Section S Manual

S0120. Residence Prior to Admission

Intent:

To document location the resident's last community address.

Definition:

Prior Primary Residence - The community address where the resident last resided prior to nursing facility admission. A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing facility or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing facility, etc.

Process:

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

Coding:

Enter first five digits of the zip code. Enter one digit per box beginning with the left most box. For example, Augusta, ME 04330 should be entered as

0	4	3	3	0

S0170. Advanced Directive

Intent: To record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending on the resident's condition, multiple options may apply. For example, a resident with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a resident may have executed a limited power of attorney to someone responsible only for legal affairs. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law.

Definition:

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

B. Durable Power of Attorney for Health Care: Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney for health care proxy terms can be revoked by the resident at any time.

C. Living Will: A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

D. Do Not Resuscitate: In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

E. Do Not Hospitalize: A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

F. Do Not Intubate: The resident or responsible party (family or legal guardian) does not wish the resident to have a tube inserted in order to breath by artificial means (e.g., tracheostomy or respirator/ventilator-supported) if unable to breath independently.

G. Feeding Restrictions: The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

H. Other Treatment Restrictions: The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

Z. None of the above

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

• The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.

• If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, do not intubate, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded, but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.

• If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Check all that apply. If none of the directives are verified by documentation in the medical records, check *NONE OF ABOVE*.

S0510. PASRR Level I Screening

Intent: Pre-Admission Screening and Resident Review (PASRR) is not a requirement of the resident assessment process, but is an OBRA provision that is required to be coordinated with the resident assessment process.

Definition: The PASRR Level I screen is the preliminary screen conducted on all persons seeking admission to a Medicaid certified nursing facility (NF) or skilled nursing facility (SNF), to identify individuals with major mental illness, intellectual disability, or other related conditions. Maine requires the completion of a Level I Screen on all people being admitted to an NF, even if the expected length of stay is 30 calendar days or less, as a way of following these individuals in case they remain at the facility for permanent placement, at which time a Level II Assessment may be required.

Coding:

• MDS 3.0 Item S0510 will be on all MDS assessment types.

• A pre-admission screening and resident review (PASRR) is mandatory under federal regulations therefore on admission the response must be yes. In addition to responding yes to MDS 3.0 Item S0510 on admission, you must complete the date of the pre-admission screening in MDS 3.0 Item S0511.

• When you complete your annual or significant change in status assessment and you determine that there has been *new, sudden or exacerbated emotional, behavioral, mental health problems and/or new medications or diagnosis RELATED to mental health or developmental disabilities* that was not known at the time of your last pre-admission screening you will need to complete a pre-screening at this time and refer for Level II review. You will answer yes to MDS 3.0 Item S0510 and record the date of your pre-screening in MDS 3.0 Item S0511.

• If there are *no new, sudden or exacerbated emotional, behavioral, mental health problems and/or no new medications or diagnosis RELATED to mental health or developmental disabilities* since the time of the last pre-screening you will answer no to MDS 3.0 Item S0510 and proceed to the next question.

• MDS 3.0 Item ID S0510 can only be marked not applicable (NA) if you are not a Medicaid certified nursing facility.

• Refer to the RAI User's Manual for information on PASRR requirements related to a significant change in status. The RAI Manual can be found on the CMS website at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp

S0511. PASRR Level I Date: Complete only if S0510 = 1

Intent: To document the completion of a new or changed PASRR level I screening. This item is completed only if S0510 = 1 (Yes)

Process: See S0510, "Coding" for additional information on completing a "changed condition" PASRR.

Coding: Enter the date of the last screening, as appropriate. Enter date as "YYYY-MM-DD"

S0513. PASRR Level I Screening Outcome

Intent: To identify the outcome of the most recent PASRR screening.

Process: The Level I screening process makes only two determinations:

- there is no known or suspected mental illness, intellectual disability or other related condition, or
- there is a known or suspected mental illness, intellectual disability or other related condition.

If the outcome indicates there is a known or suspected mental illness, intellectual disability or other related condition, the outcome is forwarded to the State's PASRR Coordinator.

Coding:

- Code "0" to indicate the completed assessment was sent to the nursing facility with no diagnosis, suspected diagnosis, or need for specialized services.
- Code "1" to indicated the completed assessment was sent to the PASRR Coordinator for determination of need.

Specialized needs specifically related to a resident's weight.

S3300. Weight-based Equipment Need

Intent:

The intent of S3300 and S3305 is to gather information related to the need for specialized equipment or care based on a resident's weight.

Definition: Specialized equipment or care is defined as care that is required for certain residents specifically related to the resident's weight, i.e. residents with morbid obesity, etc.

Process: Review nurses notes, PT/OT notes and recommendations, ADL flow sheets, consult with staff across all shifts for evidence that the resident requires care and/or equipment that is greater than was taken into consideration during standard time study reviews.

Coding:

- Code "0" to indicated this resident did not require specialized equipment since the last assessment or since admission if there were no previous assessments, based on his/her weight.
- Code "1" to indicated this resident required specialized equipment.

S3305. Requirements for Care, Specifically related to Weight

Intent:

To gather information related to the need for specialized equipment or care based on a resident's weight.

Definition: The equipment described below is non-standard equipment that would represent devices for which there was a specialized need due to a resident's weight.

- Lifting device: a specialized, non-standard equipment to assist with moving a resident from one surface to another surface, i.e. bed to chair, etc.
- Wheelchair or mobility device: an oversized, non-standard mobility device used to move a resident from one location to another location.
- Bed: a specialized, non-standard device or piece of equipment where the resident sleeps.
- Seating: a non-standard device used for seating, i.e. oversized chair, etc.
- More than 2 staff: Were 3 or more staff required in providing assistance with activities of daily living, including assistance with the above referenced equipment?
- Other: other specialized, non-standard equipment required to safely care specifically due to the resident's weight

Process: Review nurses notes, PT/OT notes and recommendations, ADL flow sheets, consult with staff across all shifts for evidence that the resident requires care and/or equipment that is greater than most other residents in the facility due to weight or was taken into consideration during standard time study reviews. Care needs would have occurred since the last assessment or since admission if there is no previous assessment.

Coding:

Check all boxes that apply.

S6020. Specialized needs specifically related to a resident's need for a Ventilator/Respirator.

Intent:

To gather information about the care, equipment, and specialized staffing needs for a resident who is dependent on a ventilator/respirator for breathing.

Definition:

- RN expertise: RN with specialized training in the management of ventilator equipment and the care of a resident who is dependent on a ventilator for breathing.
- CNA expertise: resident required care from a CNA who has specialized training
- Therapy expertise: resident required care from a therapist (PT, OT, RT) who has specialized training in the management of ventilator equipment and the care of a resident who is dependent on a ventilator for breathing.
- Equipment: the resident requires specialized equipment that most residents in the facility do not require.
- Other: the resident has specialized needs that do not fit in the above categories.
- Check "none, if none of the categories applies to this resident.

Process: Review nurses notes, PT/OT notes and recommendations, ADL flow sheets, consult with staff across all shifts for evidence that the resident requires care, staff with specialized training and/or equipment that is greater than most residents in the facility specifically due to use of ventilator equipment and was taken into consideration during standard time study reviews. Care needs would have occurred since the last assessment or since admission if there is no previous assessment.

Coding: check all boxes that apply

S6022. Direct care by a Licensed Nurse

Intent: to gather information about the frequency the resident who is dependent on a ventilator/respirator required direct care by a licensed nurse.

Definition:

- Hourly intervals: the number of *days*, during the last seven days, the licensed nurse provided direct care to a resident who is dependent on a ventilator/respirator at least one time every hour.
- 15-minute intervals: the number of *days*, during the last seven days, the licensed nurse provided direct care to a resident who is dependent on a ventilator/respirator at least one time every 15 minutes.
- 5-minute intervals: the number of *days*, during the last seven days, the licensed nurse provided care to a resident who is dependent on a ventilator/respirator at least one time every five (5) minutes.

Coding: Within the last seven (7) days, indicate the number of *days*, the resident required direct care by a licensed nurse at the indicated frequency. Code a number from 0 to 7 to indicate the number of days.

S6023. Direct Care by a CNA

Intent: to gather information about the frequency the resident who is dependent on a ventilator/respirator required direct care by a CNA.

Definition:

- Hourly intervals: the number of *days*, during the last seven days, the CNA provided direct care to a resident who is dependent on a ventilator/respirator at least one time every hour.
- 15-minute intervals: the number of *days*, during the last seven days, the CNA provided care to a resident who is dependent on a ventilator/respirator at least one time every 15 minutes.
- 5-minute intervals: the number of *days*, during the last seven days, the CNA provided care to a resident who is dependent on a ventilator/respirator at least one time every five (5) minutes.

Coding: Within the last seven (7) days, indicate the number of days, the resident required direct care by a CNA at the indicated frequency. Code a number from 0 to 7 to indicate the number of days.

S6024. Direct Care by a Respiratory Therapist

Intent: to gather information about the frequency the resident who is dependent on a ventilator/respirator required direct care by a respiratory therapist.

Definition:

- Hourly intervals: the number of *days*, during the last seven days, the respiratory therapist provided direct care to a resident who is dependent on a ventilator/respirator at least one time every hour.
- 15-minute intervals: the number of *days*, during the last seven days, the respiratory therapist provided care to a resident who is dependent on a ventilator/respirator at least one time every 15 minutes.
- 5-minute intervals: the number of *days*, during the last seven days, the respiratory therapist provided care to a resident who is dependent on a ventilator/respirator at least one time every five (5) minutes.

Coding: Within the last seven (7) days, indicate the number of days, the resident required direct care by a respiratory therapist at the indicated frequency. Code a number from 0 to 7 to indicate the number of days.

Resident Stays Outside of the Facility

S6200. Hospital Stays

Intent: to gather information about the number of times a resident was admitted to a hospital for at least one overnight stay.

Definition: Admitted means the resident was added to the hospital census for active patients; this does not refer to time spent in the emergency room or receiving other

outpatient services.

Coding: code the number of days a resident was considered to be an inpatient client of the hospital for at least one overnight in the last 90 days or since the last assessment if less than 90 days. Enter a two–digit number, between 00 and 99.

S6205. Observation Stays

Intent: to gather information about the number of times a resident stayed overnight for at least one night without being admitted to the hospital.

Definition: an observation stay refers to days spent in the hospital without admitted as a patient.

Coding: code the number of *times* the resident was in the hospital without being admitted (not days), as a single digit number 0 to 9.

S6210. Emergency Room (ER) Visits

Intent: to gather information about the number of times a resident was evaluated or treated in the emergency room (ER) without being admitted to the hospital.

Definition: an emergency room visit refers to time spent in the hospital for evaluation or treatment without admitted to the hospital as a patient.

Coding: code the number of *times* the resident was in the hospital without being admitted (not days), as a three digit number between 0 and 999.

S8010. Payment Source

Intent:

To determine if MaineCare is a payment source(s) that covers the all or a portion for the resident's stay in the nursing facility; determined at the time of the assessment reference date for the MDS assessment being completed.

Definition:

C3. MaineCare per diem

Room, board, nursing care, activities, and services included in the routine daily charge. Do **NOT** check this item if MaineCare is pending. Checking this item means that MaineCare is the primary payer source for this resident's stay in the nursing facility.

G3. MaineCare covers the Medicare Co-pay

MaineCare payment for resident's co-pay during Medicare stay. Checking this item means that MaineCare is the payer source for the Medicare co-pay portion of the resident's stay in the nursing facility.

Process:

The facility must check with their billing office to review current payment sources. Do not rely exclusively on information recorded in the resident's clinical record, as the resident's clinical condition may trigger different sources of payment over time. Usually business offices track such information.

Coding:

Check the payer source that is covering the resident's stay at the time of the assessment. We recognize that many facility staff have difficulty with reporting payment source. To a great extent, the problems are the result of lack of information; business office staff is more aware of payment source(s) than clinical staff.

S8099. None of Above

If none of the listed payment sources apply, check S8099 None of Above.

S8510. MaineCare Therapeutic Leave Days

Intent: To determine the number of therapeutic leave days used by a resident.

Definition: The number of days a resident is away from a nursing facility for a therapeutic purpose. The resident's plan of care must provide for such an absence. Therapeutic leave days would include days spent in a hospice facility. A leave of absence may not be used to extend a bed hold during a hospital stay.

Coding:

S8510A: enter the number of days the resident was out of the facility at midnight for therapeutic purposes since the last assessment (ARD date to ARD date). Enter a two-digit number. If the correct response is zero, enter 00.

S8510B: enter the number of days the resident was out of facility at might for therapeutic purposes since the beginning of the current State fiscal year (most recent July 1 to current ARD date). Enter a two-digit number. If the correct response is zero, enter 00.

S8512. MaineCare Hospital Bed-Hold Days

Intent: To determine the number of bed- hold *days* used by a resident.

Definition: the number of *days* a resident was absent from the facility due to inpatient hospitalization, and the resident was expected to return to the nursing facility.

Coding:

S8512A. Enter the number of *days* a resident was absent from the facility due to inpatient hospitalization since the last assessment (ARD date to ARD date). Enter a two-digit number. If the correct response is zero, enter 00.

S8515B. Enter the number of *days* a resident was absent from the facility due to inpatient hospitalization since the beginning of the current State fiscal year (most recent July 1 to current ARD date). Enter a two-digit number. If the correct response is zero, enter 00.