

Section J

Health Conditions

Objectives₁

- State the intent of Section J Health Conditions.
- 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.

Objectives₂

- 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.

Intent of Section J

- Document health conditions that impact a resident's functional status and quality of life:

- o Pain
- o Dyspnea
- o Tobacco use
- o Prognosis
- o Problem conditions
- o Falls



Pain Assessment

- Consists of an interview with resident.
- Conduct a staff assessment only if resident is unable to participate in the interview.
- Pain items assess:
 - Presence of pain
 - Frequency of pain
 - Effect on function
 - Intensity
 - Management
 - Control



Item J0100

Pain Management

J0100 Importance

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

J0100 Conduct the Assessment

- Determine what, if any, pain management interventions the resident **received** during the look-back period.
 - o Review the medical record.
 - o Interview staff and direct caregivers.

J0100 Assessment Guidelines

- The look-back period is **5 days**.
- Include information from all disciplines.
- Determine all interventions provided to the resident.
- Answer these items even if resident denies pain.

J0100A Scheduled Pain Medication Regimen Coding Instructions

- Code **0. No** if 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.

A. Been on a scheduled pain medication regimen?

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 <input type="checkbox"/>	A. Been on a scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Received PRN pain medications? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Received non-medication intervention for pain? 0. No 1. Yes

J0100B Received PRN Pain Medications Coding Instructions

- Code **0. No** if record does not contain documentation that a **PRN medication** was received or offered.
- Code **1. Yes** if record contains documentation that a **PRN medication** was either received OR offered but was declined.

B. Received PRN pain medications?

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 <input type="checkbox"/>	A. Been on a scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Received PRN pain medications? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Received non-medication intervention for pain? 0. No 1. Yes

J0100C Received Non-Medication Intervention Coding Instructions

- Code **0. No** if medical record does not contain documentation that a **non-medication** pain intervention was received.
- Code **1. Yes** if medical record contains documentation that:
 - Non-medication pain intervention scheduled as part of the care plan.
 - Intervention actually received and assessed for efficacy.

Enter Code <input type="checkbox"/>	C. Received non-medication intervention for pain? 0. No 1. Yes
----------------------------------------	-----------------------------------------------------------------------------

J0100 Scenario

- The resident's medical record documents that she received the following pain management in the past 5 days:
 - Hydrocodone/ acetaminophen 5/ 500 1 tab PO every 6 hours. Discontinued on day 1 of look-back period.
 - Acetaminophen 500mg PO every 4 hours. Started on day 2 of look-back period.
 - Cold pack to left shoulder applied by PT BID. PT notes that resident reports significant pain improvement after cold pack applied.

J0100 Scenario Coding₁

- Code J0100A as **1. Yes.**
- The medical record indicated that the resident received a scheduled pain medication during the 5-day look-back period.
- Code J0100B as **0. No.**
- 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.

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 <input type="text" value="1"/>	A. Been on a scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="text" value="0"/>	B. Received scheduled pain medications?
Enter Code <input type="text" value="1"/>	C. Received scheduled non-medication intervention for pain?

Enter Code

Enter Code

Enter Code

J0100 Pain Management Practice

- The resident's medical record includes the following pain management documentation:
 - 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.

How should J0100A be coded?

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

J0100A Coding

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

Enter Code <input type="text" value="0"/>	A. Been on a scheduled pain medication regimen? 0. No 1. Yes
Enter Code <input type="text" value="0"/>	A.

How should J0100B be coded?

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

J0100B Coding

- The correct coding is **0. No.**
- 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.

How should J0100C be coded?

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

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.

Enter Code 0	C. Received non-medication intervention for pain? 0. No 1. Yes
Enter Code 0	C.

Item J0200

**Should Pain Assessment
Interview Be Conducted?**

J0200 Importance

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

J0200 Conduct the Assessment

- Determine whether resident is understood at least sometimes.
- Review A1100 to determine whether resident needs or wants an interpreter.
- Make every effort to have an interpreter present if needed or requested.
- Skip to J1100 if the resident is comatose (B0100 = 1).

J0200 Coding Instructions

- Code **0. No** if resident is rarely/ never understood or an interpreter is required but not available.
- Code **1. Yes** if resident is at least sometimes understood and an interpreter is present or not required.

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain

1. **Yes** → Continue to J0300, Pain Presence

Items J0300- J0600

Pain Assessment Interview

Importance of Pain Assessment₁

- Effects of unrelieved pain impact the individual.
 - Functional decline
 - Complications of immobility
 - Skin breakdown
 - Infections
- Pain significantly adversely affects quality of life.
 - Depressed mood
 - Diminished self-confidence and self-esteem
 - Increase in behavior problems, particularly for cognitively-impaired residents

Importance of Pain Assessment₂

- Some older adults limit their activities in order to avoid having pain.
- Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

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

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 look-back period.
- Ask each question in order and as written.
- Code **9** if the resident refuses to answer and move on to the next question.
- Use other terms for “pain” or follow-up discussion if resident seems unsure or hesitant.

Pain Assessment Interview Guidelines₂

- If the resident is unsure about whether pain occurred during the look-back period:
 - Prompt resident to think about the most recent episode.
 - Try to determine whether it occurred during the look-back period.
- The interview is considered complete if:
 - Resident answers “No” to J0300 Pain Presence.

OR

 - Resident answers “Yes” to J0300 and answers J0400 Pain Frequency.

Pain Assessment Interview Guidelines₃

- Complete the Staff Assessment for Pain if:
 - Resident is unable to or does not respond to J0300 Pain Presence (J0300 = **9**).
 - Resident answers “Yes” to J0300 but cannot or will not answer J0400 Pain Frequency (J0400 = **9**).
- Complete the rest of the pain interview **even if** the resident cannot or will not answer J0400 Pain Frequency in order to enable pain assessment.
- Completing the staff assessment if J0400 = **9** helps determine presence **AND** frequency.

Conduct the Interview

- Establish a conducive environment.
- Use an interpreter if needed.
- Make sure the resident can hear you.
- Explain the reason for the interview.
- Explain the response choices.
- Show responses in large font as appropriate.
- Allow resident to write responses if needed.

Item J0300

Pain Presence

J0300 Pain Presence Conduct the Assessment/ Guidelines

- Ask the question as written.
- Code for the presence or absence of pain regardless of pain management efforts.
- Rates of self-reported pain are higher than observed rates.

"Have you had pain or hurting at any time in the last 5 days?"

Pain Assessment Interview

J0300. Pain Presence

Enter Code

Ask resident: ***"Have you had pain or hurting at any time in the last 5 days?"***

0. **No** → Skip to J1100, Shortness of Breath

1. **Yes** → Continue to J0400, Pain Frequency

9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0300 Coding Instructions₁

- **Code 0. No.**
 - Resident responds “no” to presence of pain.
 - Even if resident received pain management interventions.
 - Interview is complete.
 - Skip to J1100 Shortness of Breath.
- **Code 1. Yes.**
 - Resident responds “yes” to presence of pain during the look-back period.
 - Continue with the pain assessment interview.

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).

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.”

J0300 Scenario Coding

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

Pain Assessment Interview	
J0300. Pain Presence	
Enter Code	Ask resident: " Have you had pain or hurting at any time in the last 5 days? "
0	0 - No → Skip to J1100, Shortness of Breath
	1 - Yes → Skip to J0400, Pain Frequency
	2 - Other → Skip to J0800, Indicators of Pain or Possible Pain

Enter Code

0

J0300 Practice #1

- When asked about pain, Mr. T. responds, “No pain, but I have had a terrible burning sensation all down my leg.”

How should J0300 be coded?

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

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.

Pain Assessment Interview	
J0300. Pain Presence	
Enter Code	Ask resident: " Have you had pain or hurting at any time in the last 5 days? "
1	0 - No → Skip to J1100, Shortness of Breath 1 - Yes → Skip to J0400, Pain Frequency 2 - Other → Skip to J0800, Indicators of Pain or Possible Pain

Enter Code

1

Item J0400

Pain Frequency

J0400 Pain Frequency

Conduct the Assessment

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

"How much of the time have you experienced pain or hurting over the last 5 days?"

J0400. Pain Frequency

Enter Code

Ask resident: *"How much of the time have you experienced pain or hurting over the last 5 days?"*

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0400 Pain Frequency Assessment Guidelines

- Do not offer definitions of response options.
- Resident's response should be based on the resident's interpretation of the frequency options.
- Use echoing to help clarify the preferred option if the resident does not respond according to the response scale.

J0400 Coding Instructions

- Code the resident's response.
- If the resident has difficulty choosing between two responses:
 - Use echoing to help resident clarify the response.
 - Code the more frequent of the two responses.

J0400. Pain Frequency											
Enter Code	Ask resident: " How much of the time have you experienced pain or hurting over the last 5 days? "										
<input type="checkbox"/>	<table border="1"><tbody><tr><td>1. Almost constantly</td><td>1. Almost constantly</td></tr><tr><td>2. Frequently</td><td>2. Frequently</td></tr><tr><td>3. Occasionally</td><td>3. Occasionally</td></tr><tr><td>4. Rarely</td><td>4. Rarely</td></tr><tr><td>9. Unable to answer</td><td>9. Unable to answer</td></tr></tbody></table>	1. Almost constantly	1. Almost constantly	2. Frequently	2. Frequently	3. Occasionally	3. Occasionally	4. Rarely	4. Rarely	9. Unable to answer	9. Unable to answer
1. Almost constantly	1. Almost constantly										
2. Frequently	2. Frequently										
3. Occasionally	3. Occasionally										
4. Rarely	4. Rarely										
9. Unable to answer	9. Unable to answer										

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.”

J0400 Scenario Coding

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

J0400. Pain Frequency

Ask resident: "*How much of the time have you experienced pain or hurting over the last 5 days?*"

Enter Code	1. Almost constantly
4	2. Frequently
	3. Occasionally
	4. Rarely
	9. Other

Enter Code

4

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.”

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

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

Ask resident: "*How much of the time have you experienced pain or hurting over the last 5 days?*"

Enter Code	1. Almost constantly
3	2. Frequently
	3. Occasionally
	4. Seldom
	9. Other

Enter Code

3

J0400 Practice #2

- When asked about pain, Mr. J. responds:
 - “I don’t know if it is frequent or occasional.
 - My knee starts throbbing every time they move me from the bed or the wheelchair.”
- The interviewer says:
 - “Your knee throbs every time they move you.
 - 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.

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

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.

Item J0500

Pain Effect on Function

J0500 Pain Effect on Function

Conduct the Assessment

- Ask each question as written.

"Over the past 5 days, has pain made it hard for you to sleep at night?"

J0500. Pain Effect on Function	
Enter Code <input type="checkbox"/>	A. Ask resident: <i>"Over the past 5 days, has pain made it hard for you to sleep at night?"</i> 0. No 1. Yes 9. Unable to answer
Enter Code <input type="checkbox"/>	B. Ask resident: <i>"Over the past 5 days, have you limited your day-to-day activities because of pain?"</i> 0. No 1. Yes 9. Unable to answer

"Over the past 5 days, have you limited your day-to-day activities because of pain?"

J0500 Pain Effect on Function Assessment Guidelines

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

J0500 Coding Instructions

- Code the resident's response to each question.

0 No
1 Yes
9 Unable to answer

J0500. Pain Effect on Function	
Enter Code <input type="checkbox"/>	A. Ask resident: " <i>Over the past 5 days, has pain made it hard for you to sleep at night?</i> " 0. No 1. Yes 9. Unable to answer
Enter Code <input type="checkbox"/>	B. Ask resident: " <i>Over the past 5 days, have you limited your day-to-day activities because of pain?</i> " 0. No 1. Yes 9. Unable to answer

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.”

J0500A Scenario Coding

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

J0500. Pain Effect on Function	
Enter Code	A. Ask resident: " <i>Over the past 5 days, has pain made it hard for you to sleep at night?</i> "
<input type="text" value="0"/>	0. No
	1. Yes
	9. Unable to answer

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.”

How should J0500A be coded?

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

J0500A Practice #1 Coding

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

J0500. Pain Effect on Function	
Enter Code	A. Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"
<input type="text" value="1"/>	0. No
	1. Yes
	9. Unable to answer

Enter Code

J0500A Practice #2

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

How should J0500A be coded?

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

J0500A Practice #2 Coding

- The correct coding is **0. No.**
- Mr. E. reports that his sleep problems are not related to pain.

J0500. Pain Effect on Function	
Enter Code	A. Ask resident: "Over the past 5 days, <i>has pain made it hard for you to sleep at night?</i> "
<input type="text" value="0"/>	0. No
	1. Yes
	9. Unable to answer

Enter Code

J0500B Scenario

- Mrs. N. responds, “Yes, I haven’t been able to play the piano, because my shoulder hurts.”

J0500B Scenario Coding

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

Enter Code

1

B. Ask resident: "Over the past 5 days, *have you limited your day-to-day activities because of pain?*"

0. No
1. Yes
9. Unable to answer

Enter Code

1

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?

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

J0500B Practice #1 Coding

- The correct coding is **0. No.**
- Although Ms. L. reports pain, she did not limit her activity because of it.

Enter Code	B. Ask resident: " <i>Over the past 5 days, have you limited your day-to-day activities because of pain?</i> "
<input type="text" value="0"/>	0. No
	1. Yes
	9. Unable to answer

Enter Code
<input type="text" value="0"/>

J0500B Practice #2

- Mrs. S. responds, “I don’t know.
- 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.”

How should J0500B be coded?

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

J0500B Practice #2 Coding

- The correct coding is **1. Yes.**
- Mrs. S. avoided a usual activity because of fear that her pain would increase.

Enter Code 1	B. Ask resident: " <i>Over the past 5 days, have you limited your day-to-day activities because of pain?</i> " 0. No 1. Yes 9. Unable to answer
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Enter Code
1

Item J0600

Pain Intensity

J0600 Pain Intensity

- Numeric Rating Scale (scale of **00** to **10**)
- Verbal Descriptor Scale
- Complete only one of these items, not both.

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating <input type="text"/> <input type="text"/>	A. Numeric Rating Scale (00-10) Ask resident: " <i>Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.</i> " (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.
Enter Code <input type="text"/>	B. Verbal Descriptor Scale Ask resident: " <i>Please rate the intensity of your worst pain over the last 5 days.</i> " (Show resident verbal scale) 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

J0600 Conduct the Assessment

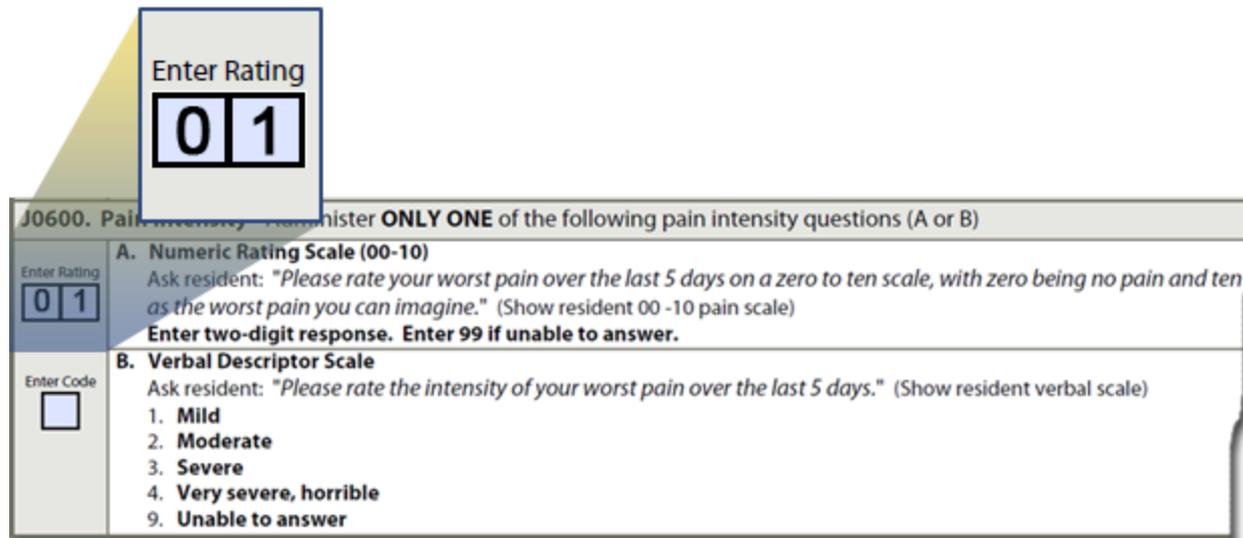
- Read the question and response options slowly.
- Ask the resident to rate his or her **worst** pain.
 - “Please rate your worst pain over the last 5 days with zero being no pain, and ten as the worst pain you can imagine.”
 - “Please rate the intensity of your worst pain over the last 5 days.”
- Use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

J0600 Assessment Guidelines

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

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.



Enter Rating
01

J0600. Pain Intensity. Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating
01

A. Numeric Rating Scale (00-10)
Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code

B. Verbal Descriptor Scale
Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale)

1. Mild
2. Moderate
3. Severe
4. Very severe, horrible
9. Unable to answer

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.

Enter Code	
1	
J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter Rating <input type="text"/>	A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.
Enter Code 1	B. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale) 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

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.”

J0600 Scenario #1 Coding

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

Enter Rating	
06	
J0600. Pain intensity. Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter Rating	A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.
06	
Enter Code	B. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale)
<input type="checkbox"/>	1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

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.”

J0600 Scenario #2 Coding

- Code J0600B as **3**. Severe.
- The resident said his worst pain was “Severe.”

Enter Code	
3	
J0600. Pain Intensity - Administer ONLY ONE of the following pain intensity questions (A or B)	
Enter Rating <input type="text"/>	A. Numeric Rating Scale (00-10) Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." (Show resident 00 -10 pain scale) Enter two-digit response. Enter 99 if unable to answer.
Enter Code 3	B. Verbal Descriptor Scale Ask resident: "Please rate the intensity of your worst pain over the last 5 days." (Show resident verbal scale) 1. Mild 2. Moderate 3. Severe 4. Very severe, horrible 9. Unable to answer

Section J

Pain Assessment Interview Activity

Activity Instructions

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

Pain Assessment Interview Video



The Video on Interviewing Vulnerable Elders (VIVE) was funded by the Picker Institute and produced by the UCLA/ JH Borun Center. DVD copies can be obtained from CMS.

Pain Assessment Interview Coding

- J0300 1. Yes
- J0400 1 Almost constantly
- J0500A (sleep) 1. Yes
- J0500B (activities) 1. Yes
- J0600A Numeric Rating Scale code **08**

Item J0700

**Should the Staff
Assessment for Pain
Be Conducted**

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.

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.

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?

Enter Code

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

Items J0800 & J0850

Staff Assessment for Pain

J0800/ J0850 Importance₁

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

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:
 - o Dependence
 - o Contractures
 - o Skin breakdown
 - o 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.

Indicators of Pain₁

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

Indicators of Pain₂

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

J0800 Conduct the Assessment

- Review the medical record.
 - Look for documentation of indicators of pain.
 - Confirm presence of indicators of pain with direct care staff on all shifts who work with resident during ADLs.
- Interview staff.
 - Question staff who observe or assist the resident.
 - Ask about presence of each indicator not in the record.
- Observe the resident.

J0800 Assessment Guidelines

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

J0800 Coding Instructions

- Check all indicators of pain that apply.
- Based on staff observation of indicators of pain.
- Check **Z** if no indicators of pain are observed.

Staff Assessment for Pain	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ Check all that apply	
<input type="checkbox"/>	A. Non-verbal sounds (crying, whining, gasping, moaning, or groaning)
<input type="checkbox"/>	B. Vocal complaints of pain (that hurts, ouch, stop)
<input type="checkbox"/>	C. Facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
<input type="checkbox"/>	D. Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
<input type="checkbox"/>	Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

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.

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	
J0800. Indicators of Pain or Possible Pain in the last 5 days	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Non-verbal sounds (crying, whining, gasping, moaning, or groaning)
<input checked="" type="checkbox"/>	B. Vocal complaints of pain (that hurts, ouch, stop)
<input checked="" type="checkbox"/>	C. Facial expressions (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
<input checked="" type="checkbox"/>	D. Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
<input type="checkbox"/>	Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850 Frequency of Pain Indicators

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

J0850 Coding Instructions

- Code **1** if indicators observed 1-2 days.
- Code **2** if indicators observed 3-4 days.
- Code **3** if indicators observed daily.
- Do not code the number of times that indicators of pain were observed or documented.

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code

Frequency with which resident complains or shows evidence of pain or possible pain

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**

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.

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	
Enter Code	Frequency with which resident complains or shows evidence of pain or possible pain
1	<ol style="list-style-type: none">1. Indicators of pain or possible pain observed 1 to 2 days2. Indicators of pain or possible pain observed 3 to 4 days3. Indicators of pain or possible pain observed daily

Item J1100

Shortness of Breath

J1100 Importance

- Can be an extremely distressing symptom to residents.
- Can lead to decreased interaction and quality of life.
- Some residents compensate by:
 - Limiting activity
 - Lying flat by elevating the head of the bed
- Do not alert caregivers to the problem.

J1100 Conduct the Assessment₁

- Interview the resident.
 - Ask about shortness of breath or trouble breathing.
 - If not, ask if shortness of breath occurs during certain activities.
- Review the medical record.
- Interview staff on all shifts and family/ significant other.
 - History of shortness of breath
 - Allergies
 - Other environmental triggers

J1100 Conduct the Assessment₂

- Observe resident for signs.
 - Increased respiratory rate
 - Pursed lip breathing
 - Prolonged expiratory phase
 - Audible respirations
 - Gasping for air at rest
 - Interrupted speech pattern
 - Use of shoulder/ other accessory muscles to breathe
- Note whether shortness of breath occurs with certain positions or activities.

J1100 Assessment Guidelines

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

J1100 Coding Instructions

- J0800A Exertion
 - Limited activity (turning or moving in bed)
 - Strenuous activity (transferring, walking, bathing)
 - Avoids or unable to engage in activity
- J0800C Lying Flat
 - Resident attempts or avoids lying flat

Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
<input type="checkbox"/>	A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)
<input type="checkbox"/>	B. Shortness of breath or trouble breathing when sitting at rest
<input type="checkbox"/>	C. Shortness of breath or trouble breathing when lying flat
<input type="checkbox"/>	Z. None of the above

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.

J1100 Scenario #1 Coding

- Check J1100A with exertion.
- Check J1100C when lying flat.
- Mrs. W. reported being short of breath when lying down as well as during outings that required ambulating longer distances.

Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)
<input type="checkbox"/>	B. Shortness of breath or trouble breathing when sitting at rest
<input checked="" type="checkbox"/>	C. Shortness of breath or trouble breathing when lying flat
<input type="checkbox"/>	Z. None of the above

J1100 Scenario #2

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

J1100 Scenario #2 Coding

- Check J1100A with exertion.
- Check J1100B when sitting at rest.
- Mr. T. was short of breath at rest and was noted to avoid activities because of shortness of breath.

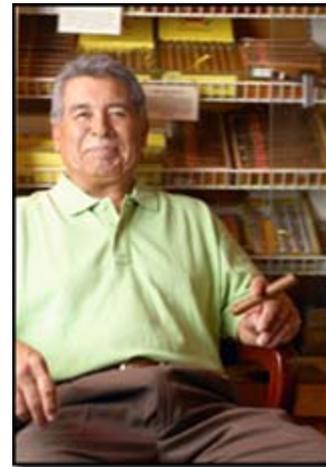
Other Health Conditions	
J1100. Shortness of Breath (dyspnea)	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)
<input checked="" type="checkbox"/>	B. Shortness of breath or trouble breathing when sitting at rest
<input type="checkbox"/>	C. Shortness of breath or trouble breathing when lying flat
<input type="checkbox"/>	Z. None of the above

Item J1300

Current Tobacco Use

J1300 Importance

- The negative effects of smoking can shorten life expectancy.
- Create health problems that interfere with daily activities and adversely affect quality of life.
- Includes tobacco used in any form.



J1300 Conduct the Assessment

- Ask the resident if used tobacco in any form during the look-back period.
- Review the medical record and interview staff about indications of tobacco use.
 - Resident is unable to answer.
 - Resident indicates that he or she did not use tobacco during the look-back period.

J1300 Coding Instructions

- Code **0. No** if there are no indications of use during the look-back period.
- Code **1. Yes** if the resident or any other source indicates tobacco use of some form.

J1300. Current Tobacco Use	
Enter Code <input type="checkbox"/>	Tobacco use 0. No 1. Yes

Item J1400

Prognosis

J1400 Importance

- Residents with conditions or diseases that may result in a life expectancy of less than 6 months:
 - o Have special needs.
 - o May benefit from palliative or hospice services in the nursing home.

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.

J1400 Coding Instructions

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

J1400. Prognosis

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

0. No	0 No
1. Yes	1 Yes

J1400 Scenario

- Mrs. T. has a diagnosis of heart failure.
- During the past few months, she has had three hospital admissions for acute heart failure.
- Her heart has become significantly weaker despite maximum treatment with medications and oxygen.
- 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.

J1400 Scenario Coding

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

J1400. Prognosis	
Enter Code	Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation)
<input type="text" value="1"/>	0. No 1. Yes

Item J1550

Problem Conditions

J1550 Problem Conditions/ Conduct the Assessment

- Review the medical record
- Interview staff on all shifts.
- Observe the resident.
- Identify any indications of the conditions listed in J1550 during the look-back period.
- Further medical assessment may be indicated if resident presents with these conditions.
- Code any diagnosis in Section I.

J1550 Assessment Guidelines₁

- Temperature of 100.4° F (38° C) on admission would be considered a fever.
- Dehydration requires at least two indicators:
 - o Takes in less than 1,500 ml of fluids daily.
 - o Has one or more clinical signs of dehydration.
 - o Fluid loss exceeds amount of fluids residents takes in.

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

J1550 Coding Instructions

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

J1550. Problem Conditions	
↓ Check all that apply	
<input type="checkbox"/>	A. Fever
<input type="checkbox"/>	B. Vomiting
<input type="checkbox"/>	C. Dehydrated
<input type="checkbox"/>	D. Internal bleeding
<input type="checkbox"/>	Z. None of the above

Item J1700

Fall History on Admission

J1700 Importance

- Falls are a leading cause of injury, morbidity, and mortality in older adults.
- A previous fall are the most important predictors of risk for future falls and injurious falls.
- Persons with a history of falling may limit activities because of a fear of falling and should be evaluated for reversible causes of falling.
- J1700 tracks history of falls and fractures related to a fall within the month prior to admission and the six months prior to admission.

Definition of a Fall

- Unintentional change in position coming to rest on the ground, floor, or next lower surface.
- May be witnessed, reported by resident or identified by finding resident on the floor or ground.
- May occur in any setting.
- Not a result of overwhelming external force.
- Intercepted fall where resident catches himself or herself or is intercepted by another person is still considered a fall.

J1700 Conduct the Assessment

- Ask resident and family/ significant other:
 - Month prior to admission
 - Six months prior to admission
- Review inter-facility transfer information.
- Review all relevant medical records from facilities where resident resided in 6 months prior to admission.
- Review any other medical records for evidence of a fall.

J1700 Assessment Guidelines₁

- Complete this item only for an admission assessment or the first assessment since the most recent entry of any kind.
- J1700A documents whether the resident had any falls during the month prior to the resident's entry date.
- J1700B documents whether the resident had any falls during the 2 – 6 months prior to the resident's entry date.

J1700 Assessment Guidelines₂

- J1700C documents whether the resident experienced a fracture due to fall in the 6 months prior to the entry date.
 - Documented in medical record, x-ray report, or resident history.
 - Occurred as direct result of a fall or later attributed to a fall.
 - Do not include car crashes, pedestrian 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 A0310A = 01 or A0310E = 1

Enter 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

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.

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 A0310A = 01 or A0310E = 1		
Enter Code	A. Did the resident have a fall any time in the last month prior to admission?	
1	0. No 1. Yes 9. Unable to determine	

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.

J1700 Scenario #2 Coding

- J1700A would be coded **1. Yes.**
- J1700C would be coded **1. Yes.**
- Ms. P. had a fall-related fracture less than 1 month prior to entry.

J1700 Scenario #3

- Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures.
- The record does not mention falls, and Mr. O. denies any history of falling.

J1700 Scenario #3 Coding

- J1700C would be coded **0. No.**
- The fractures were not related to a fall.

Items J1800 & J1900

Any Falls & Number of Falls

**Since Admission or Prior
Assessment (OBRA or PPS)
Whichever is More Recent**

J1800/ J1900 Importance

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

J1800/ J1900

Conduct the Assessment

- Determine if any falls occurred during the look-back period and level of injury for each fall.
- Review the medical record.
 - Physician/ authorized, licensed staff notes
 - Nursing, therapy, and nursing assistant notes
- Review all available sources.
 - Nursing home incident reports
 - Fall logs
 - Medical records generated in any health care setting
- Ask the resident and family/ significant other.

J1800/ J1900 Assessment Guidelines₁

- Review the time period from the day after the ARD of the last MDS assessment to ARD of the current MDS assessment.
- Review the time period since the admission date to the ARD if this is an admission assessment (A310E = 1).
- Code falls that occur in any setting:
 - Community
 - Nursing home
 - Acute hospital

J1800/ J1900 Assessment Guidelines₂

- Code falls reported by the resident, family, or significant other even if not documented in the medical record.
- Code the level of injury for each fall that occurred during the look-back period.
- If the resident has multiple injuries in a single fall, code for the highest level of injury.

J1800 Any Falls Since Admission or Prior Assessment Coding Instructions

- Code whether the resident had any falls during the look-back period.
- Skip to K0100 Swallowing Disorder if **0. No.**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code

Has the resident **had any falls since admission or the prior assessment (OBRA, PPS, or Discharge), whichever is more recent?**

0. **No** → Skip to K0100, Swallowing Disorder

1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1800 Scenario

- 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.
- He lost his balance and bumped into the wall but was able to grab onto the hand rail and steady himself.

J1800 Scenario Coding

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

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent	
Enter Code	Has the resident had any falls since admission or the prior assessment (OBRA, PPS, or Discharge), whichever is more recent?
<input type="text" value="1"/>	0. No → Skip to K0100, Swallowing Disorder 1. Yes → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900 Number of Falls Since Admission or Prior Assessment Coding Instructions

- Enter a code for each item to indicate the number of falls resulting in that level of injury.
- Code the level of injury for each fall that occurred during the look-back period.
- Code each fall only once.

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent	
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. 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
	<input type="checkbox"/> B. 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
<input type="checkbox"/> C. Major Injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma	

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.

J1900 Scenario #1 Coding

- Code J1900A as 1. One fall with no injury.
- Slipping to the floor is a fall.
- No injury is noted.

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent	
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes
	<input type="text" value="1"/> A. 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
	<input type="text" value="0"/> B. 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
<input type="text" value="0"/> C. Major Injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma	

J1900 Scenario #2

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

J1900 Scenario #2 Coding

- Code J1900C as 1. One fall with major injury.
- The resident received multiple injuries in this fall.
- Code each fall for the highest severity level only.
- Code each fall only once.

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent							
Coding: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes						
	<table border="1"> <tr> <td style="text-align: center; width: 30px;">0</td> <td> A. 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 </td> </tr> <tr> <td style="text-align: center;">0</td> <td> B. 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 </td> </tr> <tr> <td style="text-align: center;">1</td> <td> C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma </td> </tr> </table>	0	A. 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	0	B. 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	1	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
	0	A. 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					
0	B. 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						
1	C. Major injury - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma						

Section J

Summary

Pain Assessment

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

Additional Assessments

- Complete the assessment for additional health conditions.
 - o Shortness of breath
 - o Tobacco use
 - o Prognosis
 - o Problem conditions (vomiting, fever, internal bleeding, potential indicators of dehydration)

Falls

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