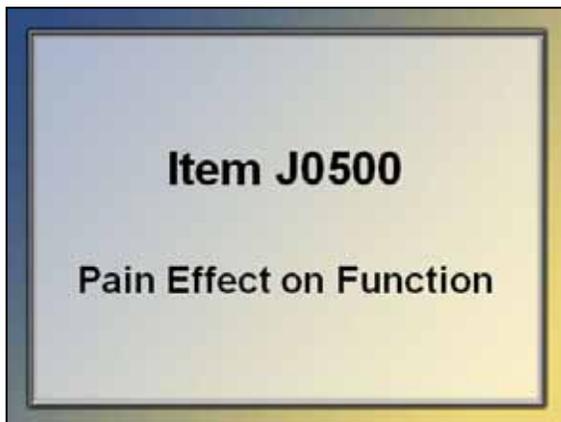
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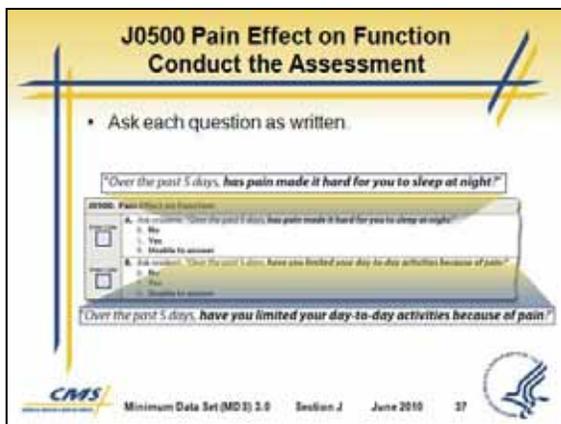
2. The interviewer says:
 - a. “Your knee throbs every time they move you.
 - b. If you had to choose an answer, would you say that you have pain frequently or occasionally?”
3. Mr. J. is still unable to choose between frequently and occasionally.
4. How should J0400 be coded?
 - a. Correct answer is B. Code **2. Frequently**.
5. J0400 Practice #2 Coding
 - a. The correct coding is **2. Frequently**.
 - b. The interviewer appropriately echoed Mr. J.'s comment and provided related response options to help him clarify which response he preferred.
 - c. Mr. J. remained unable to decide between frequently and occasionally.
 - d. The interviewer therefore coded for the higher frequency of pain.

SLIDES

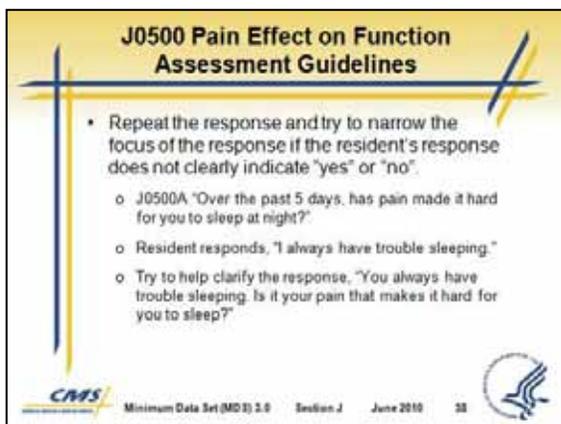
INSTRUCTIONAL GUIDANCE



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VII. J0500 Pain Effect on Function

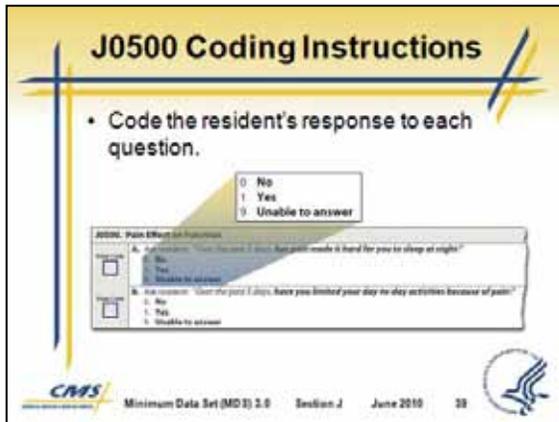
**A. J0500 Pain Effect on Function
Conduct the Assessment**

1. Ask each of the two questions exactly as written.
 - a. "Over the Past 5 Days, Has Pain Made It Hard for You to Sleep at Night?"
 - b. "Over the Past 5 Days, Have You Limited Your Day-to-day Activities because of Pain?"

**B. J0500 Pain Effect on Function
Assessment Guidelines**

1. Repeat the response and try to narrow the focus of the response if the resident's response does not clearly indicate "yes" or "no".
 - a. J0500A "Over the past 5 days, has pain made it hard for you to sleep at night?"
 - b. Resident responds, "I always have trouble sleeping."
 - c. Try to help clarify the response, "You always have trouble sleeping. Is it your pain that makes it hard for you to sleep?"

SLIDES



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INSTRUCTIONAL GUIDANCE

C. J0500 Coding Instructions

1. Code the resident's response to each question.
 - **Code 0. No.** (pain did not interfere)
 - **Code 1. Yes.** (pain did interfere)
 - **Code 9. Unable to answer.**

Instructor Notes

J0500A Detailed Coding Instructions

- **Code 0.** No if the resident responds “no,” indicating that pain did not interfere with sleep.
- **Code 1.** Yes if the resident responds “yes,” indicating that pain interfered with sleep.
- **Code 9.** Unable to answer if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to J0500B, J0600, and J0700.

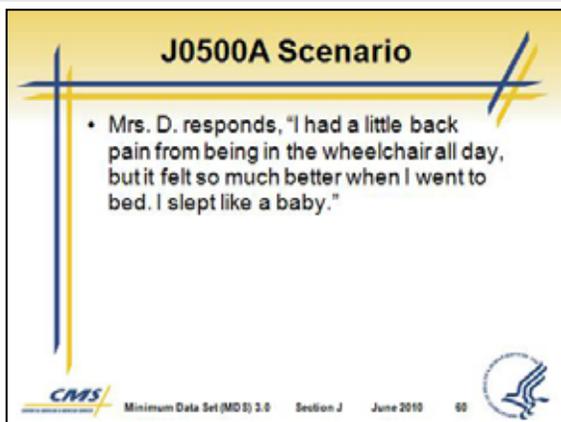
J0500B Detailed Coding Instructions

- **Code 0.** No: if the resident indicates that pain did not interfere with daily activities.
- **Code 1.** Yes: if the resident indicates that pain interfered with daily activities.
- **Code 9,** Unable to answer: if the resident is unable to answer the question, does not respond or gives a nonsensical response. Proceed to J0600 and J0700.

Instructor Notes

SLIDES

INSTRUCTIONAL GUIDANCE



J0500A Scenario

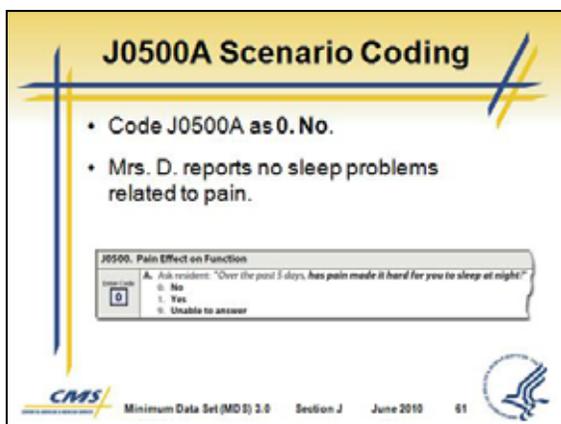
- Mrs. D. responds, "I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby."

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D. J0500A Scenario

1. Mrs. D. responds, "I had a little back pain from being in the wheelchair all day, but it felt so much better when I went to bed. I slept like a baby."



J0500A Scenario Coding

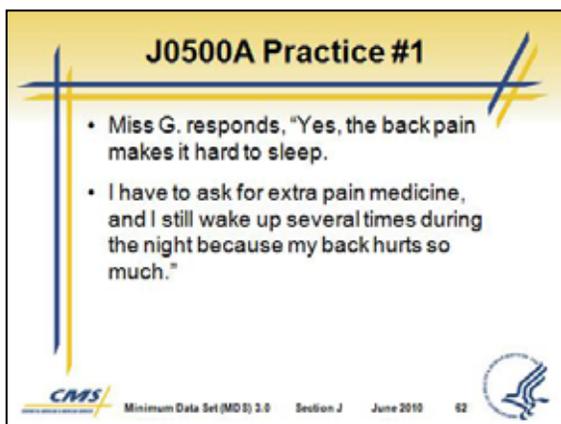
- Code J0500A as **0. No.**
- Mrs. D. reports no sleep problems related to pain.

J0500. Pain Effect on Function
A. Ask resident: "Over the past 3 days, has pain made it hard for you to sleep at night?"
 0. No
 1. Yes
 2. Unable to answer

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2. J0500A Scenario Coding
 - a. Code J0500A as **0. No.**
 - b. Mrs. D. reports no sleep problems related to pain.



J0500A Practice #1

- Miss G. responds, "Yes, the back pain makes it hard to sleep.
- I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

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E. J0500A Practice #1

1. Miss G. responds, "Yes, the back pain makes it hard to sleep.
2. I have to ask for extra pain medicine, and I still wake up several times during the night because my back hurts so much."

SLIDES

INSTRUCTIONAL GUIDANCE

How should J0500A be coded?

- A. Code 0. No.
- B. Code 1. Yes.
- C. Code 9. Unable to answer.

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J0500A Practice #1 Coding

- The correct coding is 1. Yes.
- The resident reports pain-related sleep problems.

J0500A Pain Effect on Function
 Ask resident: "Over the past 7 days, has pain made it hard for you to sleep at night?"

Enter Code
1

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J0500A Practice #2

- Mr. E. responds, "I can't sleep at all in this place."
- The interviewer clarifies by saying,
 - o "You can't sleep here.
 - o Would you say that was because pain made it hard for you to sleep at night?"
- Mr. E. responds,
 - o "No. It has nothing to do with me. I have no pain.
 - o It is because everyone is making so much noise."

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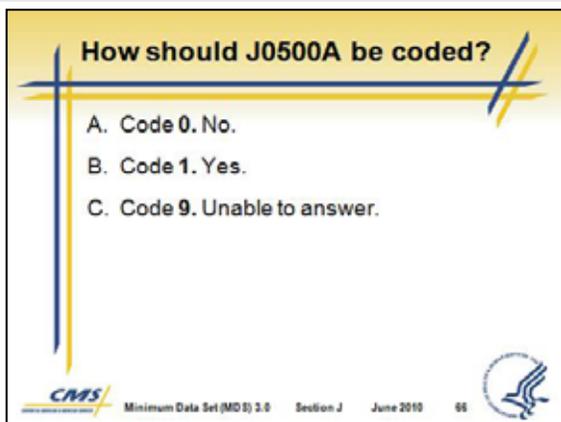
3. How should J0500A be coded?
 - a. The correct answer is B.
Code 1. Yes.

4. J0500A Practice #1 Coding
 - a. The correct coding is **1. Yes.**
 - b. The resident reports pain-related sleep problems.

- F. J0500A Practice #2
1. Mr. E. responds, "I can't sleep at all in this place."
 2. The interviewer clarifies by saying,
 - a. "You can't sleep here.
 - b. Would you say that was because pain made it hard for you to sleep at night?"
 3. Mr. E. responds,
 - a. "No. It has nothing to do with me. I have no pain.
 - b. It is because everyone is making so much noise."

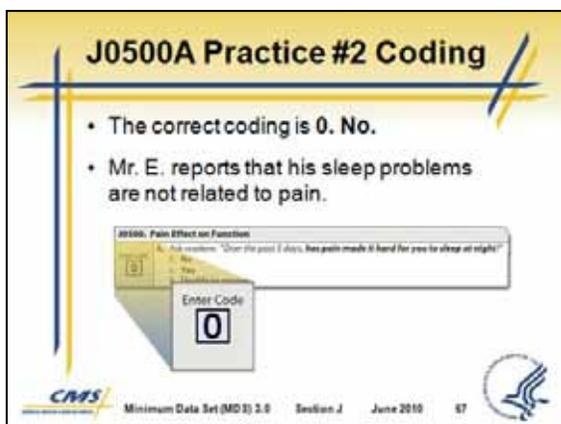
SLIDES

INSTRUCTIONAL GUIDANCE



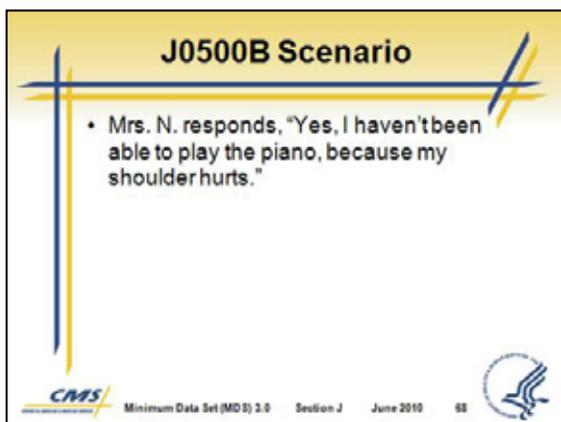
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4. How should J0500A be coded?
 - a. The correct answer is A. Code **0. No.**



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5. J0500A Practice #2 Coding
 - a. The correct coding is **0. No.**
 - b. Mr. E. reports that his sleep problems are not related to pain.



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G. J0500B Scenario

Indicate to participants that now doing examples for the second question in this item.

1. Mrs. N. responds, "Yes, I haven't been able to play the piano, because my shoulder hurts."

SLIDES

J0500B Scenario Coding

- Code J0500B as **1. Yes.**
- Mrs. N. reports limiting her activities because of pain.

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J0500B Practice #1

- Ms. L. responds, "No, I had some pain on Wednesday, but I didn't want to miss the shopping trip, so I went."

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How should J0500B be coded?

- Code 0. No.
- Code 1. Yes.
- Code 9. Unable to answer.

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INSTRUCTIONAL GUIDANCE

- J0500B Scenario Coding
 - Code J0500B as **1. Yes.**
 - Mrs. N. reports limiting her activities because of pain.

H. J0500B Practice #1

- Ms. L. responds, "No, I had some pain on Wednesday, but I didn't want to miss the shopping trip, so I went."

- How should J0500B be coded?
 - The correct answer is A. Code **0. No.**

SLIDES

INSTRUCTIONAL GUIDANCE

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3. J0500B Practice #1 Coding
 - a. The correct coding is **0. No.**
 - b. Although Ms. L. reports pain, she did not limit her activity because of it.

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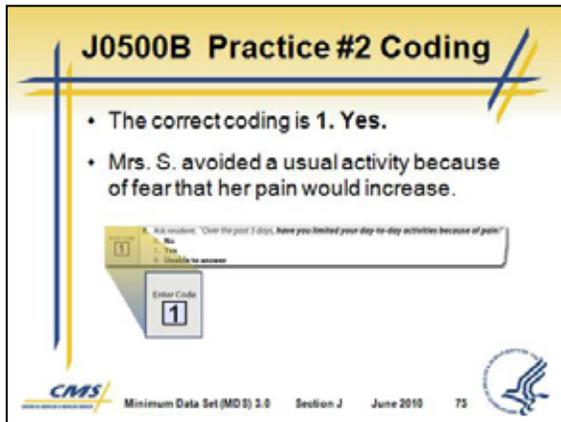
- I. J0500B Practice #2
 1. Mrs. S. responds, "I don't know."
 2. I have not tried to knit since my finger swelled up yesterday, because I am afraid it might hurt even more than it does now."

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3. How should J0500B be coded?
 - a. The correct answer is B. Code **1. Yes.**

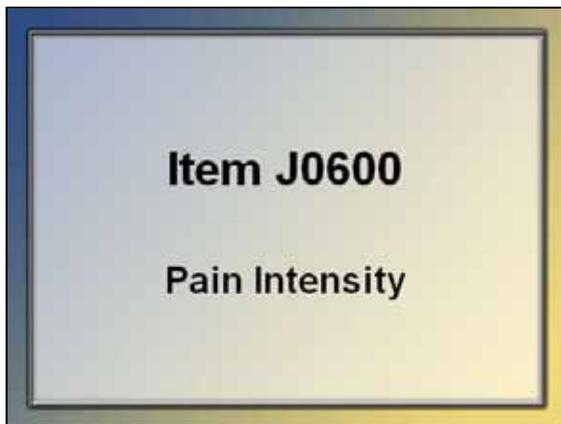
SLIDES

INSTRUCTIONAL GUIDANCE



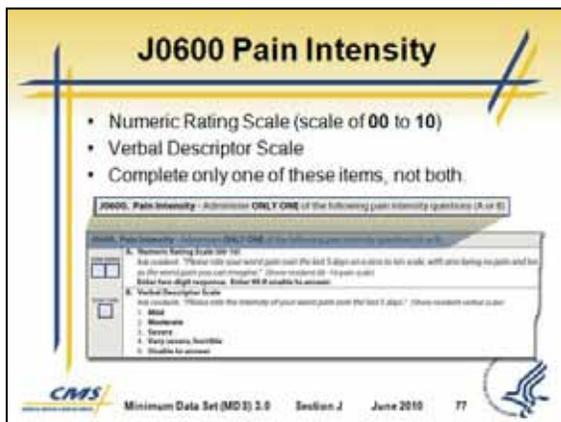
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4. J0500B Practice #2 Coding
 - a. The correct coding is **1. Yes.**
 - b. Mrs. S. avoided a usual activity because of fear that her pain would increase.



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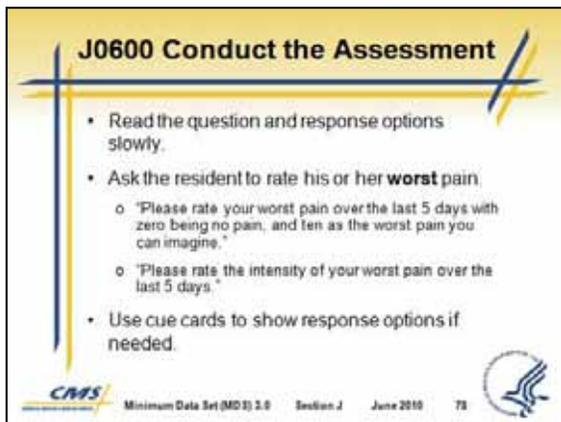
VIII. J0600 Pain Intensity



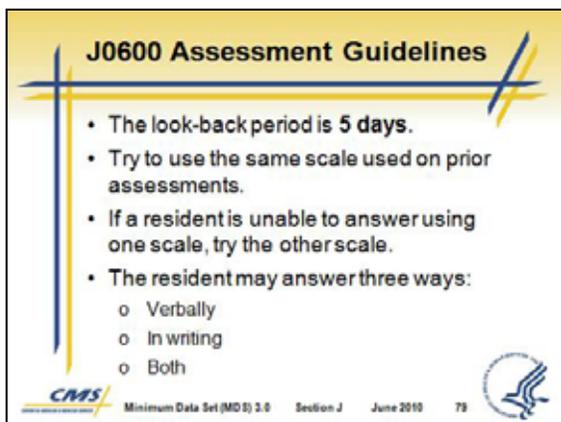
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- A. J0600 Pain Intensity
 1. May complete this item assessing the intensity of the resident's pain using one of two scales.
 2. Numeric Rating Scale (scale of **00 to 10**)
 - a. Zero (**00**) represents no pain.
 - b. Ten (**10**) represents worst pain imaginable.
 3. Verbal Descriptor Scale
 4. Complete only one of these items, not both.

SLIDES



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INSTRUCTIONAL GUIDANCE

B. J0600 Conduct the Assessment

1. Read the question and response options slowly.
2. Ask the resident to rate his or her **worst** pain.
 - a. **Numeric Rating Scale:**
“Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine.”
 - b. **Verbal Descriptor Scale:**
“Please rate the intensity of your worst pain over the last 5 days.”
3. Use cue cards to show the response options if needed.

C. J0600 Assessment Guidelines

1. The look-back period is **5 days**.
2. Try to use the same scale used on prior assessments.
3. If a resident is unable to answer using one scale, try the other scale.
4. The resident may answer three ways:
 - a. Verbally
 - b. In writing
 - c. Both

SLIDES

J0600A Numeric Rating Scale Coding Instructions

- Code as a two-digit value.
 - Use a leading zero for values less than 10
 - Enter 99 if unable to answer or does not answer.
- Leave the response for J0600B blank.

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J0600B Verbal Descriptor Scale Coding Instructions

- Code as a one-digit value.
- Enter 9 if unable to answer or does not answer.
- Leave the response for J0600A blank.

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INSTRUCTIONAL GUIDANCE

D. J0600A Numeric Rating Scale Coding Instructions

1. Code as a two-digit value.
2. Use a leading zero for values less than 10.
3. Code **99** if unable to answer or does not answer.
4. Leave the spaces for J0600B blank.

E. J0600B Coding Instructions

1. Code as a one-digit value.
2. Code **9** if unable to answer or does not answer.
3. Leave the spaces for J0600A blank.

Instructor Notes

J0600B Verbal Descriptor Scale Detailed Coding Instructions

- **Code 1.** Mild if resident indicates that his or her pain is “mild.”
- **Code 2.** Moderate if resident indicates that his or her pain is “moderate.”
- **Code 3.** Severe if resident indicates that his or her pain is “severe.”
- **Code 4.** Very severe, horrible if resident indicates that his or her pain is “very severe or horrible.”
- **Code 9.** Unable to answer: if resident is unable to answer, chooses not to respond, does not respond or gives a nonsensical response. Proceed to J0700.

Instructor Notes

SLIDES

INSTRUCTIONAL GUIDANCE

J0600 Scenario #1

- The nurse asks Ms. T. to rate her pain on a scale of 0 to 10.
- Ms. T. states that she is not sure, because she has shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK.
- The nurse reminds Ms. T. to think about all the pain she had during the last 5 days and select the number that describes her worst pain.
- She reports that her pain is a "6."

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J0600 Scenario #1 Coding

- Code J0600A as **06**.
- The resident said her pain was 6 on the 0 to 10 scale.

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J0600 Scenario #2

- The nurse asks Mr. R. to rate his pain using the verbal descriptor scale.
- He looks at the response options presented using a cue card and says his pain is "severe" sometimes, but most of the time it is "mild."

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F. J0600 Scenario #1

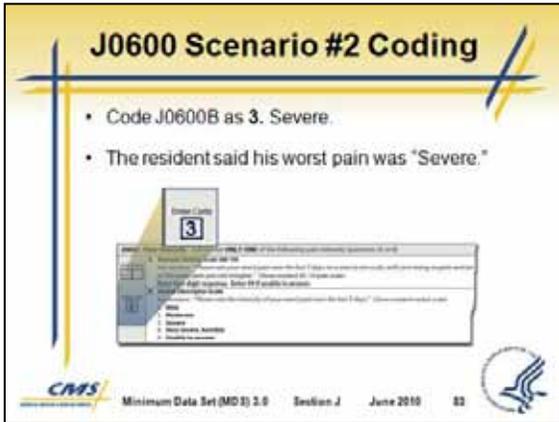
1. The nurse asks Ms. T. to rate her pain on a scale of 0 to 10.
2. Ms. T. states that she is not sure, because she has shoulder pain and knee pain, and sometimes it is really bad, and sometimes it is OK.
3. The nurse reminds Ms. T. to think about all the pain she had during the last 5 days and select the number that describes her worst pain.
4. She reports that her pain is a "6."
5. J0600 Scenario #1 Coding
 - a. Code J0600A as **06**.
 - b. The resident said her pain was 6 on the 00 to 10 scale.

G. J0600 Scenario #2

1. The nurse asks Mr. R. to rate his pain using the verbal descriptor scale.
2. He looks at the response options presented using a cue card and says his pain is "severe" sometimes, but most of the time it is "mild."

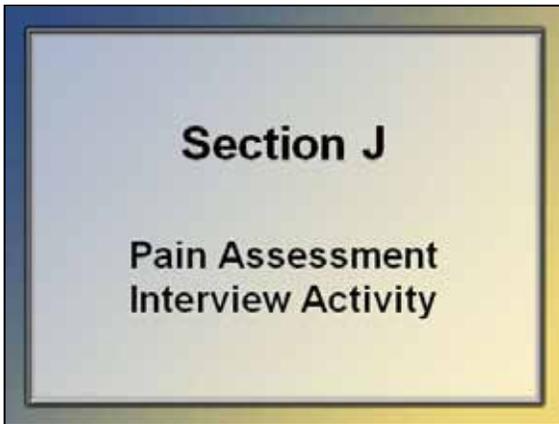
SLIDES

INSTRUCTIONAL GUIDANCE



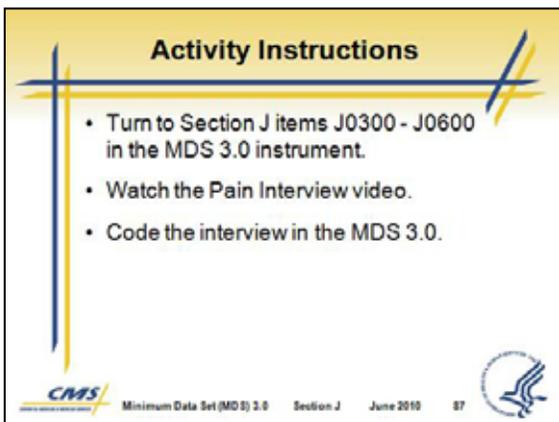
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3. J0600 Scenario #2 Coding
 - a. Code J0600B as **3. Severe.**
 - b. The resident said his worst pain was “Severe.”



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IX. Section J Pain Assessment Interview Activity



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A. Activity Instructions

Review instructions for activity with participants.

1. Turn to Section J items J0300 - J0600 in the MDS 3.0 instrument.
2. Watch the Pain Interview video.
3. Code the interview in the MDS 3.0 instrument.

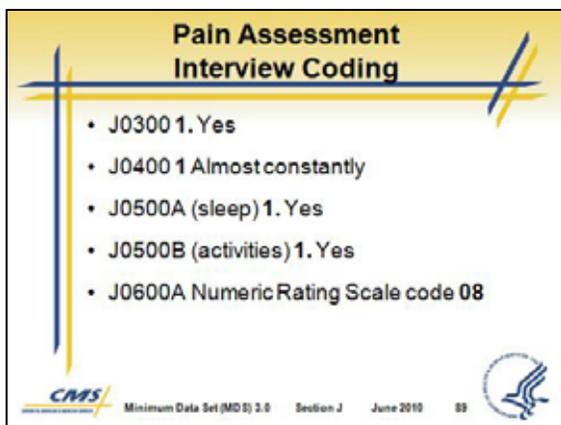
Review instructions for activity with participants.

SLIDES

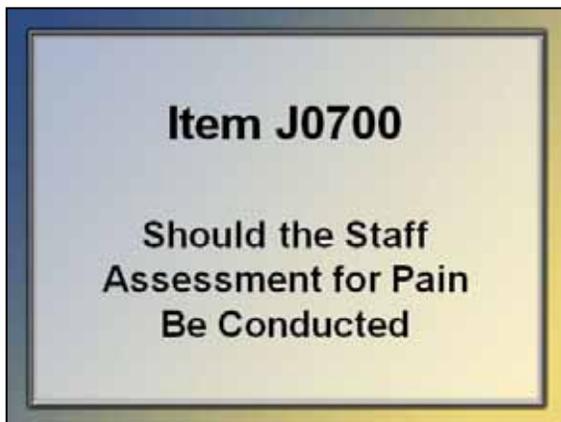
INSTRUCTIONAL GUIDANCE



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B. Pain Assessment Interview Video
Play Pain Assessment Interview video at this time.

- C. Pain Assessment Interview Coding
1. J0300 **1. Yes**
 2. J0400 **1** Almost constantly
 3. J0500A (sleep) **1. Yes**
 4. J0500B (activities) **1. Yes**
 5. J0600A Numeric Rating Scale code **08**

D. If you were conducting a Staff Assessment for pain, consider the following indicators of pain:

1. J0800 Nonverbal indicators
 - a. Frowning
 - b. Rubbing her hip
 - c. Not moving much (guarding herself to some extent)

X. J0700 Should the Staff Assessment for Pain Be Conducted

SLIDES

J0700 Importance

- Resident interview for pain is preferred because it improves the detection of pain.
- A small percentage of residents is unable or unwilling to complete the pain interview.
- Persons unable to complete the pain interview may still have pain.

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J0700 Conduct the Assessment

- Review the resident's responses to J0200 - J0400.
- Determine if the pain assessment interview was completed.
 - J0300 Presence of Pain coded **0. No.**
 - OR**
 - J0300 Presence of Pain coded **1. Yes.**
 - J0400 Pain Frequency is answered.

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J0700 Coding Instructions

- **Code 0. No.**
 - Resident completed the Pain Assessment Interview.
 - Skip to J1100 Shortness of Breath (dyspnea).
- **Code 1. Yes.**
 - Resident unable to complete the Pain Assessment Interview.
 - Continue to J0800 Indicators of Pain or Possible Pain.

J0700, Should the Staff Assessment for Pain be Conducted?

0. No (J0400 = 1 thru 4) -> Skip to J1100, Shortness of Breath (dyspnea)

1. Yes (J0400 = 9) -> Continue to J0800, Indicators of Pain or Possible Pain

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INSTRUCTIONAL GUIDANCE

A. J0700 Importance

1. Resident interview for pain is preferred because it improves the detection of pain.
2. A small percentage of residents is unable or unwilling to complete the pain interview.
3. Persons unable to complete the pain interview may still have pain.

B. J0700 Conduct the Assessment

1. Review the resident's responses to J0200 through J0400.
2. Determine if the pain assessment interview was completed.
3. The interview is complete if the resident answers no to J0300 Presence of Pain coded **0. No.**

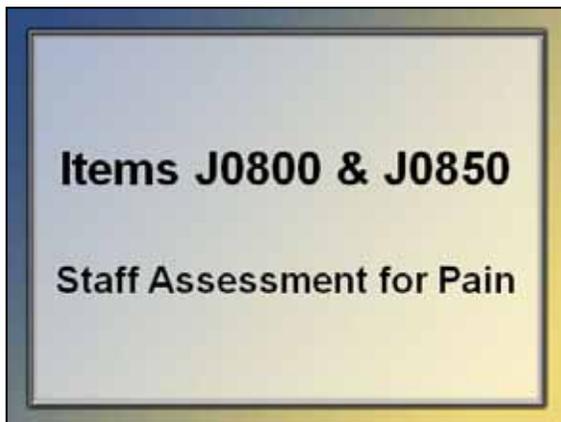
OR

- a. J0300 Presence of Pain coded **1. Yes.**
- b. J0400 Pain Frequency is answered.

C. J0700 Coding Instructions

- **Code 0. No.**
If the resident completed the Pain Assessment Interview (J0400 = **1, 2, 3, or 4.**)
Skip to Shortness of Breath (dyspnea) item (J1100).
- **Code 1. Yes.**
If the resident was unable to complete the Pain Assessment Interview (J0400 = **9**)
Continue to Indicators of Pain or Possible Pain item (J0800).

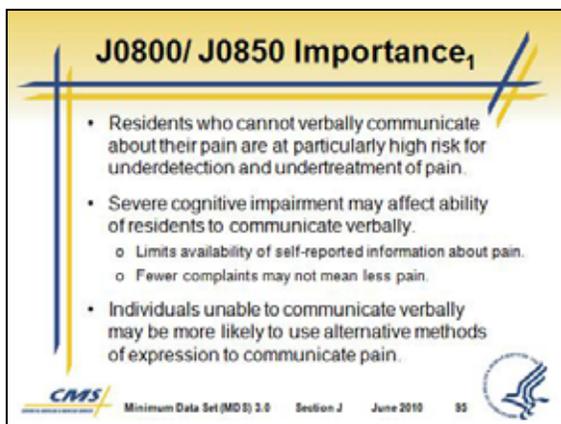
SLIDES



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INSTRUCTIONAL GUIDANCE

XI. J0800 & J0850 Staff Assessment for Pain



Slide 95

A. J0800/ J0850 Importance

1. Residents who cannot verbally communicate about their pain are at particularly high risk for underdetection and undertreatment of pain.
2. Severe cognitive impairment may affect ability of residents to communicate verbally.
 - a. This limits availability of self-reported information about pain.
 - b. Fewer complaints may not mean less pain.
3. Individuals unable to communicate verbally may be more likely to use alternative methods of expression to communicate pain.

SLIDES

J0800/ J0850 Importance₂

- Some verbal complaints of pain may be made and should be taken seriously.
- Unrelieved pain adversely affects function and mobility, contributing to:
 - Dependence
 - Skin breakdown
 - Contractures
 - Weight loss
- Pain significantly adversely affects quality of life and is tightly linked to depressed mood, diminished self-confidence and self-esteem, as well as to an increase in behavior problems.

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4. Some verbal complaints of pain may be made and should be taken seriously.
5. Unrelieved pain adversely affects function and mobility, contributing to:
 - a. Dependence
 - b. Skin breakdown
 - c. Contractures
 - d. Weight loss
6. Pain significantly adversely affects quality of life and is tightly linked to depressed mood, diminished self-confidence and self-esteem, as well as to an increase in behavior problems.

Indicators of Pain₁

- Non-Verbal Sounds include but not limited to:
 - Crying
 - Whining
 - Gasping
 - Moaning
 - Groaning
 - Other audible indications
- Vocal Complaints of Pain include but not limited to:
 - "That hurts."
 - "Ouch."
 - "Stop."

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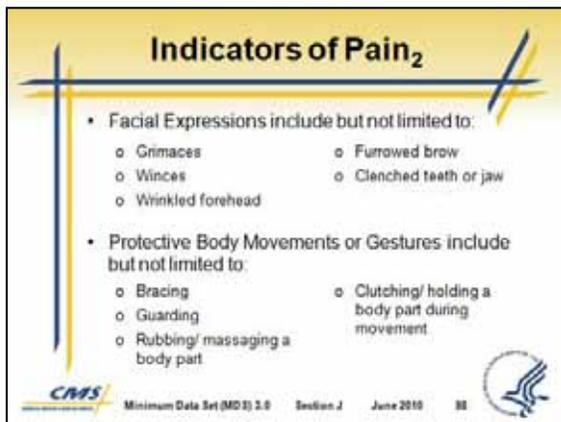
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B. Indicators of Pain

1. Non-Verbal Sounds including but not limited to:
 - Crying
 - Whining
 - Gasping
 - Moaning
 - Groaning
 - Other audible indications
2. Vocal Complaints of Pain including but not limited to:
 - "That hurts."
 - "Ouch."
 - "Stop."

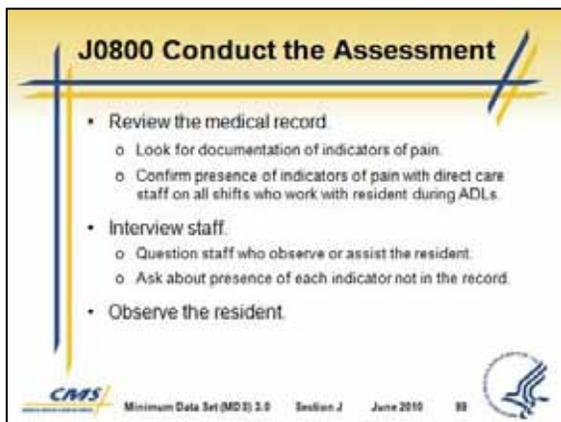
SLIDES

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2. Facial Expressions including but not limited to:
 - Grimaces
 - Wincing
 - Wrinkled forehead
 - Furrowed brow
 - Clenched teeth or jaw
3. Protective Body Movements or Gestures including but not limited to:
 - Bracing
 - Guarding
 - Rubbing/ massaging a body part
 - Clutching/ holding a body part during movement



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- C. J0800 Conduct the Assessment
 1. Review the medical record.
 - a. Look for documentation of each indicator of pain listed in J0800 that occurred during the 5-day look-back period.
 2. If the record documents the presence of any of the signs and symptoms listed, confirm record review with the direct care staff on all shifts who work most closely with the resident during ADLs.
 3. Interview staff.
 - a. The medical record may fail to note all observable pain behaviors.

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- b. Interview direct care staff on all shifts who work with the resident during ADLs.
 - c. Ask directly about the presence of each indicator that was not noted as being present in the record.
4. Observe the resident during care activities.
 - a. Code the corresponding items if additional indicators of pain are observed during the 5-day look-back period.
 - b. Observations for pain indicators may be more sensitive if the resident is observed during ADL or wound care.



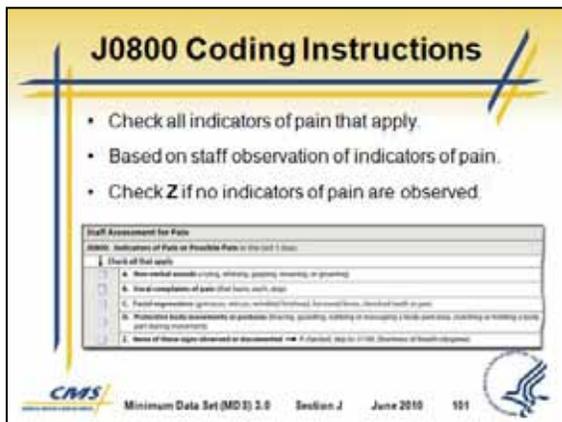
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D. J0800 Assessment Guidelines

1. The look-back period is **5 days**.
2. Some symptoms may be related to pain:
 - Behavior change
 - Depressed mood
 - Rejection of care
 - Decreased participation in activities
3. Do not report here as pain screening items.

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E. J0800 Coding Instructions

1. Check all indicators of pain that apply.
 - a. During the 5-day look-back period
 - b. Based on staff observation of pain indicators
 - c. Continue to item J0850.
2. Check **J0800Z**. *None of these signs observed or documented* if the medical record review, the interview with direct care providers, and observation on all shifts provide no evidence of pain indicators.
 - a. Proceed to Shortness of Breath item (J1100).

Instructor Notes

J0800 Indicators of Pain or Possible Pain Detailed Coding Instructions

- **Check J0800A.** Non-verbal sounds: included but not limited to if crying, whining, gasping, moaning, or groaning were observed or reported during the look-back period.
- **Check J0800B.** Vocal complaints of pain: included but not limited to if the resident was observed to make vocal complaints of pain (e.g. “that hurts,” “ouch,” or “stop”).
- **Check J0800C.** Facial expressions: included but not limited to if grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw were observed or reported during the look-back period.
- **Check J0800D.** Protective body movements or postures: included but not limited to if bracing, guarding, rubbing or massaging a body part/area, or clutching or holding a body part during movement were observed or reported during the look-back period.
- **Check J0800Z.** None of these signs observed or documented: if none of these signs were observed or reported during the look-back period.

Instructor Notes

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J0800 Scenario

- Mr. P. has advanced dementia and is unable to verbally communicate.
- A note in his medical record documents that he has been awake during the last night crying and rubbing his elbow.
- When you go to his room to interview the certified nurse aide (CNA) caring for him, you observe Mr. P. grimacing and clenching his teeth.
- The CNA reports that he has been moaning and said "ouch" when she tried to move his arm.

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F. J0800 Scenario

1. Mr. P. has advanced dementia and is unable to verbally communicate.
2. A note in his medical record documents that he has been awake during the last night crying and rubbing his elbow.
3. When you go to his room to interview the certified nurse aide (CNA) caring for him, you observe Mr. P. grimacing and clenching his teeth.
4. The CNA reports that he has been moaning and said "ouch" when she tried to move his arm.

How should this be coded?

G. J0800 Scenario Coding

1. Code J0800 by checking items A-D.
2. Mr. P. has demonstrated:
 - Non-verbal sounds (crying and moaning)
 - Vocal complaints of pain ("ouch")
 - Facial expression of pain (grimacing and clenched teeth)
 - Protective body movements (rubbing his elbow)

J0800 Scenario Coding

- Mr. P. has demonstrated:
 - Non-verbal sounds (crying and moaning)
 - Vocal complaints of pain ("ouch")
 - Facial expression of pain (grimacing and clenched teeth)
 - Protective body movements (rubbing his elbow)

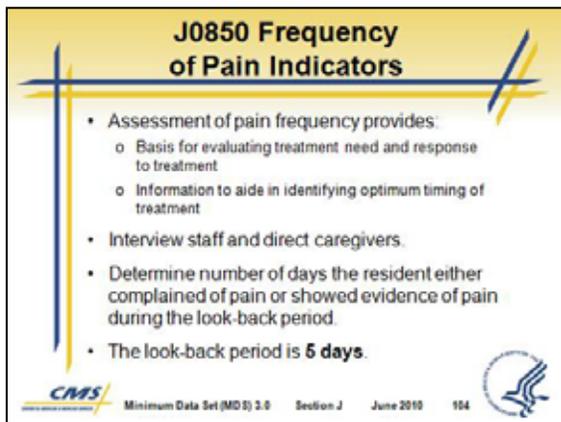
Staff Assessment for Pain
 08000 Indicators of Pain or Possible Pain in the last 7 days
 Check all that apply:

<input checked="" type="checkbox"/>	A. Non-verbal sounds (crying, whining, moaning, groaning)
<input checked="" type="checkbox"/>	B. Vocal complaints of pain (that "ouch", "ouch", "ouch")
<input checked="" type="checkbox"/>	C. Facial expressions (grimacing, stress, clenched fist/clenched teeth, clenched teeth/grip)
<input checked="" type="checkbox"/>	D. Protective body movements or gestures (crying, guarding, holding or protecting a body part, etc., clenching or holding a hand part during movement)
<input type="checkbox"/>	E. None of these signs observed or documented - If checked, skip to 0100, Section of Health History

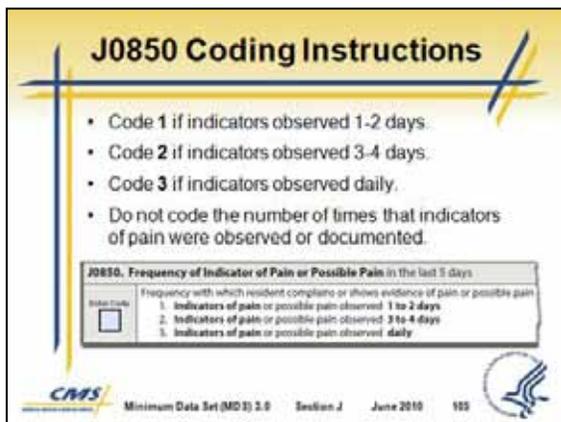
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H. J0850 Frequency of Pain Indicators

1. Assessment of pain frequency provides:
 - a. Basis for evaluating treatment need and response to treatment
 - b. Information to aid in identifying optimum timing of treatment
2. Interview staff and direct caregivers.
3. Determine the number of days the resident either complained of pain or showed evidence of pain during the look-back period.
4. The look-back period is **5 days**.

I. J0850 Coding Instructions

1. Code the number of days that indicators of pain were observed or documented.
 - **Code 1.** Indicators of pain or possible pain observed 1 to 2 days.
If based on staff observation, the resident complained or showed evidence of pain 1 to 2 days
 - **Code 2.** Indicators of pain or possible pain observed 3 to 4 days.
If based on staff observation, the resident complained or showed evidence of pain on 3 to 4 of the last 5 days

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J0850 Scenario

- Mr. M. is an 80-year old male with advanced dementia.
- Mr. M. was noted to be grimacing and verbalizing "ouch" over the past 2 days when his right shoulder was moved during the 5-day look-back period.

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J0850 Scenario Coding

- Code J0850 as **1**, Indicators of pain or possible pain observed 1 – 2 days.
- He has demonstrated vocal complaints of pain ("ouch") and facial expression of pain (grimacing) on 2 of the last 5 days.

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days	
Code	Frequency with which resident complains or shows evidence of pain or possible pain
1	1. Indicators of pain or possible pain observed 1 to 2 days
	2. Indicators of pain or possible pain observed 3 to 4 days
	3. Indicators of pain or possible pain observed daily

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- **Code 3.** Indicators of pain or possible pain observed daily.

If based on staff observation, the resident complained or showed evidence of pain on a daily basis

2. Do not code the number of times that indicators of pain were observed or documented.

J. J0850 Scenario

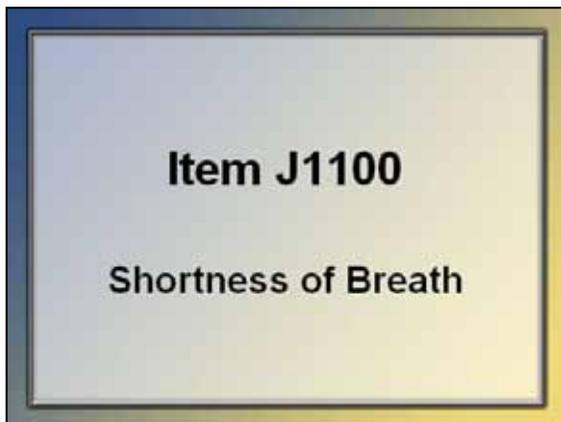
1. Mr. M. is an 80-year old male with advanced dementia.
2. Mr. M. was noted to be grimacing and verbalizing "ouch" over the past 2 days when his right shoulder was moved during the 5-day look-back period.

3. J0850 Scenario Coding

- a. Code J0850 as **1**, Indicators of pain or possible pain observed 1 – 2 days.
- b. He has demonstrated vocal complaints of pain ("ouch"), facial expression of pain (grimacing) on 2 of the last 5 days.

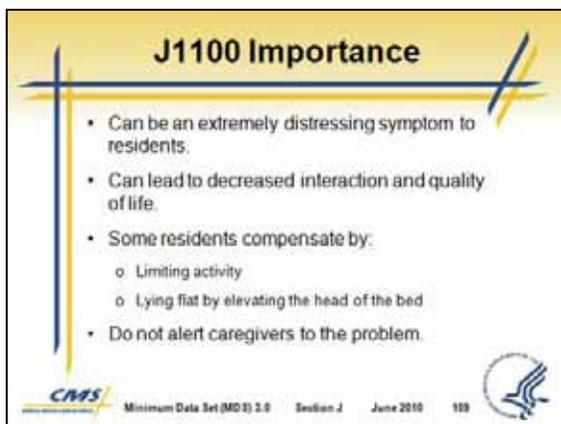
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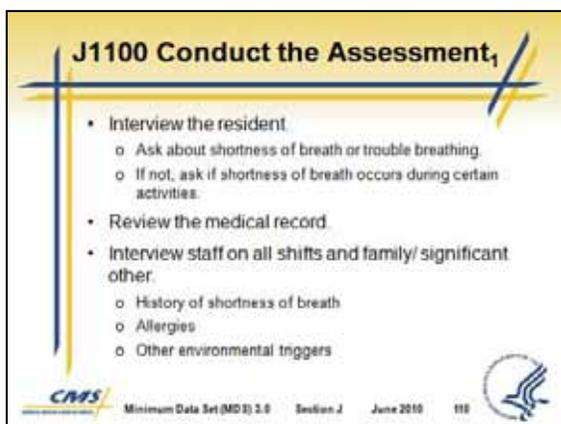
XII. Item J1100 Shortness of Breath



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A. J1100 Importance

1. Shortness of breath can be an extremely distressing symptom to residents.
2. Can lead to decreased interaction and quality of life.
3. Some residents compensate for shortness of breath:
 - a. By limiting activity
 - b. By lying flat by elevating the head of the bed
4. The danger is that these residents do not always alert caregivers to the problem.



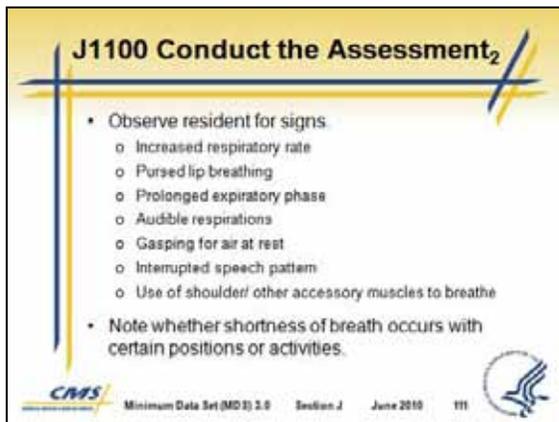
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B. J1100 Conduct the Assessment

1. Many residents may be able to provide feedback about their own symptoms.
 - a. Includes residents with mild to moderate dementia
2. Interview the resident about shortness of breath.
 - a. Ask about shortness of breath or trouble breathing.

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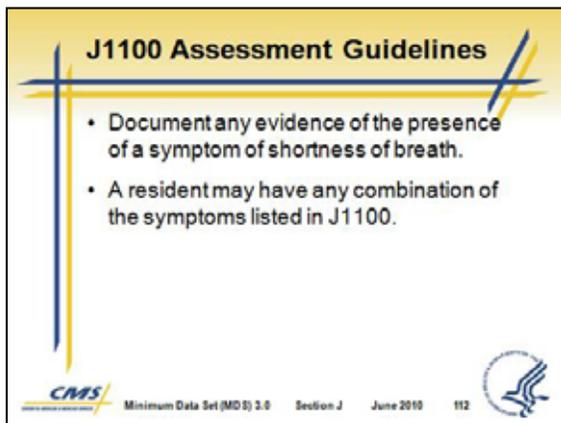


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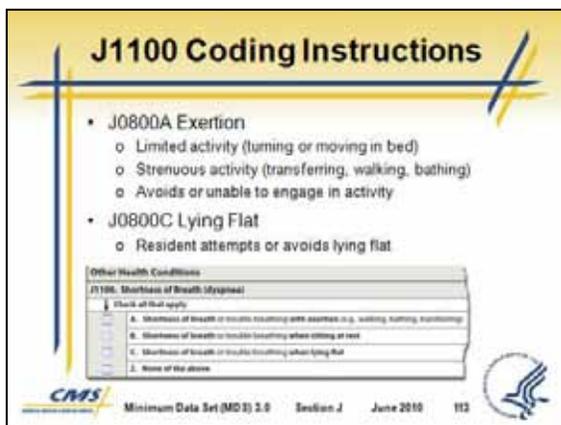
- b. If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.
3. Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing.
4. Interview staff on all shifts and family/ significant other regarding:
 - a. Resident history of shortness of breath
 - b. Allergies
 - c. Other environmental triggers of shortness of breath
5. Observe the resident for shortness of breath or trouble breathing.
6. Signs of shortness of breath include:
 - Increased respiratory rate
 - Pursed lip breathing
 - Prolonged expiratory phase
 - Audible respirations
 - Gasping for air at rest
 - Interrupted speech pattern (only able to say a few words before taking a breath)
 - Use of shoulder and other accessory muscles to breathe

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7. If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

C. J1100 Assessment Guidelines

1. Document any evidence of the presence of a symptom of shortness of breath.
2. A resident may have any combination of the symptoms listed in J1100.

D. J1100 Coding Instructions

1. Check all that apply during the look-back period.
2. J0800A Exertion
 - a. Limited activity (turning or moving in bed)
 - b. Strenuous activity (transferring, walking, bathing)
 - c. Avoids or unable to engage in activity
3. J0800B Sitting at Rest
 - a. Shortness of breath or trouble breathing present when the resident is sitting at rest.
4. J0800C Lying Flat
 - a. Resident attempts or avoids lying flat

SLIDES

INSTRUCTIONAL GUIDANCE

Instructor Notes

J1100 Shortness of Breath Detailed Coding Instructions

- **Check J1100A** if shortness of breath or trouble breathing is present when the resident is engaging in activity. Shortness of breath could be present during activity as limited as turning or moving in bed during daily care or with more strenuous activity such as transferring, walking, or bathing. If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- **Check J1100B** if shortness of breath or trouble breathing is present when the resident is sitting at rest.
- **Check J1100C** if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath.
- **Check J1100Z** if the resident reports no shortness of breath or trouble breathing and the medical record and staff interviews indicate that shortness of breath appears to be absent or well controlled with current medication.

Instructor Notes

J1100 Scenario #1

- Mrs. W. has diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure.
- She is on 2 liters of oxygen and daily respiratory treatments.
- With oxygen she is able to ambulate and participate in most group activities.
- She reports feeling "winded" when going on outings that require walking one or more blocks and has been observed having to stop to rest several times under such circumstances.
- Recently, she describes feeling "out of breath" when she tries to lie down.

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E. J1100 Scenario #1

1. Mrs. W. has diagnoses of chronic obstructive pulmonary disease (COPD) and heart failure.
2. She is on 2 liters of oxygen and daily respiratory treatments.
3. With oxygen she is able to ambulate and participate in most group activities.
4. She reports feeling "winded" when going on outings that require walking one or more blocks and has been observed having to stop to rest several times under such circumstances.
5. Recently, she describes feeling "out of breath" when she tries to lie down.

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6. J1100 Scenario #1 Coding
 - a. Check J1100A with exertion.
 - b. Check J1100C when lying flat.
 - c. Mrs. W. reported being short of breath when lying down as well as during outings that required ambulating longer distances.

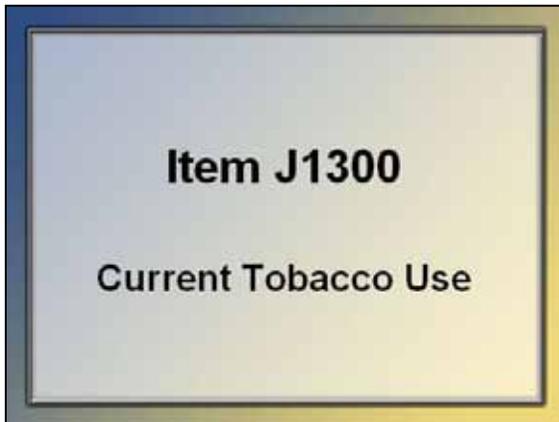
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- F. J1100 Scenario #2
 1. Mr. T. has used an inhaler for years.
 2. He is not typically noted to be short of breath.
 3. Three days ago, during a respiratory illness, he had mild trouble with his breathing, even when sitting in bed.
 4. His shortness of breath also caused him to limit group activities.

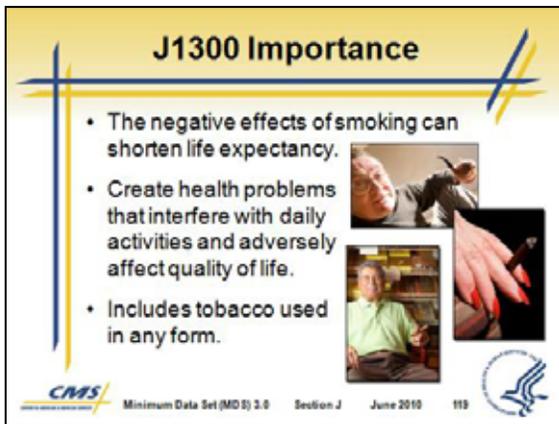
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5. J1100 Scenario #2 Coding
 - a. Check J1100A with exertion.
 - b. Check J1100B when sitting at rest.
 - c. Mr. T. was short of breath at rest and was noted to avoid activities because of shortness of breath.

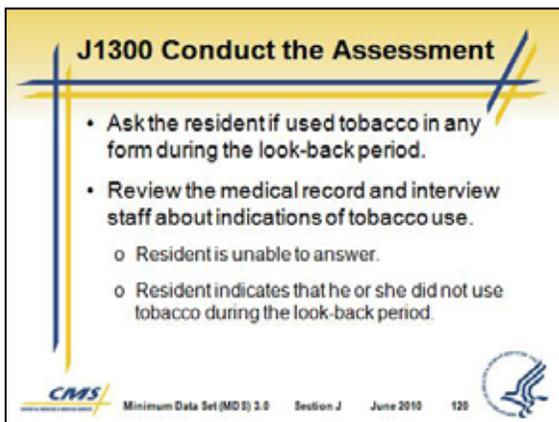
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XIII. Item J1300 Current Tobacco Use**A. J1300 Importance**

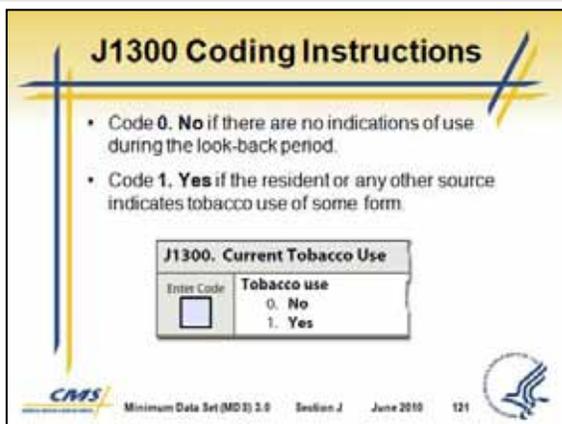
1. The negative effects of smoking can shorten life expectancy.
2. Create health problems that interfere with daily activities and adversely affect quality of life.
3. This item includes tobacco used in any form.

B. J1300 Conduct the Assessment

1. Ask the resident if he or she used tobacco in any form during the look-back period.
2. Review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.
 - a. If the resident is unable to answer
 - b. Resident indicates that he or she did not use tobacco of any kind during the look-back period.

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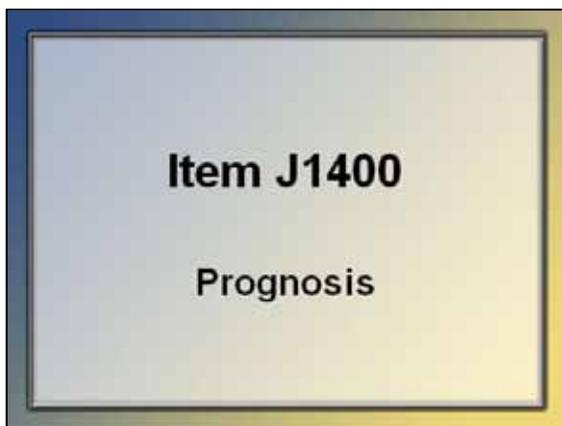
C. J1300 Coding Instructions

1. **Code 0. No.**

If there are no indications that the resident used any form of tobacco

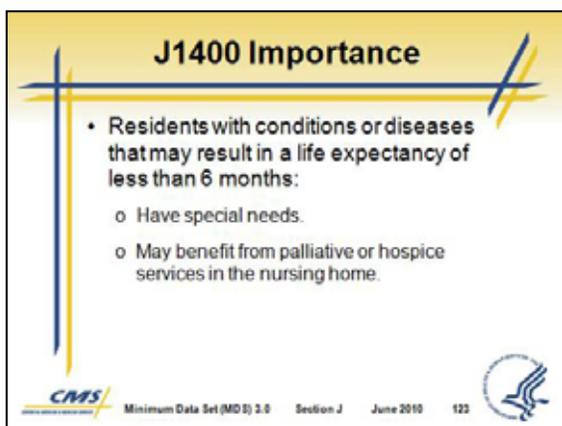
2. **Code 1. Yes.**

If the resident or any other source indicates that the resident used tobacco in some form during the look-back period



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XIV. Item J1400 Prognosis



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A. J1400 Importance

1. Residents with conditions or diseases that may result in a life expectancy of less than 6 months:

- a. Have special needs.
- b. May benefit from palliative or hospice services in the nursing home.

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Instructor Notes

Condition or Chronic Disease that May Result in a Life Expectancy of Less Than 6 Months

In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months.

This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.

Instructor Notes

J1400 Conduct the Assessment

- Review medical record for documentation.
 - Condition or chronic disease that may result in life expectancy of less than 6 months.
 - Terminal illness
 - Indication of hospice services
- Request documentation in the medical record if physician or other authorized, licensed staff as permitted by state law states that resident life expectancy is less than 6 months.

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B. J1400 Conduct the Assessment

- Review the medical record.
 - Documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months
 - Documentation by the physician that the resident has a terminal illness
 - Whether the resident is receiving hospice services

J1400 Coding Instructions

- Code 1. Yes** only if the medical record contains documentation of terminal illness, hospice services, or condition/chronic disease.

J1400 - Progress
 Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician)

0 No
 1 Yes

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C. J1400 Coding Instructions

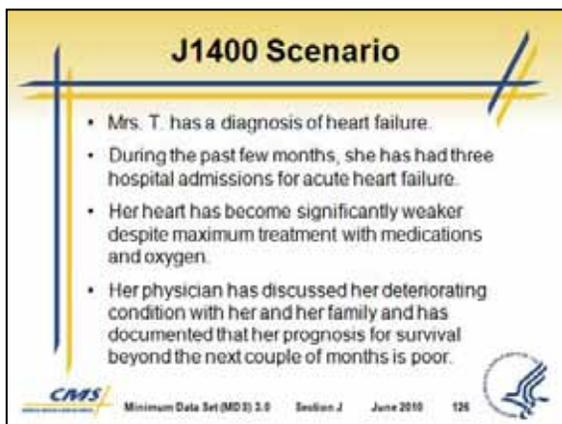
- Code 0. No.**
 If the medical record does not contain physician documentation that the resident has a terminal disease or a condition or chronic disease that may result in a life expectancy of less than 6 months and the resident is not receiving hospice services

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• **Code 1. Yes.**

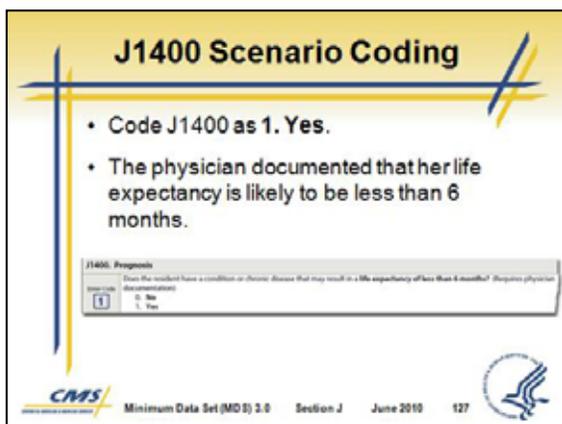
If the medical record includes physician documentation that the resident has a terminal disease or that the resident's condition or chronic disease may result in a life expectancy of less than 6 months or whether the resident is receiving hospice services



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D. J1400 Scenario

1. Mrs. T. has a diagnosis of heart failure.
2. During the past few months, she has had three hospital admissions for acute heart failure.
3. Her heart has become significantly weaker despite maximum treatment with medications and oxygen.
4. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival beyond the next couple of months is poor.

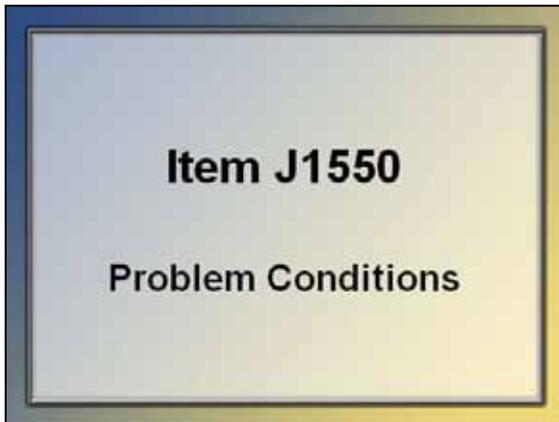


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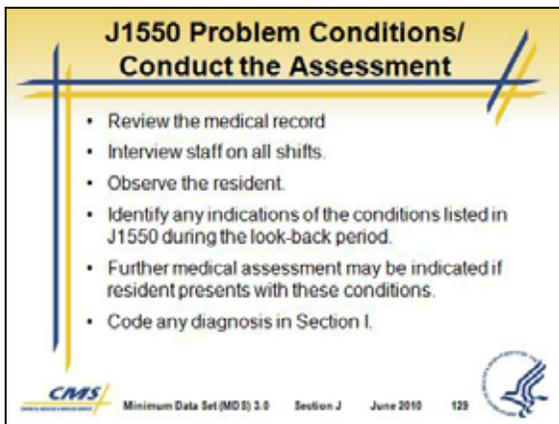
E. J1400 Scenario Coding

1. Code J1400 as **1. Yes**.
2. The physician documented that her life expectancy is likely to be less than 6 months.

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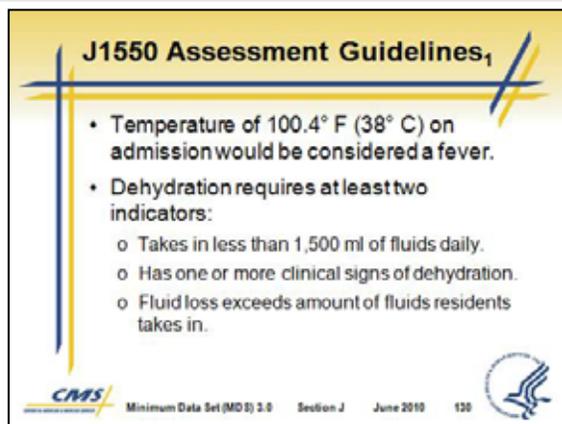
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INSTRUCTIONAL GUIDANCE

XV. Item J1550 Problem Conditions

- A. This item provides an opportunity for screening in the areas of fever, vomiting, fluid deficits, and internal bleeding.
- B. Clinical screenings provide indications for further evaluation, diagnosis and clinical care planning.
- C. J1550 Problem Conditions/ Conduct the Assessment
1. Timely assessment needed to identify:
 - a. Underlying causes
 - b. Risk for complications
 2. Review the medical record
 3. Interview staff on all shifts.
 4. Observe the resident.
 5. Identify any indications of the conditions listed in J1550 during the look-back period.
 - a. Vomiting
 - b. Fever
 - c. Potential indicators of dehydration
 - d. Internal bleeding
 6. If a resident present with any of these health conditions, further medical assessment may be indicated.
 7. If the resident is diagnosed with a specific condition, code the diagnosis in Section I.

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- B. J1550 Assessment Guidelines
1. Indication of fever
 - a. A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.
 2. To code dehydrated, the resident must present with at least 2 of the following 3 indicators:
 - a. Resident usually takes in less than the recommended 1,500 ml of fluids daily.
 - Water
 - Liquids in beverages
 - Water in foods with high fluid content (such as gelatin and soups).
 - b. 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).

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J1550 Assessment Guidelines₂

- **Internal bleeding guidelines:**
 - May be frank or occult.
 - Observe clinical indicators.
- **Do not code as internal bleeding:**
 - Nosebleeds that are easily controlled
 - Menses
 - Urinalysis that shows a small amount of red blood cells

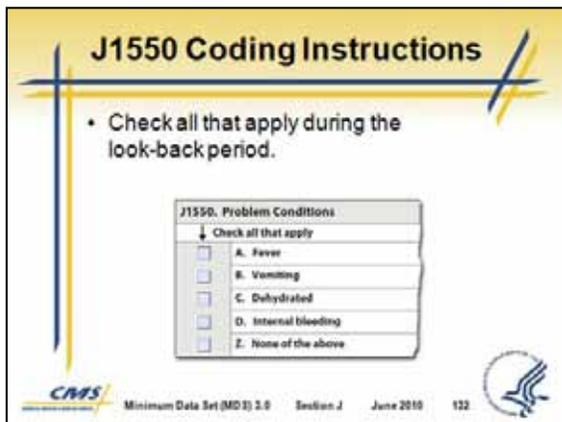
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- c. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
3. A resident who presents with only clinical signs of dehydration (the second indicator) does not meet the requirement for coding.
 4. Internal Bleeding
 - a. Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools).
 - b. Clinical indicators include:
 - Black, tarry stools
 - Vomiting "coffee grounds"
 - Hematuria (blood in urine)
 - Hemoptysis (coughing up blood)
 - Severe epistaxis (nosebleed) that requires packing
 - c. Do not code as internal bleeding:
 - Nose bleeds that are easily controlled
 - Menses
 - Urinalysis that shows a small amount of red blood cells

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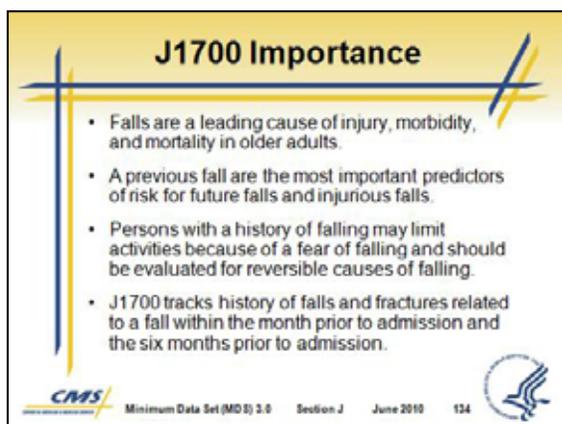
B. J1550 Coding Instructions

1. Check all that apply during the look-back period.



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XVI. Item J1700 Fall History on Admission



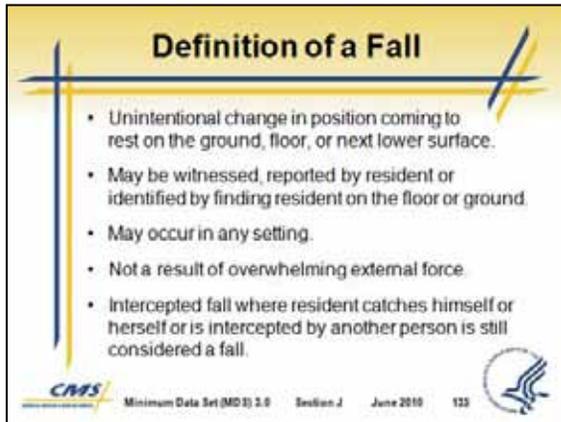
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A. J1700 Importance

1. Falls are a leading cause of injury, morbidity, and mortality in older adults.
2. A previous fall is the most important predictors of risk for future falls and injurious falls.
 - a. Recent fall
 - b. Recurrent falls
 - c. Falls with significant injury
3. Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.

SLIDES

INSTRUCTIONAL GUIDANCE



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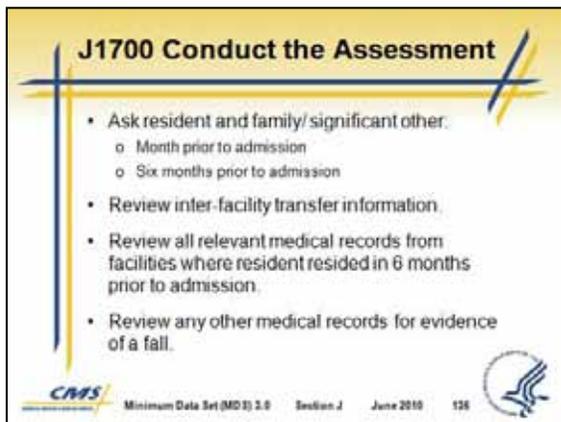
4. J1700 tracks history of falls and fractures related to a fall within the month prior to admission and the six months prior to admission.

B. Definition of a Fall

1. Unintentional change in position coming to rest on the ground, floor, or next lower surface.
 - Bed
 - Chair
 - Bedside mat
2. May be witnessed, reported by the resident, or identified by finding resident on the floor or ground.
3. May occur in any setting.
 - Home
 - Out in the community
 - In an acute hospital
 - In a nursing home
4. Not a result of overwhelming external force (e.g., a resident pushes another resident)
5. An intercepted fall occurs when the resident would have fallen if he or she had not caught himself or herself or had not been intercepted by another person
6. An intercepted fall is still considered a fall.

SLIDES

INSTRUCTIONAL GUIDANCE



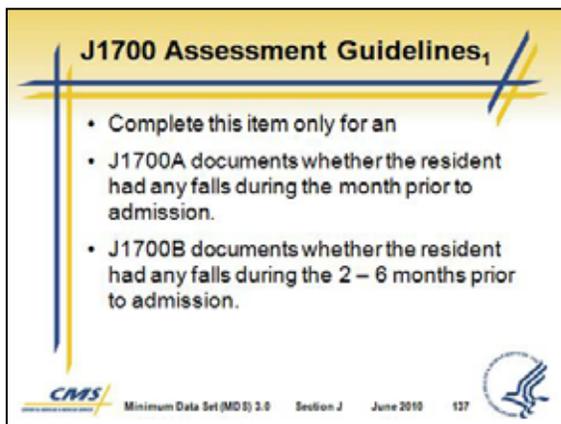
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C. J1700 Conduct the Assessment

1. Ask resident and family/significant other about a history of falls:
 - a. Month prior to admission
 - b. Six months prior to admission
 - c. This includes any fall, no matter where it occurred
2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls.
3. Review all relevant medical records from facilities where resident resided in 6 months prior to admission.
4. Review any other medical records received for evidence of one or more falls.

D. J1700 Assessment Guidelines

1. Complete this item only for an admission assessment or the most recent assessment since admission.
2. J1700A documents whether the resident had any falls in the month prior to admission to the facility.
3. J1700B documents whether the resident had any falls in the 2 – 6 months prior to admission.



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SLIDES

J1700 Assessment Guidelines₂

- J1700C documents whether the resident experienced a fracture due to fall in 6 months prior to admission.
 - o Documented in medical record, x-ray report, or resident history.
 - o Occurred as direct result of a fall or later attributed to a fall.
 - o Do not include car crashes, pedestrian accidents, or impact of person/ object against the resident.

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INSTRUCTIONAL GUIDANCE

4. J1700C documents whether the resident had any fracture related to a fall in the 6 months prior to admission.
 - a. Includes any documented bone fracture in a problem list from a medical record, an x-ray report, or by history of the resident or other caregiver
 - b. That occurred as a direct result of a fall or was recognized and later attributed to a fall
 - c. Do not include fractures caused by car crashes, pedestrian versus car accidents, or impact of person/ object against the resident.

J1700 Coding Instructions

- Code **0. No** if there is no report or documentation of falls or fracture due to falls.
- Code **1. Yes** if there is a report or documentation of falls or fracture due to falls.
- Code **9. Unable to determine** if resident, family or significant other cannot provide information and documentation is inadequate.

Section J Health Conditions
J1700, Fall History on Admission
Complete only if A0110A = 01 or A0111E = 1

Item Code A. Did the resident have a fall any time in the last month prior to admission?

0. No
 1. Yes
 9. Unable to determine

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E. J1700 Coding Instructions

1. Code **0. No** if there is no report or documentation of falls or fracture due to falls.
2. Code **1. Yes** if there is a report or documentation of falls or fracture due to falls.
3. Code **9. Unable to determine** if resident, family or significant other cannot provide information and documentation is inadequate.

SLIDES

INSTRUCTIONAL GUIDANCE

Instructor Notes

J1700A Did the Resident Have a Fall Any Time in the Last Month Prior to Admission? Detailed Coding Instructions

- **Code 0. No** if resident and family report no falls and transfer records and medical records do not document a fall in the month preceding the resident’s entry date (A1600).
- **Code 1. Yes** if resident or family report or transfer records or medical records document a fall in the month preceding the resident’s entry date (A1600).
- **Code 9.** Unable to determine if the resident is unable to provide the information or if the resident and family are not available or do not have the information and medical record information is inadequate to determine whether a fall occurred.

J1700B Did the Resident Have a Fall Any Time in the 2 – 6 Months Prior to Admission? Detailed Coding Instructions

- **Code 0. No** if resident and family report no falls and transfer records and medical records do not document a fall in the 2-6 months prior to the resident’s entry date (A1600).
- **Code 1. Yes** if resident or family report or transfer records or medical records document a fall in the 2-6 months prior to the resident’s entry date (A1600).
- **Code 9.** Unable to determine: if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

Instructor Notes

Instructor Notes

J1700C. Did the Resident Have Any Fracture Related to a Fall in the 6 Months prior to Admission? Detailed Coding Instructions

- **Code 0. No.** if resident and family report no fractures related to falls and transfer records and medical records do not document a fracture related to fall in the 6 months (0-180 days) preceding the resident’s entry date (A1600).
- **Code 1.** Yes if resident or family report or transfer records or medical records document a fracture related to fall in the 6 months (0-180 days) preceding the resident’s entry date (A1600).
- **Code 9.** Unable to determine if the resident is unable to provide the information, **or** if the resident and family are not available or do not have the information, and medical record information is inadequate to determine whether a fall occurred.

Instructor Notes

SLIDES

J1700 Scenario #1

- On admission interview, Mrs. J. is asked about falls and says she has "not really fallen."
- However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

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J1700 Scenario #1 Coding

- J1700A would be coded **1. Yes.**
- Falls caused by slipping meet the definition of falls.

Section J Health Conditions

J1700. Fall History on Admission
Complete only if AG010A = 01 or AG010E = 1

Q. Did the resident have a fall any time in the last month prior to admission?

1. Yes

2. No

3. Unable to determine

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J1700 Scenario #2

- Ms. P. has a history of a "Colle's fracture" of her left wrist about 3 weeks before nursing home admission.
- Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

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INSTRUCTIONAL GUIDANCE

F. J1700 Scenario #1

- On admission interview, Mrs. J. is asked about falls and says she has "not really fallen."
- However, she goes on to say that when she went shopping with her daughter about 2 weeks ago, her walker got tangled with the shopping cart and she slipped down to the floor.

3. J1700 Scenario #1 Coding

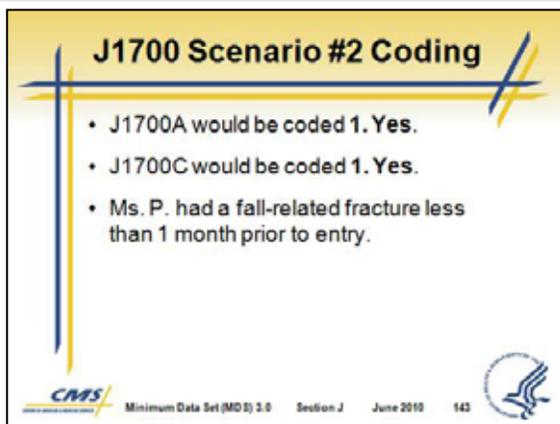
- J1700A would be coded **1. Yes.**
- Falls caused by slipping meet the definition of falls.

G. J1700 Scenario #2

- Ms. P. has a history of a "Colle's fracture" of her left wrist about 3 weeks before nursing home admission.
- Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

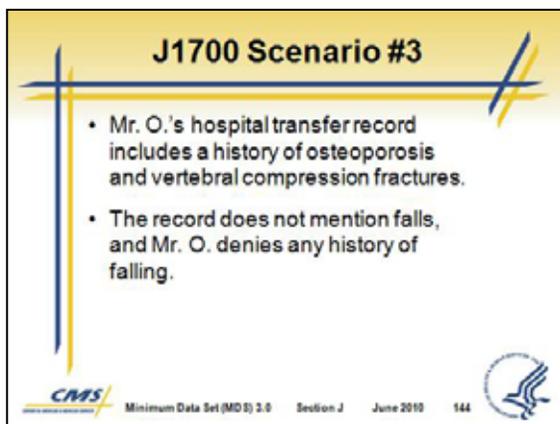
SLIDES

INSTRUCTIONAL GUIDANCE



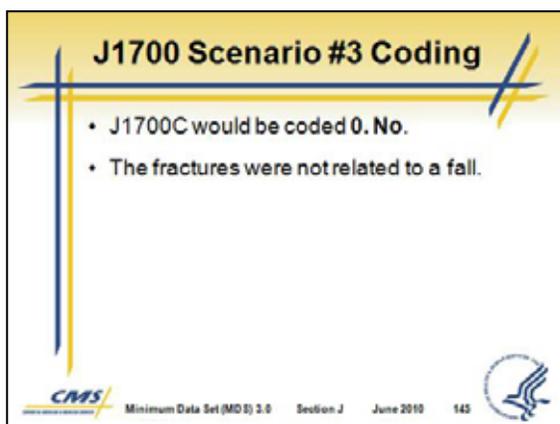
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3. J1700 Scenario #2 Coding
 - a. J1700A would be coded **1. Yes.**
 - b. J1700C would be coded **1. Yes.**
 - c. Ms. P. had a fall-related fracture less than 1 month prior to entry.



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- H. J1700 Scenario #3
 1. Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures.
 2. The record does not mention falls, and Mr. O. denies any history of falling.

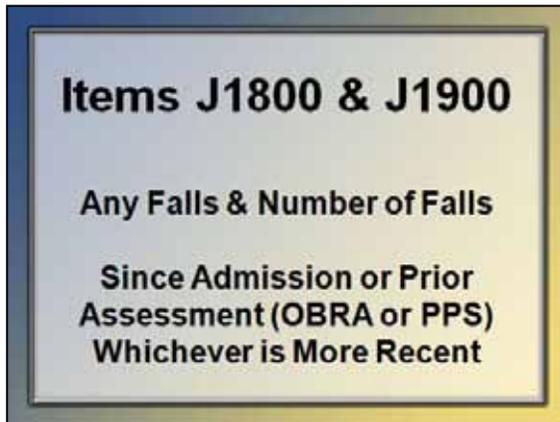


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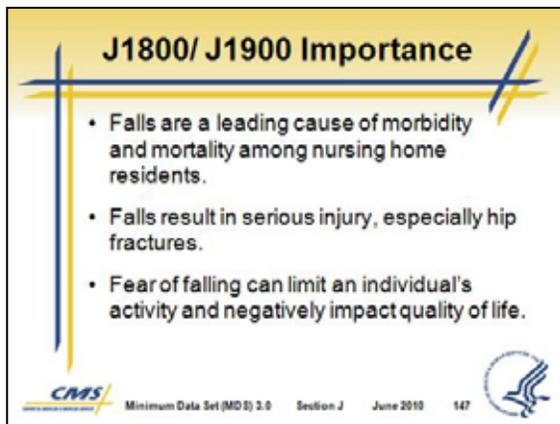
3. J1700 Scenario #3 Coding
 - a. J1700C would be coded **0. No.**
 - b. The fractures were not related to a fall.

SLIDES

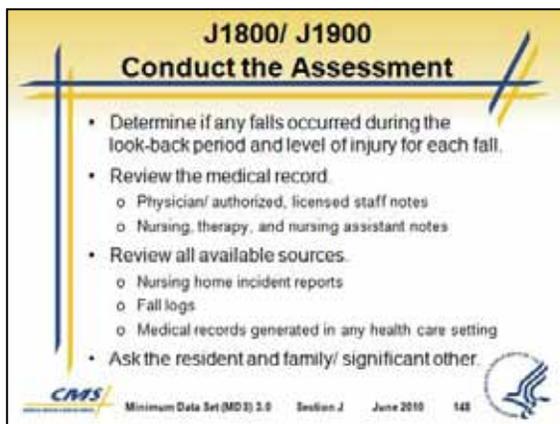
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XVII. Items J1800 & J1900 Any Falls & Number of Falls Since Admission or Prior Assessment (OBRA or PPS) Whichever is More Recent

A. J1800/ J1900 Importance

1. Falls are a leading cause of morbidity and mortality among nursing home residents.
2. Falls result in serious injury, especially hip fractures.
3. Fear of falling can limit an individual's activity and negatively impact quality of life.

B. J1800/ J1900 Conduct the Assessment

1. Determine if any falls occurred during the look-back period and the level of injury for each fall.
2. Review the medical record.
 - a. Physician/ authorized, licensed staff notes
 - b. Nursing, therapy, and nursing assistant notes
3. Review all available sources for any fall since the last assessment.

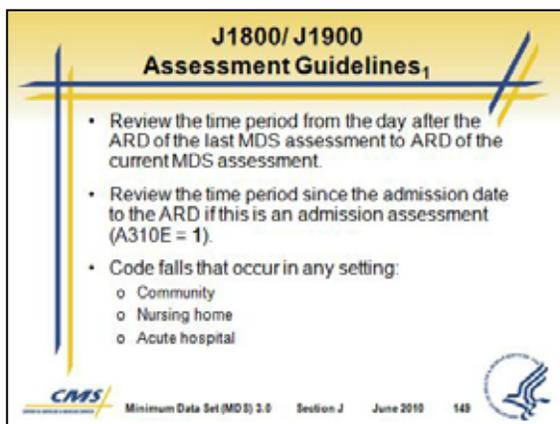
SLIDES

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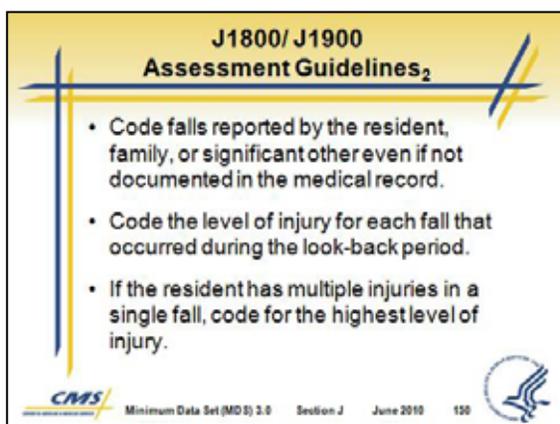
- a. Nursing home incident reports
 - b. Fall logs
 - c. Medical records generated in any health care setting
4. Ask the resident and family about falls during the look-back period.

C. J1800/ J1900 Assessment Guidelines

1. Review the time period from the day after the ARD of the last MDS assessment to ARD of the current MDS assessment.
2. Review the time period since the admission date to the ARD if this is an admission assessment (A310E = 1).
3. Code falls that occur in any setting:
 - a. Community
 - b. Nursing home
 - c. Acute hospital
4. Code falls reported by the resident, family, or significant other even if not documented in the medical record.
5. Code the level of injury for each fall that occurred during the look-back period.
6. If the resident has multiple injuries in a single fall, code for the highest level of injury.



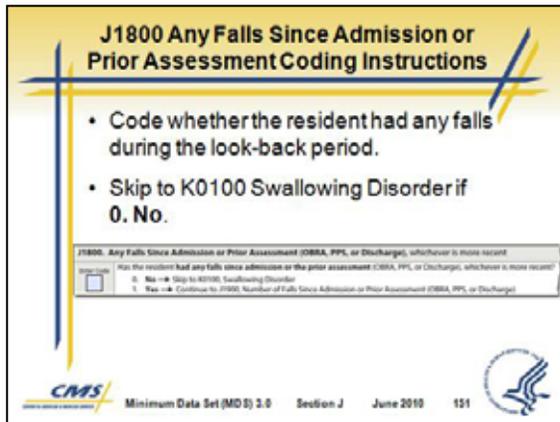
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D. J1800 Any Falls Since Admission or Prior Assessment Coding Instructions

- Code 0. No

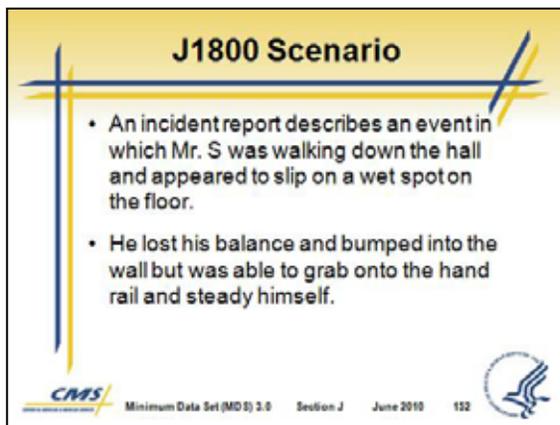
If the resident has not had any fall since the last assessment.

Skip to Swallowing Disorder item (K0100).

- **Code 1. Yes**

If the resident has fallen since the last assessment.

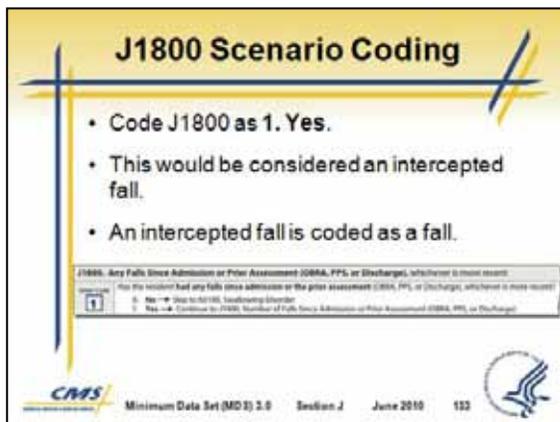
Continue to Number of Falls Since Admission or Prior Assessment (OBRA or PPS) item (J1900), whichever is more recent.



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E. J1800 Scenario

1. An incident report describes an event in which Mr. S was walking down the hall and appeared to slip on a wet spot on the floor.
2. He lost his balance and bumped into the wall but was able to grab onto the hand rail and steady himself.



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3. J1800 Scenario Coding

- a. Code J1800 as **1. Yes**.
- b. This would be considered an intercepted fall.
- c. An intercepted fall is coded as a fall.

SLIDES	INSTRUCTIONAL GUIDANCE
	<p>F. J1900 Number of Falls Since Admission or Prior Assessment Coding Instructions</p> <ol style="list-style-type: none"> 1. Enter a code for each item to indicate the number of falls resulting in that level of injury. <ul style="list-style-type: none"> • Code 0. None • Code 1. One • Code 2. Two or more 2. Code the level of injury for each fall that occurred during the look-back period. <ul style="list-style-type: none"> • A. No injury • B. Injury (except major) • C. Major injury 3. Code each fall only once.

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	Instructor Notes	
Notes	<p>Injury Related to a Fall</p> <p>Any documented injury that occurred as a direct result of or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.</p>	Notes
	Instructor Notes	
	Instructor Notes	
Notes	<p>Injury Definitions</p> <ul style="list-style-type: none"> • No injury - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall. • Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain • Injury (except major) - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain 	Notes
	Instructor Notes	

SLIDES

INSTRUCTIONAL GUIDANCE

Instructor Notes

J1900A. No Injury Detailed Coding Instructions

- **Code 0. None** if the resident had no injurious fall since the admission or prior assessment.
- **Code 1. One** if the resident had one fall with no injury since admission or prior assessment.
- **Code 2. Two or more** if the resident had two or more falls with no injury since admission or prior assessment.

J1900B. Injury (Except Major) Detailed Coding Instructions

- **Code 0. None** if the resident had no injurious fall (except major) since admission or prior assessment.
- **Code 1. One** if the resident had one injurious fall (except major) since admission or prior assessment.
- **Code 2. Two or more** if the resident had two or more injurious falls (except major) since admission or prior assessment.

J1900C. Major Injury Detailed Coding Instructions

- **Code 0. None** if the resident had no major injurious fall since admission or prior assessment.
- **Code 1. One** if the resident had one major injurious fall since admission or prior assessment.
- **Code 2. Two or more** if the resident had two or more major injurious falls since admission or prior assessment.

Instructor Notes

J1900 Scenario #1

- A nursing note states that Mrs. K slipped out of her wheelchair onto the floor while at the dining room table.
- Before being assisted back into her chair, an assessment was completed that indicated no injury.

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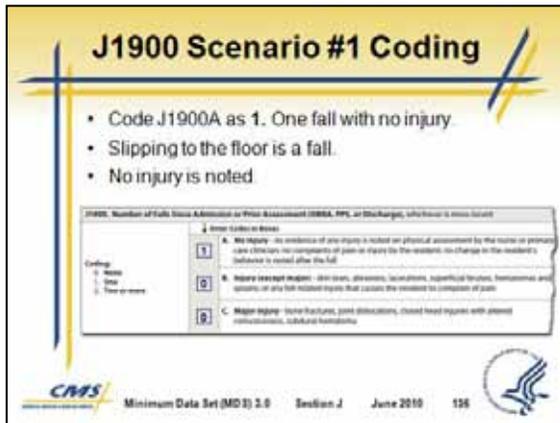
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G. J1900 Scenario #1

1. A nursing note states that Mrs. K slipped out of her wheelchair onto the floor while at the dining room table.
2. Before being assisted back into her chair, an assessment was completed that indicated no injury.

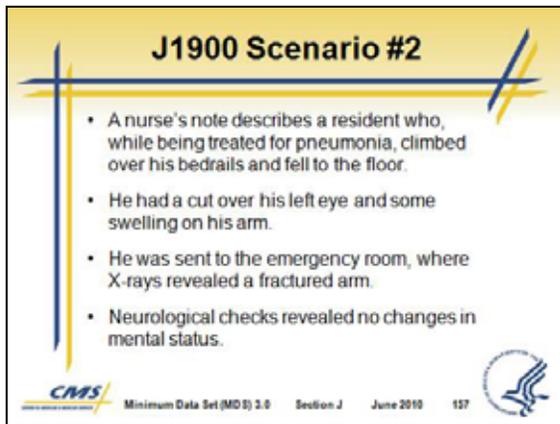
SLIDES

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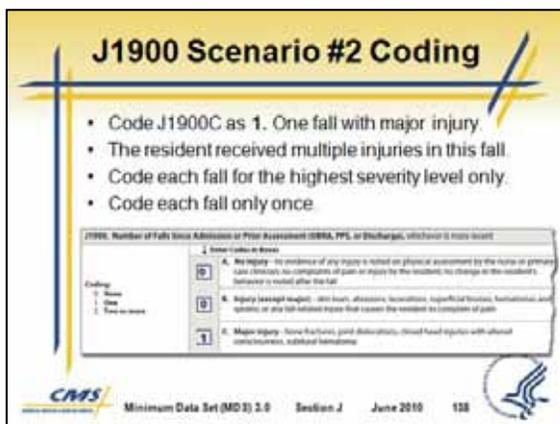
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3. J1900 Scenario #1 Coding
 - a. Code J1900A as **1**. One fall with no injury.
 - b. Slipping to the floor is a fall.
 - c. No injury is noted.



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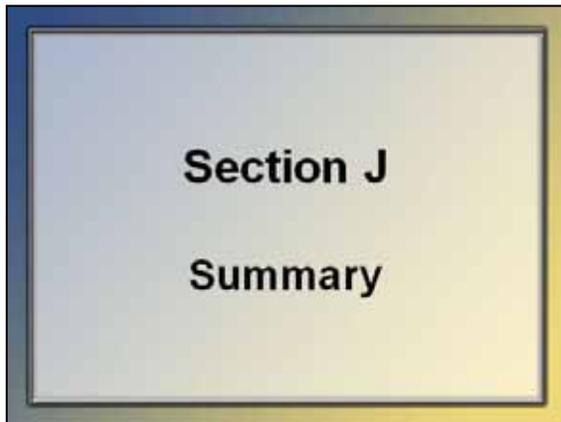
- H. J1900 Scenario #2
 1. A nurse's note describes a resident who, while being treated for pneumonia, climbed over his bedrails and fell to the floor.
 2. He had a cut over his left eye and some swelling on his arm.
 3. He was sent to the emergency room, where X-rays revealed a fractured arm.
 4. Neurological checks revealed no changes in mental status.



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5. J1900 Scenario #2 Coding
 - a. Code J1900C as **1**. One fall with major injury.
 - b. The resident received multiple injuries in this fall.
 - c. Code each fall for the highest severity level only.
 - d. Code each fall only once.

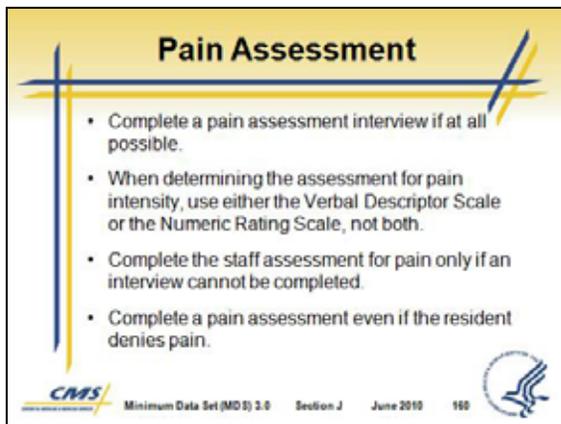
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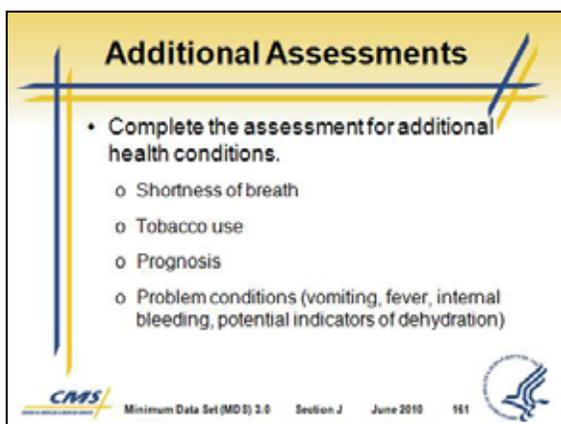
XVIII. Section J Summary



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A. Pain Assessment

1. Complete a pain assessment interview if at all possible.
2. When determining the assessment for pain intensity, use either the Verbal Descriptor Scale or the Numeric Rating Scale, not both.
3. Complete the staff assessment for pain only if an interview cannot be completed.
4. Complete a pain assessment even if the resident denies pain.

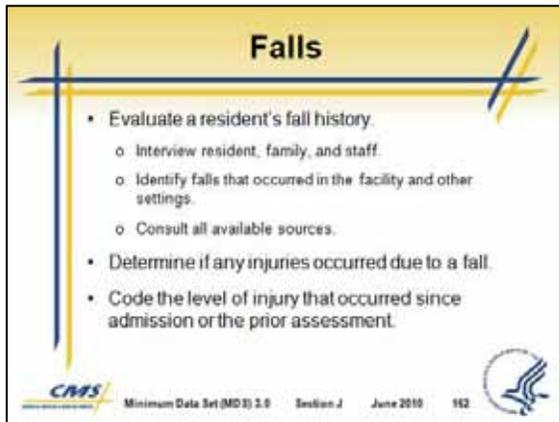


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B. Additional Assessments

1. Complete the assessment for additional health conditions.
2. Shortness of breath
3. Tobacco use
4. Prognosis
5. Problem conditions (vomiting, fever, internal bleeding, potential indicators of dehydration)

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C. Falls

1. Evaluate a resident's fall history.
 - a. Interview resident, family, and staff.
 - b. Identify falls that occurred in the facility and other settings.
 - c. Consult all available sources.
2. Determine if any injuries occurred due to a fall.
3. Code the level of injury that occurred since admission or the prior assessment.